Compulsory Community Care in New Zealand Mental Health Legislation 1846-1992

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Abstract
Community treatment orders are considered a new development in mental health care and are consistent with current New Zealand mental health policy of care in the community. However, since its first adoption in 1846, New Zealand mental health legislation has always made provision for compulsory mental health care out of hospital. Analysis of the text of each of the five iterations of mental health legislation shows that an initial (1846) provision for a friend or relative to take a committed patient into his or her care, as an alternative to committal to hospital, continued though various revisions until its current expression as a community treatment order. Using Rochefort’s model of change in mental health policy, we argue that a long static period until 1911 was followed by progressive change throughout the 20th century, although provision for compulsory out-of-hospital care has been continuous over the life of New Zealand’s legislation. In the late-20th century, compulsory mental health care is tied to medical treatment and mental health service surveillance of the patient’s social circumstances. We conclude with recommendations for how reformed legislation may contribute to future mental health policy by giving effect to agendas of positive rights and social inclusion.

Keywords
compulsory care, community care, social policy, mental health legislation, community treatment order

What is known about this topic?
Community treatment orders have been introduced in many jurisdictions
Community treatment orders are considered to be a new innovation
Mental health legislation reflects social policy

What this article adds
Since 1846, New Zealand mental health legislation has made provision for compulsory out-of-hospital care
Most people under New Zealand mental health legislation are subject to community treatment orders
Compulsory community care involves mental health service surveillance of patients’ social circumstances, but without a reciprocal responsibility to improve those circumstances

Introduction
Community treatment orders are generally considered a new approach to mental health care and have been subject to intense debate internationally (Lawton-Smith, Dawson, & Burns, 2008; Walsh, 2010). New Zealand and many other jurisdictions have introduced community treatment orders as part of mental health policy commitments to less restrictive care, and to a wider social policy agenda of reduced state intervention. In this article, we argue that notwithstanding the novelty of community treatment orders, they also embody significant historical continuities in social responses to mental illness, and to provision of mental health care. We discuss New Zealand mental health legislation as a component of mental health policy, arguing that the community treatment order is the most recent expression of a long-standing legislative recognition of the place of family and community in mental health care. Understanding the role of legislation in mental health policy is important because “legislation is the driving force through which the modern state defines the structures of health care systems” (Bertolote, Taborda, Arboleda-Florez, & Torres-Gonzales, 2002, p. 79).

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Bartlett (2001) observed that legal sources are underexploited in the history of madness. We found no studies in which the text of mental health legislation served as the primary source of interpretive material. This article therefore takes the text of New Zealand mental health legislation as its data source and uses that material as a window to mental health policy. The focus of our analysis is the text of New Zealand mental health legislation from its first introduction in 1846 to the current 1992 Mental Health (Compulsory Assessment and Treatment) Act (1992). Our aim is to show that current provisions for compulsory treatment orders share significant features with past legislation. In particular, we argue that New Zealand mental health legislation, rather than exclusively directing the mentally ill toward institutions, has always implied a role for family in compulsory mental health care out of hospital. Increasingly, the role of families is enacted alongside that of psychiatry as compulsory care out of hospital. Under current legislation, compulsory community care extends psychiatric surveillance into the private sphere of the home and to the social circumstances of the patient. The almost exclusive focus of current legislation on criteria for committal and procedural protections does little to recognize the positive rights of people subject to compulsion or to promote their social inclusion. In this respect, the 1992 legislation is out of step with contemporary thinking about societal responses to people with mental illness.

Community Treatment Orders

Like many other jurisdictions, New Zealand mental health legislation makes provision for compulsory community-based care (Dawson, 2005). Community treatment orders (and similar legal procedures in non-Commonwealth jurisdictions such as the United States (see O’Brien, McKenna, & Kydd, 2009) generally mandate that the patient receive treatment (usually medication and some form of case management) while living out of hospital or face sanctions such as return to hospital where medication may be given involuntarily. Although there is continuing debate about their effectiveness (Kisely & Campbell, 2007; Molodynski, Rugkasa, & Burns, 2010), in recent years, community treatment orders have been widely adopted internationally. Community treatment orders are used in all Australian states and territories and in most Canadian provinces, although their exact criteria vary between jurisdictions (Gray, McSherry, O’Reilly, & Weller, 2011). Community treatment orders have recently been introduced in Scotland (Lawton-Smith, 2005) and England (Woolley, 2010) and are under consideration in Ireland (Walsh, 2010). Like other aspects of mental health legislation, community treatment orders can be understood as an expression of mental health policy (Kaiser, 2009). In the New Zealand context, community treatment orders were introduced toward the end of the period of deinstitutionalization and form part of the broad policy initiative of community-based care.

New Zealand Mental Health Legislation

Beginning in 1846, New Zealand has seen five iterations of mental health legislation, with each providing out-of-hospital alternatives to institutional care for certified (committed) patients. Although the current 1992 legislation is explicit in mandating compulsory community treatment, rather than simply living out of hospital, its provisions for compulsory out-of-hospital care resonate with those of earlier periods. A summary of the provisions of legislation relevant to out-of-hospital compulsory care is provided in Table 1.

Lunatics Ordinance (1846)

The Lunatics Ordinance of 1846 (10 Victoriae, 21) was New Zealand’s first mental health legislation. This was a brief document of only 15 parts, 1 of which (Section 2) provided for relatives or friends to take a person certified insane “under his own care and protection” provided they guaranteed to two Justices of the Peace or a Judge, the person’s peaceable behavior. The Section 2 provision may have been intended as a limitation on the powers of the state to detain, but it also recognized, while maintaining the person’s legal status as lunatic, a role for compulsory care out of hospital. There was no doubt an additional pragmatic imperative to the New Zealand Section 2 provision, the available hospital resources being very limited in 1846 (Brunton, 2003). A further provision for care outside the hospital setting was contained in Section 4 of the Lunatics Ordinance. Section 4 provided that relatives, guardians, or friends could remove an insane person from an asylum subject to their guarantee, to Justices of the Peace or a Judge, of the security and safe custody of the insane person. It is notable that removal of a patient by relatives did not require that the patient was cured or recovered, suggesting that in 1846, safe containment was paramount over treatment. The required guarantee addressed both public safety and the protection of the individual. The New Zealand provisions for out-of-hospital placement reflected the situation in England and Scotland where out-of-hospital alternatives were seen as a means of reducing demand for asylum beds (Sturdy & Parry-Jones, 1999). Although the Lunatics Ordinance made mention of asylums as a means of disposition, there were no asylums in New Zealand in 1846. Anyone certified insane was detained in a gaol or public hospital (Brunton, 2003). This early legislation set in place a precedent for out-of-hospital compulsory care for certified patients. In this regard, it was different from English legislation which made no provision, at the point of committal, for regulated care out of hospital. There is some similarity to the Scottish legislation, not adopted until 1857, which diverted potential asylum admissions while extending regulatory controls in the form of boarding out (Sturdy & Parry-Jones, 1999). However, the Scottish system was extensive and programmatic, where the New Zealand provision was ad hoc.
Table 1. Legislative Provisions for Compulsory Out-of-Hospital Care in New Zealand Mental Health Legislation 1846-1992.

| Lunatics Ordinance, 1846 | Lunatics Act, 1868 | Mental Defectives Act, 1911 | Mental Health Act, 1969 | Mental Health Act, 1992 |
|-------------------------|-------------------|-----------------------------|------------------------|------------------------|
| **Provisions for out-of-hospital care** | **Legislated responsibility for people subject to committal living in the community** | **Recognition of families and lay caregivers** | **Medical role in out-of-hospital compulsory care** | **Medical role in out-of-hospital compulsory care** |
| Relatives or friends could take a person certified insane “under his own care and protection” provided they guaranteed to a Justice of the Peace or Judge, the person’s peaceable behavior (s2) | Justice of the Peace or Judge | Relatives or friends were legal custodians of people subject to committal living in the community | No medical role |
| Relatives or friends could remove an insane person from a hospital subject to their guarantee to Justices of the Peace or a Judge of the security and safe custody of the insane person (s4) | Justice of the Peace or Judge | License houses were subject to medical oversight | Patient assumed to be living with family |
| A “single lunatic” could be accommodated in a licensed house (s48-s50) | Two Justices or a Resident Magistrate | Patient assumed to be living with family | There was effectively no medical role apart from in the one Licensed House established under the 1868 Act |
| Trial absence (s64) | Licensed houses were subject to medical oversight | Patient assumed to be living with family | There was effectively no medical role apart from in the one Licensed House established under the 1868 Act |
| | Houses of more than 100 required a resident keeper who was a medical practitioner | | |
| | | | |
| Relative or friend could make application to take custody of a committed patient (s66) | Placement of single patient subject to medical approval. | Householder could be a family member | Householder must arrange visits by a medical practitioner. The frequency of visits was at the discretion of the Inspector General |
| A “single patient” could be placed in the care of a householder (s19) | The householder and their premises were subject to Magisterial review as to their suitability | Leave assumed to be with family | Licensed houses subject to medical oversight |
| | | | |
| Provision for licensed houses retained (s45-s63) | Medical superintendent or Inspector General could revoke leave | | |
| Leave of absence allowed for up to 12 months (s80) | | | No medical role in day-to-day supervision or care, but leave could be revoked by a medical superintendent |
| | | | Medical role exercised through home visits, usually by psychiatric nurses, from the hospital base |
| Mental Health Act, 1969 | Provision for “single patient” to be placed with a householder (s38-s40) | Placement of single patients subject to medical approval | Householder could be a family member; reference to medical practitioner as householder removed | |
| | Leave of absence provision maintained. Included provision for readmission (s66) | Leave at the discretion of medical practitioner and could be revoked and the patient returned to hospital | Leave assumed to be with family | |
| | Inpatient on leave replaced leave of absence (s31). | Leave at the discretion of medical practitioner and could be revoked and the patient returned to hospital | Consultation with family or whanau mandatory | Attendance for treatment is a requirement of a community treatment order |
| Community treatment order introduced (s29). | Community treatment order at the discretion of “responsible clinician” who in most cases is a medical practitioner. | Leave assumed to be with family | |

*Whanau* is the Maori word for “family.” Both words are used in the 1999 amendment that provides for family or whanau consultation.
**Lunatics Act (1868)**

Following a period of rapid development of regional asylums (Brunton, 2005), more comprehensive mental health legislation was adopted in 1868. The new legislation followed the establishment in 1852 of an elected system of self-government and fulfilled a recommendation of the 1858 Select Committee for revision of lunacy law (Brunton, 2005). The 1868 Lunatics Act (32 Victoreae, 16) made four provisions for care of certified patients outside institutions. Section 5 followed the earlier Lunatics Ordinance with the provision for a relation or friend to take “such lunatic under his care and protection” provided a Magistrate was satisfied that peaceable behavior, safe custody, and proper treatment were provided. The second provision was for “single lunatics” (Sections 48-50) who could be accommodated in a “licensed house” (Sections 28-47). The licensed house was a new measure that could provide for anything from 1 to more than 100 patients. Section 29 detailed the medical oversight required of licensed houses, including a provision for a resident keeper (a medical practitioner) for houses of more than 100 patients. In the case of single lunatics, Section 50 made explicit provisions for medical oversight and for reporting of any need for restraint. The extensive requirements for reporting, inspection, and record keeping reflected English concerns of the time, when numerous private houses (formerly “madhouses”) comprised a significant component of overall provision for care of the insane (Parry-Jones, 1972). A third provision, contained in Section 64 of the Act, was for trial leave. Under this provision, patients could be absent from an asylum or licensed house if they were under “proper control.” Leave was for a “definite time” but the length of time was not fixed. A final provision that might lead to out-of-hospital care for a committed patient was contained in Section 66. This section allowed a friend or relative to make application to take custody of the patient on condition that the patient was properly cared for and was prevented from harming himself or others. The Act did not specify who would exercise authority over patients discharged under Section 66 and it seems safe to assume care was provided by families. The regulatory control extended to single lunatics reflects similar measures in place in Scotland under boarding out provisions and the 1845 English practice of trial discharge (Bartlett & Wright, 1999). In the New Zealand case, perhaps representing the less developed concerns of the time, when numerous private houses (formerly “madhouses”) comprised a significant component of overall provision for care of the insane (Parry-Jones, 1972). A third provision, contained in Section 64 of the Act, was for trial leave. Under this provision, patients could be absent from an asylum or licensed house if they were under “proper control.” Leave was for a “definite time” but the length of time was not fixed. A final provision that might lead to out-of-hospital care for a committed patient was contained in Section 66. This section allowed a friend or relative to make application to take custody of the patient on condition that the patient was properly cared for and was prevented from harming himself or others. The Act did not specify who would exercise authority over patients discharged under Section 66 and it seems safe to assume care was provided by families. The regulatory control extended to single lunatics reflects similar measures in place in Scotland under boarding out provisions and the 1845 English practice of trial discharge (Bartlett & Wright, 1999). In the New Zealand case, perhaps representing the less developed health infrastructure of a young country, the out-of-hospital regime involved legal rather than medical oversight, although revocation of leave took place under medical authority. While for many patients the 1868 procedures of committal would have meant loss of liberties through confinement to an asylum, the legislation also extended the range of options for compulsory out-of-hospital care and created obligations on caregivers to adhere to minimum standards, to maintain records, and to report to statutory authorities. Most notably, the 1868 Act retained provisions for a relative or friend to provide care for a certified person without medical supervision.

**Mental Defectives Act (1911)**

The Lunatics Act of 1868 was repealed in favor of the Mental Defectives Act (1911) (2 Geo V) and while the new legislation retained provisions for out-of-hospital compulsory care, it also positioned medicine to assume a greater role in those provisions. The option for a Magistrate to authorize a relative or friend to take responsibility for a certified patient, a feature of the 1846 and 1868 legislation, was dropped in 1911. The provision for single lunatics (renamed “single patients”) was retained with the option that a single patient could be placed in the care of a “householder” (Section 19). The Act anticipated that the householder could be a medical practitioner (Section 20), a practice that had been common in England in the 19th century (Parry-Jones, 1972). Placement with a householder was subject to medical approval (Section 19), meaning that for the first time, Magistrates had no independent power to decide disposition. Single patients were also to be visited by a medical practitioner. These provisions extended medical authority beyond the asylum into the community, although Magistrates retained the power to scrutinize householders and their premises for suitability as a place of care for single patients. The 1911 Act introduced the concept of “voluntary boarders” (Sections 39 and 40) suggesting that as early as 1911, the notion of the asylum as exclusively a place of compulsory confinement was already under review. The 1868 provision for trial leave was further defined under Section 80 of the 1911 Act. Patients could be absent for up to 12 months, renewable for 12 months, on the condition that they were “under proper control.” As in 1868, the Act did not specify who would exercise authority over a patient absent on leave, but in the absence of any community-based system of psychiatric care, it must be assumed that this role fell to family members. The leave of absence provision also applied to single patients in the care of a householder. Single patients were permitted up to 28 days leave from their accommodation. Leave could be revoked by medical superintendent or inspector general who, it must be assumed, would be alerted to the need to revoke leave by the householder or family member. The 1911 Act contained no provision for a friend or family member to initiate discharge as the legislation for 1846 and 1868 had done. From 1911, leave and discharge were initiated by and at the discretion of medical practitioners. When the 1911 Act was replaced by the 1969 Mental Health Act, the era of deinstitutionalization had commenced and the notion of “community care” had assumed a prominent place in debate about mental health service provision.

**Mental Health Act (1969)**

The Mental Health Act (1969) was introduced during a period of rapid change in mental health care internationally, and New Zealand was no exception to this process. A Board
of Health Committee inquiry (1957-1960) had foreshadowed deinstitutionalization by recommending an increase in psychiatric services provided by general hospitals, an initiative that reduced reliance on the network of institutions in the provision of mental health care (Brunton, 2005). It could be argued that New Zealand carried deinstitutionalization further than most Western countries, as by the late 1990s, all stand-alone psychiatric hospitals had been closed in favor of small inpatient facilities attached to general hospitals (Brunton, 2013). Although numbers of patients resident in hospitals had been declining since the late 1940s (National Health Statistics Centre, 1973), deinstitutionalization was further advanced by the 1969 Act. The 1969 Act continued existing provisions for compulsory out-of-hospital care, including those for single patients and leave of absence.

A provision for single patients was retained in the 1969 Act (Sections 38-40), although the extent of the provision was much reduced from that of 1911, occupying only a brief, almost perfunctory section. Single patients were placed with a “householder,” but unlike the 1911 legislation, there is no reference to the householder being a medical practitioner. The single small section of the 1969 Act suggests that by 1969, the notion of the “single patient” was becoming anachronistic (Brunton, 1985) especially in light of other changes introduced in the new Act. Schedule I of the Act maintained the provisions for licensed houses (now “licensed institutions”) under medical supervision.

As in the 1911 Act, a patient could be granted “leave of absence” for up to 12 months (Section 66), renewable at the end of that time for a further 12 months. Mental health policy was beginning to focus on community care, and the 1969 legislation gave cautious support to that policy. Services delivered in the community to patients on leave were provided from a hospital base (Ministry of Health, 2006). For many patients, leave of absence consisted of living in a regulated boarding house, many of which had an institutional ambience. It is likely, given the policy of deinstitutionalization, that many more patients were subject to the 1969 leave provisions than had been granted leave under the 1868 or 1911 Acts. Although leave of absence reduced the relationship between committed status and institutional care, it maintained a legislative relationship between patients and their psychiatric caregivers. This relationship was supported by the newly developing psychiatric home visiting services which began in the late 1960s (Robinson, 1972). Where hospital discharge severed the legislative relationship, under leave of absence status, this relationship was maintained and carried the possibility ofrehospitalization. Leave of absence facilitated community living, albeit under psychiatric supervision. Patients on leave could more readily be returned to the hospital by a simple revocation of their leave status (Section 66), a process made easier by the availability of community psychiatric services, further underscoring the role of medical authority over committed patients living outside the hospital.

**The Mental Health (Compulsory Assessment and Treatment) Act (1992)**

The 1969 legislation provided a template for the community treatment order which was to come with the next (and current) iteration of mental health legislation, the Mental Health (Compulsory Assessment and Treatment) Act (1992). The introduction of the 1992 Act saw provisions for single patients and licensed institutions repealed, so that provisions for compulsory out-of-hospital care were consolidated within the provisions for community treatment orders (Section 29) or inpatient on leave status (Section 31). For the first time, mental health legislation referred directly to medical treatment of the person subject to compulsory out-of-hospital care. Section 28 requires that the mental health service provides “care and treatment” and Section 29 requires that the person subject to a community treatment order attends a specified place for that treatment. The Act requires that appropriate services are available and that the social circumstances of the patient permit provision of mental health care. Vestiges of the institutional era remain with the 1992 Act, in the Section 29 provision that patients under community treatment orders are required to attend for treatment by “employees of the specified institution or service.”

The position of inpatients on leave under the 1969 legislation changed little with the introduction of the 1992 Act, which contained a provision (Section 144) for inpatient on leave status to be converted to either a new inpatient on leave status or a community treatment order. In practice, the former provision is little used in most regions, whereas the latter is used in every region (Ministry of Health, 2012a).

Another feature of the 1992 legislation is of interest. Unlike some Australian and Canadian jurisdictions (Gray et al., 2011), New Zealand legislation does not require an inpatient admission prior to the issuing of a community treatment order. A community treatment order can be invoked following a period of compulsory community care which might be provided in the person’s home or some other non-hospital facility. Thus, the 1992 Act allows the entire apparatus of mental health legislation to be operationalized without recourse to a hospital admission.

Following the passage of the 1992 Act and to some extent facilitated by it, reduction in psychiatric hospital beds and the closure of the stand-alone psychiatric hospitals meant that options for long-term inpatient care became scarcer, and shorter periods of inpatient admission became the norm. For those considered to need a longer period of compulsory care, the community treatment order created the means of providing compulsory care in the community thus meeting the policy and legislative requirement for care in the least restrictive environment (Bell & Brookbanks, 2005). As hospital numbers reduced under the new legislation, numbers of people under compulsory provisions remained much the same. Community treatment orders now form an integral part of New Zealand’s mental health services. Inpatient admissions
are usually brief (Abas, Vanderpyl, Robinson, Le Prou, & Crampton, 2006) with community follow-up, in some cases under compulsion, also playing an important role. In 2005, approximately 4,000 people were subject to mental health legislation (Ministry of Health, 2006), compared with the 3,081 reported for 1984 by Dawson, Abbott, and Henning (1987). Allowing for population changes, this represents a comparable overall rate of committal although many of those subject to the current legislation are under compulsion for relatively short periods under the acute care provisions of Sections 11, 13, and 14. Current rates of committal are further discussed in the following section.

**Discussion**

In his analysis of changes in public policy, Rochefort (1988) identified four models of change: static (little change), progressive (consistent improvement), discontinuous (irregular change, shifting objectives), and cyclical (repeat alternation). To the extent that an out-of-hospital provision for committal has formed part of each iteration of mental health legislation in New Zealand, this instrument of mental health policy conforms to Rochefort's notion of static policy, that is, of no change. However, as the above analysis shows, within this context, beginning in 1868, and greatly strengthened in 1911 and 1969, the reach of compulsory psychiatric surveillance has extended from the enclosed hospital to the home of the patient. This gradual change toward a greater medical role in compulsory out-of-hospital care began with the 1868 requirement for medical approval of the placement of single patients in the care of a householder. The medical role was further emphasized through provision for leave of absence initially in 1911 and continued in 1969. Finally, with the community treatment order of 1992, the reach of compulsory psychiatric surveillance, including medical treatment, has extended from the enclosed hospital to the home of the patient. This aspect of change in legislation is more consistent with Rochefort's progressive model of change, in which policy is consistently improved. The claim to "improvement" could be seen as controversial, given debate about the effectiveness of community treatment orders (Kisely & Campbell, 2007) and about their place in mental health care (Lawton-Smith et al., 2008). One would need to agree that an increasing formal role for psychiatry in compulsory out-of-hospital care and a correspondingly reduced formal role for lay people represent improvement, rather than a displacement of informal support systems.

By 1992, provisions for compulsory out-of-hospital care created a legal requirement for medical treatment and statutory monitoring of the patient's social circumstances. The expansion of psychiatric treatment into the community resulted in an almost complete displacement of the family from the position it had in the 19th century as the legal custodian of the committed family member living out of hospital. In the 21st century, notwithstanding that many people subject to compulsory community treatment live apart from their families, families still remain the most likely guarantors of adequate social circumstances, although this is not given legislative recognition. The current requirement that "treatment" is provided, rather than simply a relative's or friend's "care and protection," is an indication that in the 21st century, the psychiatric service system has a greater stake in the lives of people receiving compulsory out-of-hospital care than it did during the institutional era.

The analysis presented in this article does not support a romanticized view that lay people in the 19th century exercised a high degree of autonomy which has been lost within the increased medicalization of the 20th century. The role afforded friends, relatives, and householders in earlier legislation could be abrogated by judicial or medical authority; it has never been entirely autonomous, and there was no legal obligation for family consultation as the 1992 Act requires. Nevertheless, the community treatment order does represent a greater degree of psychiatric surveillance than the provisions for disposition to the care of a friend or relative of the 20th century. The most recent data (Ministry of Health, 2012a) show an increasing use of community treatment orders but no comparable increase in inpatient committals, suggesting the community has become the primary site of psychiatric authority, in contrast to the secondary role it occupied in the institutional era.

The extent and patterns of community mental health care under previous legal regimes has not been a subject of investigation in New Zealand. Given the findings of this study, that legislation has always provided for compulsory out-of-hospital care, this is a topic worthy of research. Brunton (1985) has argued that it is doubtful that extensive use was ever made of provisions for single patients. The extent of use of the 19th-century provision for magistrates' discretion to authorize a friend or relative to provide care and the use of trial leave are also unknown. Nevertheless, if one assumes that the provisions of legislation reflect both the intent of parliament and the practice of social actors, then it is reasonable to expect that the provisions for out-of-hospital compulsory care bear some relationship to how the mentally ill were actually treated. The 1911 provision for trial leave does appear to have been used to a considerable extent, enough to have generated a number of specific registers of such leave, currently held by Archives New Zealand (http://archives.govt.nz/).

**Conclusion**

The community treatment order can be seen as continuous with a theme of compulsory out-of-hospital care running through all five iterations of New Zealand's mental health legislation. This theme is consistent with the role identified by social historians for family and community in the provision of mental health care throughout and following the asylum era. Although not entirely new, the community treatment
order represents a new formalization of an historical arrangement for friends and family to take an active role in the compulsory out-of-hospital care for people subject to mental health legislation, a role that has formed part of New Zealand mental health legislation since its first introduction in 1846.

Rochefort’s (1988) model of change in mental health policy provides a helpful heuristic in examining change over time, in this case in mental health legislation. Where authors such as Allderidge (1979) and Scull (1975) have noted similarities in mental health care from one period to another, their analysis is limited by examining models of care that were prominent at particular points in time, rather than considering how those models might have continued, without overt emphasis, over periods where their influence was less obvious. As this analysis shows, Rochefort’s concept of progressive change as “consistent improvement” may be more applicable if “progressive” is interpreted to mean “consistent change” toward a particular policy direction. In the case of compulsory out-of-hospital care, this direction is toward increased medical authority.

In a comparison with other Commonwealth countries, current New Zealand legislation has been favorably assessed by Fistein, Holland, Clare, and Gunn (2009) and it does not seem unreasonable to suggest that care in the community, albeit under the legal auspices of a community treatment order, really is an improvement over confinement in an institution. However, that conclusion must be tempered with a recognition that the community treatment order is an intrusive measure, as it extends psychiatric authority into the private sphere of the home. What is more, the exclusively medical model of mental health care implicit in the community treatment order provides no specified entitlement to services, social support, general health care, accommodation, or any of the other resources that might reduce the impact of mental illness. In the institutional era, these services and resources were guaranteed, implicitly if not in their actual provision, by committal to hospital.

Current mental health policy continues to emphasize community-based care and services “closer to home” (Mental Health Commission, 2012), for example, through a greater role for the primary health sector in providing care for people with enduring mental illness (Ministry of Health, 2012b). To the extent that the current Act is compatible with that policy direction, it is unlikely to be revised in the foreseeable future. However, as in the institutional era, when legislation came to be seen as out of step with contemporary thinking about mental health care, the current legislation does not seem equal to the purpose of promoting social inclusion for people with mental illness or of promoting positive rights. Where the response of the institutional era was to persist with a long-standing pattern of continuous change toward increased medical authority to facilitate community care, the current period may need what Rochefort (1988) termed discontinuous change to reduce medical authority, recognize positive rights, and promote social inclusion.

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Note
1. New Zealand’s mental health services have historically relied on public rather than private provision, and Brunton (1985) has argued that only one license for a “private house” was ever issued following the 1868 legislation. That establishment, Ashburn Hall, remains as a private provider of mental health services (Duder, 2007).

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