HAYLEY S MACDONALD

# COMPULSORY TREATMENT ORDERS UNDER THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992

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# ABSTRACT

The Mental Health (Compulsory Assessment and Treatment) Act 1992 brought into effect major changes to New Zealand's mental health laws. These changes are the product of a long period of gestation.

The Act deals only with those patients who are deemed in need of compulsory care and treatment. At the core of the Act lies the compulsory treatment order.

Part One of the paper examines in detail the criteria which must be satisfied before a court may impose a compulsory treatment order.

Part Two reviews the mechanisms for review which achieve significance after a compulsory treatment order has been imposed.

Part Three discusses the type of compulsory treatment order in favour of which there exists a presumption - the community treatment order - and the theory behind its creation.

The writer concludes that a number of the provisions establishing and relating to the compulsory treatment order, though much improved, are to varying degrees of seriousness defective and in need of amendment.

The text of this paper (excluding contents page, footnotes, bibliography and annexures) comprises approximately 17,000 words.

# INTRODUCTION

The enactment of the Mental Health (Compulsory Assessment and Treatment) Act 1992 is a significant step for New Zealand mental health law. Although a substantially original piece of legislation, it follows international trends in reforming mental health laws to accommodate civil rights concerns and to attempt to provide greater protection to those persons subject to coercive State powers by reason of their mental state.

The new provisions bring with them new terminology. Reception orders have been replaced by compulsory treatment orders and committed patients are now patients subject to compulsory status.

The doctrine of the least restrictive alternative, although not expressly enacted, represents the broad ideology and motivation behind the Act. The Act's compulsory powers are to be invoked as a last resort only.

More specifically, the doctrine also permeates the mechanisms within the Act. The imposition of a compulsory treatment order is not taken lightly. A new definition of mental disorder is laid down in an attempt to clarify and narrow the class of persons whose rights the State is justified in breaching. Imposition of a compulsory treatment order is not automatic upon satisfaction of the definition. The court must also be satisfied that, in all the circumstances of the case, such an order is necessary.

Mechanisms to determine whether the order continues to be justified have also been enacted in the form of more comprehensive avenues for ongoing review of the patient's status.

Perhaps the most overt embodiment of the least restrictive alternative doctrine is the creation of the community treatment order. Its enactment creates a



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presumption, when compulsory treatment is required, in favour of the patient's care and treatment in the community.

This paper will examine these three statutory embodiments of the least restrictive alternative doctrine, that is, the imposition of a compulsory treatment order, the review or removal of a compulsory treatment order and the likely form of a compulsory treatment order - a community treatment order.

Due to the fact that the Act is unique and still in its infancy, the relevant case law is limited. That which is relevant will be examined. The primary focus will of necessity, however, be on a close examination of the legislative provisions.

The legitimacy of compulsory treatment will not be challenged. The paper will be based on the assumption that it is, in some instances, a necessary part of mental health practice.

# PART ONE

# THE IMPOSITION OF A COMPULSORY TREATMENT ORDER

## 1 Introduction

Under the Mental Health (Compulsory Assessment and Treatment) Act 1992 ("the Act" or "the MH(CAT) Act 1992"), anyone who is 18 years of age or older may make an application to the Director of Area Mental Health Services[1] for the assessment of any person whom they believe to be mentally disordered.[2] A detailed assessment and treatment procedure may then be undertaken. This procedure contains extensive safeguards for the person alleged to be mentally disordered.[3] If, upon the conclusion of that procedure, it is found that the person requires further treatment, the responsible clinician ("RC")[4] must apply to the court[5] for a compulsory treatment order.

Before a compulsory treatment order may be imposed on a person, the court must be satisfied that:

a) the person concerned suffers from a mental disorder; and

b) a compulsory treatment order is necessary in all the circumstances of the case.[6]

Each of these limbs will be examined in turn.

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[1] Defined in s2(1) as amended by the Fourth Schedule to the Health Reforms (Transitional Provisions) Act 1993.

[2] Section 8.

[3] The assessment procedure will not be dealt with due to space constraints. Appendix A outlines the procedure in diagram form.

[4] 'Responsible clinician' is defined in s2.

[5] In s2, 'Court' means a District Court.

[6] Section 27.

## 2 The Definition of Mental Disorder

### A Introduction

The meaning of mental disorder is a core component of the Act. Its definition provides the initial threshold which must be reached before the possibility of the imposition of compulsory treatment and its resultant loss of basic human rights arises. When viewed in this way, the importance of a clear and appropriate definition of what constitutes a mental disorder is obvious.

Attempts at definition have, however, proved problematic for legislative drafters both here and overseas. The term 'mental disorder' potentially encompasses a broad range of possible disorders. Indeed, the purpose of the Act is to catch all types of mental illness which meet the particular criteria. Too great a degree of specificity is not possible without defeating this purpose. On the other hand, too vague or broad a definition is undesirable in an Act which is also an attempt to minimalise coercion. Due to such difficulties, mental disorder has been left without statutory definition in many jurisdictions.

New Zealand mental health laws have, however, always contained a definition of some sort. Under the Mental Health Act 1969 (which was repealed by the 1992 Act), mental disorder was defined as:[7]

> "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 mental illness;

[7] Section 2.

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."

The above definition was extremely wide. In addition to those suffering from psychiatric illnesses, it clearly encompassed the intellectually disabled. Further, the definition of 'mentally ill' was a circular one, that is, the meaning of the term 'mentally ill' was explained by almost exclusive reference to itself.

The 1992 Act introduces a completely new definition of mental disordered and one that is unique to this country.

Section 2 states that a mental disorder is:

> "an abnormal state of mind, whether of a continuous or an intermittent nature, which is characterized by delusions or by disorders of mood, volition, cognition or perception of such a degree that it
>
> a) poses a serious danger to the health or safety of the person or of others; or
>
> b) seriously diminishes the capacity of the person to take care of himself or herself;
>
> and 'mentally disordered', in relation to any such person, has a corresponding meaning."

There are 2 separate limbs of the definition which must be satisfied before a person can be deemed to be mentally disordered. These have been described as the qualitative limb and the quantitative limb.[8]

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[8] NZ Parliamentary debates Part 38, 1992: 6860, 6861-6862.

The first limb requires an 'abnormal state of mind'. This may be continuous or intermittent and must be represented by "specified symptoms or phenomena".[9] The second and quantitative limb lays down the "resultant outcomes"[10] which must be produced by this abnormal state of mind. These outcomes are expressed in terms of serious danger to others or serious danger to or diminished capacity for care of the person labouring under the abnormal state of mind himself/herself. Therefore, an abnormal state of mind or what may be considered in common parlance to be a 'mental illness' is no longer sufficient to bring a person within the definition of mental disorder. The definition is much more than a diagnosis of mental illness. Although terms contained in the first limb still leave much scope for interpretation,[11] the second limb has, at least in theory, a considerable narrowing effect on the definition. Resultant outcomes are actually incorporated into the definition of mental disorder. The new definition also escapes the internal circularity of the previous one.

Describing mental disorder in terms of its characteristics rather than breaking it down into particular categories should also simplify determinations as to whether a mental disorder exists for non-medical decision-makers under the Act.

In contrast to the position under the 1969 Act, the State now has no power to deal compulsorily with the confused elderly or the intellectually disabled simply by reason of the existence of that status.

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9 New Zealand Law Society Seminar *The Mental Health (Compulsory Assessment and Treatment) Act 1992*. Leaders: John Dawson, Dr Jeremy Anderson, Stephen McCarthy, Feb-March 1993, p 20.

10 Above n 9.

11 See below Part One, No 2B (i) and (ii) for a discussion of these terms.

This division of psychiatric illness and intellectual disability reflects attitudinal and policy changes towards the two groups. Intellectual disability has become "more associated with educational, welfare and disability services and legislation"[12] while the current concern in the psychiatric area is to focus on treatment and recovery.

One of the key objectives of the new Act is to prevent prolonged and unnecessary detention or constraints thereby minimising the infringements on an individual's civil liberties. The condition of the intellectually disabled or those who are deteriorating mentally due solely to the aging process is not likely to improve through compulsory detention and/or treatment. Dealing compulsorily with these people is therefore incongruous with this objective.

Under the previous Act, a different definition of mental disorder applied to those under the age of 18. The same definition now applies to everyone.

**B The Component Parts**

**(i) *Abnormal State of Mind***

'Abnormal state of mind' is not itself statutorily defined. Although the decision whether to impose a compulsory treatment order and, therefore, a determination as to the presence or absence of an abnormal state of mind is a judicial decision, it may be expected that such a determination would nevertheless be made in reliance on medical opinion. Dawson[13] states that there is no doubt that the phrase encompasses the major psychotic mental

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[12] Brunton, Warwick "Mental Health Law in New Zealand: Some Sources and Traditions" in Abbott, M and Dawson, J (eds) *The Future of Mental Health Services in New Zealand: Mental Health Law, Volume 1 of the Edited Proceedings of Mental Health Foundation of New Zealand's 1985 Conference* (1985, Mental Health Foundation of New Zealand, Parnell, Auckland) p 51.

[13] Above n 9, p 21.

illnesses (such as the schizophrenias, major depression, paranoia and mania) and the major organic mental disorders.[14] Its meaning, however, is not linked to any "diagnostic system or nomenclature". It was for this reason that Judge McElrea in *R* v *T (a mental patient)*[15] felt able to conclude that intellectual disability ('mental retardation' was accepted in the case as the preferred terminology and will be the terminology employed in the paper from this point) is an abnormal state of mind. This was despite contrary expert opinion that mental retardation is not a 'state of mind' at all. The Judge emphasised that, because the legislative definition does not consist of established medical terminology,[16] the Court must interpret the section in accordance with ordinary parlance and not in a narrow or technical sense. He held that, on the ordinary meaning of the words 'an abnormal state of mind' includes an unusual condition of the mind.

It is undoubtedly true that the legislature did not intend the courts to ascribe technical, medical meanings to the terms comprising the definition. 'Mental disorder' is a legal creation to be given a legal interpretation. With respect, however, the writer believes that there is a danger in making general statements in respect of provisions legitimising coercion to the effect that they should not be construed narrowly. Statutory provisions which restrict basic human rights must be read in a way which causes the least possible restriction of those rights.[17]

The definition of mental disorder states that the abnormal state of mind may be *of a continuous or an intermittent nature*. This element acknowledges that

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[14] Above n 9, p 21.

[15] *R* v *T (a mental patient)* (1993) 10 FRNZ 195. For a detailed discussion of the case, see below Part One, No 3.

[16] See below Part One, No 2B (ii), p 10.

[17] This statement is consistent with the approach taken in s6 NZBORA.

a mental disorder may not be a constant, unchanging condition. It ensures that the definition does not cease to apply to those who remain mentally ill and who continue to require compulsory treatment but who have temporarily ceased to exhibit outward signs of their mental illness. There is a danger here, however, that a person who is currently deemed to be 'in remission' from their abnormal state of mind may, while in that state, be brought for the first time within the arms of the definition. This gives rise to the possibility that those persons may be detained effectively on the basis of danger or diminished capacity for self-care. There is a safeguard against this, however. Even if the person is deemed to be mentally disordered by reason of an intermittent abnormal state of mind which is between 'episodes' at the time of the application for the compulsory treatment order, it must further be established that a compulsory treatment order is necessary in all the circumstances of the case.[18] A judge is unlikely to be satisfied of this if no outward signs of mental illness exist.

**ii)** ***Delusions/Specific Disorders***

The definition of mental disorder requires that the abnormal state of mind be characterised by delusions or by disorders of mood, cognition, volition or perception. These terms, like the others contained in the definition of mental disorder, are not based specifically on any psychiatric diagnostic criteria, for example, the DSM-III-R[19] or ICD-10:[20] "[T]his definition of mental disorder has created some confusion amongst psychiatrists, particularly because some of its language is not their usual language."[21]

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[18] See below Part One, No 5.

[19] The American Psychiatric Association's Diagnostic and Statistical Manual, 3rd ed, Revised.

[20] World Health Organisation's International Classification of Diseases, 10th Revision.

[21] Above n 15, p 202.

Some of the terms better correspond with medical terminology than others. For example, in *R* v *T (a mental patient)*[22] ". . . an experienced and respected psychiatrist . . . was not very familiar with the term 'disorders of cognition', and did not know what the Act meant by a 'disorder of volition'." These terms, as legal creations, or, if based on medical usage, as parts of a legally created definition of mental disorder, will depend on cases coming before the courts for their interpretation. Where a medical meaning exists, courts are more likely to give weight to such a meaning but the final determination will always rest with the court: "Such a decision is not in the ultimate made by the psychiatrists who give the evidence but by the judge who in the particular case is required to weight it."[23]

The meaning of 'disorder of cognition' has arisen for consideration in the courts. In the *T* case, the Judge accepted the medical evidence that "[t]he way that psychiatrists view cognition is in the ability to think, remember, attend and have ability for abstract thought. Orientation also comes within the ambit of cognition and adaptiveness as measured by IQ ratings is a cognitive measure . . ." and held that mental retardation is a disorder of cognition.

It has been suggested that it is particularly important to distinguish memory and orientation problems present in some elderly persons from true cognitive deficits which are attributable to organic disorder.[24]

Until further cases on the meaning of 'mental disorder' and hence its elements come before the courts, only speculation is possible regarding the meanings and boundaries of these terms.

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[22] Above n 15, p 203.

[23] Gallen J in *Re M* [1992] 1 NZLR 29, 42.

[24] Above n 9, p 57.

'Delusions' are probably the least contentious of the terms. The meaning of delusion is generally accepted, in psychiatry at least, as false beliefs comprising three elements. These are:[25]

(i) absolute conviction in the false beliefs by the person holding the beliefs;

(ii) the beliefs must not be amenable to rational argument or objective evidence to the contrary;

(iii) idiosyncracy, that is, other members of the individual's social, cultural or religious group do not share that belief.

Delusional beliefs are often absurd, for example, persecution, or impossible, and the individual's occupation with them often excludes other mental activity.[26]

It would seem that disorders of mood, volition or perception would not be difficult to establish if mood, volition and perception are given their ordinary dictionary meanings.

What may save too many persons from being caught by the definition of 'mental disorder' is not these terms but rather the resultant outcomes required from such conditions.[27] The potential width attributable to them on their ordinary meanings may, however, increase the reach of 'mental disorder' wider than was intended.[28]

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25 Above n 9, p 53.

26 Above n 9, p 53.

27 See below Part One, No 2B (iii), (iv) and (vi).

28 See the comments on the possible use of 'disorder of volition' in Part One, No 4B.

### (iii) *'Of Such A Degree'*

The abnormal state of mind must be *of such a degree that it* poses danger or seriously diminishes capacity for self-care. In other words, an abnormal state of mind and, for example, danger to others may co-exist but still not satisfy the definition of mental disorder. On the wording of the section, the danger or diminished capacity must actually result from the abnormal state of mind.

The practical effect of the need for a link between an abnormal state of mind and the presence of danger may frequently be minimal. It will be rare, for example, that threatening behaviour or a demonstration of violent tendencies of some sort by a person found to have an abnormal state of mind characterised by delusions etc . . . will be seen as a result of general criminal tendencies rather than that state of mind.

The link may, however, be useful in a situation involving a person with a minor mental retardation[29] who is threatening violence where the cause of the threats is clearly unrelated to that disability. The wording prevents their detention for no reason other than that they may commit an offence. The compulsory powers of the mental health regime were not intended nor designed to be put to such effect nor could such a use be justified.

The need for the connection assumes a strong practical significance in relation to a seriously diminished capacity for self-care. The capacity of a person with an abnormal state of mind to take care of himself/herself may be diminished not by that state of mind, but clearly by some form of physical disability (for example, paralysis).

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[29] See discussion on *R* v *T* (above n 15) in Part One, No 3 as to whether mental retardation can be mental disorder.

Establishing that the cause of the seriously diminished capacity for self-care is physical disability rather than an abnormal state of mind is less difficult than establishing that the cause of the danger, rather than the abnormal state of mind, is simply violent tendencies. This is because of the visibility of a cause like physical disability.

The required link does not prevent the possibility that a mentally retarded person who, as a result, has a seriously diminished capacity for self-care may be caught by the definition of mental disorder if it is accepted that mental retardation may satisfy the definition.[30]

**iv) *Dangerousness***

The second limb of the definition of mental disorder may be satisfied if the person concerned poses a serious danger to his/her own health or safety or to that of others.[31] This is the first express use of the word 'danger' in New Zealand as part of the criteria for compulsory status. Previous committal criteria did, however, contain an implicit concept of dangerousness, although not as part of the actual definition of mental disorder. To be committed under the 1969 Act, it had to be shown not only that the person concerned was mentally disordered,[32] but also that detention was required either for his/her own good or in the public interest. It could be said to be 'in the public interest' that mentally disordered persons be committed and compulsorily treated in the sense that society has an interest in seeing its members in a state of the best possible health. A broad interpretation of this nature would, however, render the alternative previous committal criterion, that is, that committal be for the person's own good, superfluous. This is because committal 'in the public interest' in the abovementioned sense would also be

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[30] Above n 29.

[31] Danger to property is, therefore, excluded.

[32] See 1969 definition of mental disorder in Part One, No 2A.

for the good of the person concerned. Moreover, the words 'in the public interest', although potentially broad, have been interpreted to mean requiring committal to prevent no less than serious physical violence.[33]

In *Re M*,[34] the patient had been detained in hospital under a reception order for several years following threats to kill both himself and a woman with whom he was obsessed. He had also previously been convicted on a number of fairly minor charges. He was being detained on the basis that he was mentally disordered and that his detention was required in the public interest.

Gallen J accepted that detention could only be justified in the interests of the public "on grounds which were serious enough to be categorised as predicting dangerousness or something at least comparable in seriousness."[35] Previous violent actions may be an indicator but potential dangerousness must be assessed from the person's present state of mind and ". . . in particular the possession of a particular outlook which is thought likely to give rise to unacceptable behaviour."[36] That unacceptable behaviour must be ". . . no less than serious physical violence."[37] The potential for behaviour which amounts to, for example, a nuisance or which is unacceptable to a particular governmental philosophy[38] is not sufficient to constitute dangerousness. A danger to others or serious physical violence was, therefore, previously required to detain someone 'in the public interest'.

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33 Above n 23, p 38.

34 Above n 23.

35 Gallen J in *Re M* [1990/91] 7 CRNZ 390, 400. (This is a different reported version of the case at above n 23.)

36 Above n 35.

37 Above n 35.

38 Above n 23, p 39. Note also that a person is not mentally disordered by reason only of his/her political opinions, below Part One, No 3.

A 'dangerousness' criterion was widely applied in nineteenth century English mental health legislation[39] and remains implicit in current British legislation.[40] It is currently used in the context of committal criteria in many jurisdictions.[41]

It has been suggested that the original connection between dangerousness and psychiatry ". . . can be traced through shared precarious living conditions of the mad and bad in nineteenth century Europe."[42] The link is certainly a tenuous one which is exaggerated by sensationalist publicity when incidents do occur. The proportion of psychiatrically ill persons who are dangerous is greatly overestimated.[43] (The Mason Report[44] stressed that the connection between mental illness and dangerousness is not a universally shared perception outside Western culture.) This fact in itself should not prevent its use as a criterion for committal, however, under a regime which is trying to limit the use of compulsory powers to those persons on whom their use is absolutely necessary.

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39 Soothill, K et al "Compulsory Hospital Admissions: dangerous decisions?" (1990) 30 Med Sci Law 17, 18.

40 Section 3(2)(c) Mental Health Act 1983 (UK).

41 For example, implicit in s20 Mental Health Act 1963 (Tasmania).

42 Above n 39, p 17.

43 For example, see Haines, Hilary and Barton, Richard *Alternatives to Psychiatric Institutionalization* (1984, Mental Health Foundation of New Zealand, Parnell, Auckland) p 28.

44 *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* ("The Mason Report") (New Zealand, August 1988).

The propriety of the use of dangerousness as a justification for compulsory status is, though, highly contentious and the literature on the topic is extensive.[45]

In 1974, Diamond launched a strong attack on its use in this context.[46] His assertion was that there is no scientifically reliable method for predicting dangerous behaviour[47] and he argued that psychiatrists over-predict dangerousness ". . . by a factor somewhere between 10 and 100 times the actual incidence of dangerous behaviour."[48] The reasons for this are obvious. An over-prediction of danger will be difficult to ascertain because there is no way to know whether the later absence of any dangerous behaviour is due to the compulsory status or whether it would not have occurred anyway. On the other hand, the results of a mistaken prediction of absence of danger will be obvious and may expose those responsible for the error to extreme criticism. Erring on the side of over-prediction, therefore, becomes attractive to those whose duty it is to form an opinion as to whether a person poses a danger.

Diamond concluded that psychiatrists are not able ". . . to predict the occurrence of violent behaviour with sufficient reliability to justify the restriction of freedom of persons on the basis of the label of potential dangerousness."[49]

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[45] For example, Levy, A et al "The Dangerous Psychiatric Patient Part 1: Epidemiology, Etiology, Prediction" (1989) 8 Med Law 131; Mullen, P "Dangerousness and Mental Disorder" in *Mental Health: A Case for Reform* (Legal Research Foundation Inc, 5 September 1986) p 123.

[46] B Diamond "The Psychiatric Prediction of Dangerousness" (1974) 123 Univ of Pennsylvania Law Rev 439.

[47] Above n 46, p 451.

[48] Above n 46, p 447.

[49] Above n 46, p 451.

On an application for a compulsory treatment order in New Zealand, any final determination of dangerousness is made by a judge rather than a psychiatrist. The judge may, however, ask for a report on the patient's condition from any person he or she considers qualified to do so.[50]

Although Diamond's discussion was confined to psychiatric predictions of dangerousness, the same arguments regarding the inability to predict could be made even more strongly in relation to others called upon to determine the dangerousness of a person suffering from an abnormal state of mind. This is because, if anybody, highly trained and qualified psychiatrists are in the best possible positions to make such judgments. Greig J in *Re M*[51] stated that although the decision and the responsibility for a determination of mental disorder rests with the judge, ". . . he cannot have the knowledge, training or experience to say whether a person is suffering from a psychiatric disorder or whether that substantially impairs his mental health. In those areas the judge must rely on those who have that knowledge and experience."[52]

Diamond recommended that psychiatrists should be called upon to do no more than give their opinion as to whether dangerous behaviour is a consequence of, or related to, the existence of mental illness once appropriate legal authority has declared a person dangerous on the basis of demonstrated violent behaviour. This recommendation does not eliminate the concept of dangerousness as a precondition for compulsory status but merely shifts the burden for its determination elsewhere. It does not remove the problems inherent in its definition and prediction which Diamond highlighted. Demonstrated violent behaviour does not necessarily make future violent behaviour sufficiently likely to justify compulsory status. Conversely, the

[50] Section 21.

[51] *Re M* Unreported, 21 April 1986, High Court Wellington Registry M716/85.

[52] Above n 51, p 14.

undesirability of postponing action until violent behaviour has occurred is evident.

The fact that the dangerousness criterion is so widespread despite numerous and ongoing criticisms of its use, however, indicates that it is perhaps the best option available to limit those caught by compulsory powers.

An assertion of dangerousness does not provide a satisfactory indication of the behaviour which constitutes it. As stated above,[53] Gallen J in *Re M*, in dealing with the phrase 'in the public interest', held that there must be a danger of no less than serious physical violence. The writer suggests that a more appropriate interpretation of the dangerousness requirement is a danger of no less than serious physical *harm*. Focusing on the result of behaviour rather than the behaviour itself means that, in addition to danger of actions involving serious physical violence, danger of actions which do not fit the description of violence in everyday usage but which result in physical harm, for example, poisoning, or the neglect of children, will be caught. There is certainly room for such an interpretation of dangerousness on the face of the words of the new definition. The Mason Report went even further and accepted that of dangerousness be equated with the propensity to cause serious physical injury or lasting *psychological* harm.[54]

Requiring a danger of serious physical violence to justify the imposition of compulsory status[55] is consistent, however, with the approach taken in section 5 Criminal Justice Act 1985 which contains a presumption of imprisonment for

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[53] At p 15.

[54] Above n 44, p 208.

[55] Unless, of course, a seriously diminished capacity for self-care is established, see below Part One, No 2B (vi).

only those offenders who use serious violence.[56] Under that section, courts look at the actions themselves to determine whether serious violence has occurred. The outcome of the actions in terms of physical harm is irrelevant to the application of the section.[57]

A different approach in relation to the mentally ill is arguably justified, however, on the following grounds. Although both the MH(CAT) Act 1992 and section 5 Criminal Justice Act 1985 are concerned with imposing particular restrictions on the freedom of those who are a danger to society, the objectives of the two in this regard are different. The purpose of the inclusion of the dangerousness element in the definition of mental disorder is to enable (through compulsory treatment) the protection of others. The focus in relation to dangerousness should, therefore, be on the potential for harm. Although incarceration of offenders also protects the public, an important aim and raison d'être of section 5 Criminal Justice Act 1985 is the deterrence of violent behaviour. This justifies the focus on the offender's actions. The rationale for the difference in focus lies in the existence of the capacity to reason in a non-mentally disordered person and therefore the possible effectiveness of deterrence. Further, the actions of a mentally ill person which do not constitute an offence and which demonstrate no such potential for harm cannot easily be described as causing serious danger.

**(v) *The Seriousness Element***

The inclusion of the word 'serious' seems, prima facie, to imply a difference between 'danger' and 'serious danger'.

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[56] Or just violence when an offender has previously been convicted on at least 1 occasion within the preceding 2 years of an offence punishable by 2 or more years in prison - s5(2) Criminal Justice Act 1985.

[57] *R* v *Dunn* Unreported, 9 May 1989 CA 113/89.

Such a distinction sits more comfortably with the word 'violence' than the word 'danger'. Although the boundary is not clear, there can clearly be actions which constitute serious violence and other actions which constitute violence only. The focus is on the magnitude of the violence. (This is to be distinguished from the fact of the existence of violence being a serious matter.)

In terms of magnitude, it is more contrived, however, to label some actions as constituting a danger to the health and safety of a person and others as constituting a serious danger to his/her health and safety.

The writer suggests that the intention of the legislature in including the word 'serious' was simply to allow compulsory status to be imposed on people when a reasonable possibility of danger exists, that is, 'serious danger' should be read as meaning 'a serious chance of danger'. It is suggested, therefore, that it is not the magnitude but the likelihood of danger which is at issue. Magnitude is relevant when looking at what there must be a danger of, that is, 'serious physical violence' as Gallen J stated, or 'serious physical harm' which the writer has advocated as more appropriate. This is consistent with the suggestion made in *Re O*[58] that 'serious' in this context means imminent or demonstrable.

**(vi) *Seriously Diminished Capacity for Self-Care***

The quantitative limb of the definition of mental disorder may also be satisfied if the abnormal state of mind of the person in respect of whom an application for a compulsory treatment order is made is of such a degree that it seriously diminishes the capacity of that person to take care of himself/herself.

The use of the word 'diminishes' is interesting. It seems to imply a standard relative to the person's usual ability to care for himself/herself rather than

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[58] Judge Boshier in *Re O* [1993] NZFLR 545, 546.

some sort of generally accepted standard of self-care. It is suggested that not too much can be read into this, however, and that the section equates to a particular and low, although undefined, level of self-care.

Which aspects of life self-care refers to is not clear. Obviously, the ability to maintain the basic needs of life such as food, clothing and shelter[59] (or presumably, at least recognise and attempt to fulfil these needs in times of financial hardship) constitute self-care in this context.

Dawson[60] argues that failing to take medication when it is needed may show a seriously diminished capacity for self-care. The problem with such an approach, however, is that the need for enforced medication and therefore compulsory status is only established once the definition of mentally disordered is satisfied[61] - the need for these is not a requirement of the definition itself. There is a danger of circular reasoning in the suggestion that a person has a seriously diminished capacity for self-care and therefore requires compulsory status/treatment because the person needs to be forced to take his/her medication.

Self-care must, however, be referring to something more than the basic necessities of life. Neglect of these would undoubtedly constitute a serious danger to the health or safety of the person concerned and hence would satisfy part (a) of the quantitative limb. Part (b) would, therefore, be rendered superfluous if it is not able to be interpreted more expansively. Although not the subject of argument because a serious danger to others was established, Judge McElrea in *R* v *T*[62] suggested that self-care encompassed the regular

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[59] Judge Keane in *Re C* Unreported, 14/15 June 1993, District Court Porirua Registry.

[60] Above n 9, p 29.

[61] And that in all the circumstances of the case a compulsory treatment order is deemed necessary.

[62] Above n 15. See below Part One, No 3 for an examination of the case.

taking of insulin for T's diabetes. Such an interpretation appears uncontentious.

There are dangers, however, in interpreting self-care too expansively. Although only obita, Judge Boshier in *Re O*[63] suggested that self-care may embrace the spiritual as well as the physical. It is the writer's view that acceptance of self-care as more than physical care would inject too great an element of subjectivity into the definition.

An individual's ability to take care of himself/herself depends to a certain extent on his/her relationships with family and friends. Even if the capacity for self-care is not examined against a backdrop of the individual's available current support, such support may be taken into account in deciding whether to impose a compulsory treatment order.[64]

Satisfaction of the definition of mental disorder depends on the individual's *capacity* to care of himself/herself. The focus is therefore on the individual's ability to do this rather than on any use of that ability or fulfilment of that care. The fact that an individual is neglecting his/her self-care may be evidence of a seriously diminished capacity to do this but it can be no more conclusive than this.

## 3 Exclusions

Section 4 provides that a person shall not be subject to the compulsory assessment and treatment procedures *by reason only of*:

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63 Above n 58, p 547.

64 See below Part One, No 5.

a) That person's political, religious, or cultural beliefs; or

b) That person's sexual preferences; or

c) That person's criminal or delinquent behaviour; or

d) Substance abuse; or

e) Intellectual handicap.

That section excludes persons from liability to assessment and treatment under the Act by reason only of certain characteristics and preferences they may have which are unrelated to the presence of any mental illness.

Section 4 is partially based on a provision in the Mental Health Act 1983 (UK). That provision is slightly different from this one in that the UK exclusionary rules are contained in the section which defines mental disorder and therefore are "specifically linked"[65] to their definition of mental disorder.

Section 4 complies with the World Federation for Mental Health Declaration on Human Rights and Mental Health to which New Zealand is a co-signatory and which provides:

> 'Whereas a diagnosis of mental illness by a mental health practitioner shall be in accordance with accepted medical, scientific and ethical standards and difficulty in adapting to *moral, social or political or other values in itself shall not be considered a mental illness* . . .' (emphasis added)

Factor (a) also complies with section 13 of the New Zealand Bill of Rights Act 1990 ("NZBORA") which provides that:

> "Everyone has the right to freedom of thought, conscience, religion, and belief, including the right to adopt and to hold opinions without interference."

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[65] Above n 9, p 30.

The rationale behind the inclusion of Factors (c), (d) and (e) in section 4 is not difficult to identify. Separate and specific regimes exist which are concerned with each of these factors. Criminals may be dealt with through the criminal justice system, substance abusers under the Alcoholism and Drug Addiction Act 1966, and the intellectually handicapped, if at all, through the Protection of Personal and Property Rights Act 1988 and the Disabled Persons Community Welfare Act 1975.

The words 'by reason only of' require closer examination. It is unclear whether the section is intended to mean only that compulsory status may not be imposed on a person on the basis of any one of grounds (a) to (e) on its own or whether it is also intended to prevent the use of compulsory powers on persons on a combination of two or more of these grounds. The use of 'only' and 'or' seems prima facie to suggest the former. The latter interpretation seems, however, to be the more sensible one. The purpose of the section would be defeated if a combination of characteristics makes a person liable to compulsory status when those characteristics individually do not.

Nevertheless, the writer does not believe that the section means that these attributes and preferences should be discounted completely.[66] The factors may undoubtedly be relevant in deciding whether parts of the definition of mental disorder are satisfied, for example, a particular type of sexual deviancy may aid in a determination of dangerousness. Even though it cannot be said that a person is mentally disordered purely by reason of their sexual deviancy, the person may demonstrate a tendency to act in some harmful way because of that deviancy. This may assist in establishing dangerousness.

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[66] Note the contrary view in *R* v *Mental Health Review Tribunal, ex p Clatworthy* [1985] 3 All E R 699, 703 where Mann J commented that sexual deviancy is to be *discounted* under the equivalent provision in the UK Act.

As seen above,[67] it may be argued that mental retardation is an abnormal state of mind characterised by a disorder of cognition. Section 4 does not prevent a mentally retarded (or 'intellectually handicapped') person being deemed mentally disordered if the other criteria for mental disorder are also met. It simply means that the existence of the mental retardation is not sufficient on its own. If a mentally retarded person is also found to be dangerous, then he/she is not deemed mentally disordered *by reason only of* his/her mental retardation and therefore such a determination would not appear to conflict with section 4.

The danger in interpreting a mental retardation as an abnormal state of mind characterised by a disorder of cognition is that mentally retarded persons may often have seriously diminished capacities for self-care and therefore technically could be subject to compulsory treatment on that basis. This would be completely contrary to current policy and practice which regards the mentally retarded and the mentally disordered as two completely separate and unrelated groups. Although making no finding on such an interpretation, the court in *R* v *T*[68] was required to interpret the definition of mental disorder in the context of a disability hearing. T was charged with assault with intent to commit sexual violation. It was accepted that T was mentally retarded and not mentally ill. The question before the District Court was whether he was under disability and therefore should not stand trial but instead be detained in a psychiatric hospital as a special or ordinary patient. Under section 108 subsection one of the Criminal Justice Act 1985, a person charged with an offence is under disability if, because of the extent to which that person is mentally disordered,[69] he/she is unable to plead, understand the nature or purpose of the proceedings or communicate adequately with counsel for the

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[67] Above Part One, No 2B (i) and (ii).

[68] Above n 15.

[69] 'Mentally disordered' is given the same meaning as in the MH(CAT) Act 1992 by reason of s2 Criminal Justice Act 1985.

purposes of conducting a defence. The decision, therefore, turned on whether the definition of mental disorder included mental retardation or whether it is excluded by section 4 MH(CAT) Act 1992.

Judge McElrea was of the view that a mentally retarded person is capable of being mentally disordered within the definition for several reasons. Firstly, he found that mental retardation is an abnormal state of mind characterised by a disorder of cognition.[70] Dangerousness and a seriously diminished capacity for self-care were also accepted without argument. Secondly, he held that if the definition of mental disorder did not encompass mental retardation, then its express exclusion in section 4 would have been unnecessary ". . . except perhaps for the avoidance of doubt."[71] The writer suggests that the avoidance of doubt is a primary reason for the enactment of the section 4 exclusions. Their existence is acknowledgment that, although constituting an attempt to create a greater degree of precision, the definition of mental disorder remains open to interpretation by the courts.

The logical corollary of suggesting that the inclusion of mental retardation in section 4 necessarily implies that it *would* otherwise be encompassed by the definition is the suggestion that, had political or religious beliefs not been included in section 4, they too would have fallen naturally within the definition of mental disorder. Mental retardation may be caught by the definition of mental disorder but not, with respect, for this second reason.

Another reason given for the court's finding was that the definition of mental disorder ". . . is not in its own terms limited to 'mental illness' and the courts should be slow to imply such a restriction when the legislature appears to have *deliberately cast the definition in wide terms*"[72] (emphasis added).

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[70] See above Part One, No 2B (i) and (ii).

[71] Above n 15, p 204.

[72] Above n 15, p 204.

It is correct that the term 'mental illness' is now removed from the definition. The rationale behind the omission was *not,* however, to allow a meaning wider than mental illness but rather to attempt to define mental disorder as something narrower than general mental illness and to remove the circularity of the previous definition.[73] Prior to the passing of the MH(CAT) Act, the feature of the definition which was most strongly acclaimed by the legislature was its alleged precision.[74] Irrespective of whether it will *in fact* prove to be more precise, the legislature did not, with respect, deliberately cast the definition in wide terms.

A further reason for the Court's finding that mental retardation is able to fall within the definition is undeniably a valid one. Section 4 limits the *procedures* under the Act which can be invoked by reason only of intellectual handicap. A person cannot be the subject of an application for assessment or a compulsory treatment order by reason only of his/her intellectual handicap. What section 4 does not do is state that a person is not *mentally disordered* by reason only of intellectual handicap.[75] This is an important distinction. If mental retardation can be read into the words 'abnormal state of mind . . . characterised by . . . a . . . disorder of cognition' and if one of the rquired resultant outcomes is established, section 4 does not prevent other parts of the Act being invoked. In other words, section 4 only prevents the compulsory assessment and treatment procedures in Parts One and Two of the Act being invoked in such circumstances.

Clarifying areas which cannot alone constitute mental disorder is useful when viewed in the light of the scope for interpretation which still exists in the new

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73 See above Part One, No 2A.

74 Above n 8, pp 6865, 6867, 6874.

75 Contrary to that stated in *A User's Guide to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, Mental Health Policy Section, Department of Health, Wellington, 1992 at p 3.

and narrowed definition of mental disorder but, as has been seen, even section 4 may itself give rise to problems in interpretation.

## 4 Personality Disorder

An issue which arises for consideration under the definition of mental disorder is whether a person with a personality disorder or, more particularly, a psychopathic personality disorder falls within the definition, that is, whether such a person may be subjected to compulsory treatment under the Act.[76] Before considering this, the meanings of these terms need to be canvassed.

### A Defining 'Personality Disorder"

The concept 'personality' is not easy to define with any precision. It has been observed that personality ". . . will include such things as mood state, attitudes, and opinions . . . [which] . . . must be measured against how people comport themselves in their social environments."[77] Ascribing a 'normal' personality to a person indicates: ". . . that various personality traits are present to a broadly normal extent, neither to gross excess nor extreme deficiency. Abnormal personality is, therefore, a variation upon an accepted, yet broadly, conceived, range of personality."[78]

If an individual's personality is far enough removed from the concept of 'normality', he or she may be said to be labouring under a personality disorder. Personality disorder is thus a relative concept. Its diagnosis depends on a comparison with the ordinary person. It is distinguishable from most

[76] Assuming that a judge considers that in all the circumstances of the case a compulsory treatment order is necessary.

[77] H Prins *Dangerous Behaviour, the Law and Mental Disorder* (Tavistock Publications, London, 1986) p 141.

[78] Above n 77.

mental disorders (using the phrase broadly), for example, schizophrenia, in that opinion is far from unanimous that a personality disorder is a mental illness in the conventional, medical sense.

The Mason Report[79] suggested that two elements constitute the modern concept of personality disorder. These are:

i) *any* abnormality of personality which causes problems either to the person concerned or to others, *and*
ii) unacceptable, anti-social behaviour coupled with a notion of dislike for the person showing such behaviour and a rejection of them.

In summary, Prins[80] cites the following definition of personality disorders as ". . . a group of more or less well defined anomalies or deviations of personality which are not the result of psychosis or any other illness. The differentiation of these personalities is to some extent arbitrary . . ."

**B Antisocial Personality Disorder**

The psychopathic personality disorder, or anti-social personality disorder ("ASPD") as it is more recently known, is the most extreme of the personality disorders. Key characteristics include pathological egocentricity and incapacity to love, lack of remorse or shame, fantastic and uninviting behaviour, and general poverty in major affective reactions. However, there is also commonly an absence of delusions and other signs of irrational thinking.[81] These characteristics are often combined with a superficial charm, rendering the psychopath difficult to identify as someone with an 'abnormal' personality.

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79 Above n 44, p 215.

80 Above n 77, p 142, quoting from *Glossary of Mental Disorders*, General Register Office, 1968:14.

81 Above n 77, p 155.

External indicators common to mental illness, such as delusions, are also often absent.

The notion of psychopathy is ". . . much influenced by prevailing cultural notions of responsibility and what is regarded as 'decent' behaviour."[82] Determinations as to personality disorder, therefore, include making moral judgments about an individual's behaviour and/or beliefs.

Little consensus existed between mental health professionals as to whether persons with ASPD were mentally disordered under the definition in the Mental Health Act 1969 (NZ).[83] Dawson stated that the majority view, if there was one, was that they were not 'strictly' covered but did occasionally 'need' to be, and in fact were detained on this basis.[84] Even if it was agreed that ASPD could not fall under paragraph (a) of the old definition as a mental illness, paragraph (c) ('mental subnormality') was so broad that as long as the person concerned had a low level of intelligence, he/she would have been able to fall within the definition of mental disorder under that Act.

It has been suggested that the current New Zealand definition of mental disorder is wide enough to encompass personality disorders.[85] A personality disorder, it was proposed, could fall within the words 'disorders of . . . volition.' Volition can be defined as 'the ability to choose or control a course of action'.[86]

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82 Above n 77, p 144.

83 Dawson, John "The Civil Committal Process" in Legal Research Foundation, *Mental Health: A Case For Reform* (Legal Research Foundation Inc 5 September 1986) p 49.

84 Above n 83.

85 *Trapski's Family Law Volume III Mental Health - Protection of Personal and Property Rights* (Brooker and Friend Ltd, Wellington, 1992) p A-22.

86 Above n 9, p 102.

The British Mental Health Act 1983 is unusual in that it expressly includes psychopathic disorder as a mental disorder which justifies compulsory admission for treatment when such treatment is likely to alleviate or prevent a deterioration in condition.[87] Psychopathic disorder is in turn itself defined.[88] The requirement of a likelihood of response to treatment prevents the inclusion of those persons who are ". . . merely difficult, unco-operative or unlikeable".[89]

In a report made prior to the enactment of the 1983 UK Act, the Butler Committee considered that dangerous anti-social psychopaths who had previously exhibited any mental, organic or identifiable psychological or physical defect should be dealt with through the criminal justice system rather than the mental health system.[90] This argument has also been made as part of strong criticism of a US statute, the Minnesota Psychopathic Personality Statute of 1939.[91] That legislation allows indefinite confinement of a person with a psychopathic personality ". . . without any finding that the person suffers from an illness known to medical science".[92] It has been under

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[87] Section 3 Mental Health Act 1983 (UK).

[88] 'Psychopathic disorder' is defined as 'a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned'- s2.

[89] Above n 77, p 145.

[90] Report of the Committee on Mentally Abnormal Offenders (1978); (Cmnd 6244) ("Butler Report") cited in above n 77, p 144.

[91] See Erlinder, C P "Minnesota's Gulag: Involuntary Treatment for the 'Politically Ill'" (1993) 19 William Mitchell Law Rev 99.

[92] Above n 91, p 100. 'Psychopathic personality' is itself defined as 'the existence in any person of such conditions of emotional instability, or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of personal acts, or a combination of any such conditions, as to render such person irresponsible for personal conduct with respect to sexual matters and thereby dangerous to other persons.'

scrutiny lately due to its recent successful use by prosecutors as a mechanism to transfer violent sex offenders nearing the ends of their sentences to psychiatric institutions. That statute is unusual in that it exists alongside the State's commitment statute but the issues its existence and current use raises are equally applicable to any decision to deal compulsorily with someone on the basis of a personality disorder.

Although detaining and treating a person to prevent harm to others may be an attractive proposition, such an action must be seen in the light of the unreliability of predictions of danger and keeping in mind the fact that indefinite preventive detention is imposed even on offenders only in strict circumstances. Courts frequently impose finite sentences on offenders and prisons release offenders when it is quite clear that further offending is possible or even probable. The use of compulsory powers on psychopaths who have not committed offences cannot even be justified on the ground that an important rationale behind the use of compulsory powers is treatment. The Butler Report (UK) found that psychopaths are generally not treatable, at least in medical terms (that is, no specific clinical condition is present and aetiology is difficult to determine).

If a person is subjected to compulsory status on the grounds that they have a disordered personality, psychopathic or otherwise, they ". . . may never gain release by a determination that [they] have been 'cured'"[93] because their disorder is not 'medical'.

As far as the New Zealand MH(CAT) Act 1992 at least is concerned, the provision of effective treatment is one of its underlying aims. This is exemplified in the right to treatment enacted for the first time in New Zealand

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93 Above n 91, p 100.

mental health law.[94] Bringing persons into a compulsory treatment regime whom it is known are not treatable conflicts with this aim.

Gostin argues that "[t]here is no clear, consistent and rational distinction between offenders who have been labelled psychopaths and sent by the courts to hospital, and habitual offenders who are sent to prison without any psychiatric label."[95] It is arguable, therefore, that detaining a person on the basis that they have a personality disorder and without any treatment benefits is arbitrary detention contrary to section 22 NZBORA.[96] Where it is unclear whether detention is legal within the Act, that is, in this case whether personality disorder falls within the section 2 definition of mental disorder, section 6 of the NZBORA should apply. This requires that where two interpretations of a statutory provision are possible, preference should be given to a meaning that is consistent with the NZBORA.

Interpreting New Zealand's definition of mental disorder to include psychopathic personality disorder carries greater dangers than its inclusion in the UK statute because that statute defines psychopathic disorder and, further, it contains an express treatability requirement.

## 5 Compulsory Treatment Order Necessary in All the Circumstances of the Case

Even if the presence of a mental disorder within the definition is established, a compulsory treatment order may not be imposed unless the judge concerned with the application considers that in all the circumstances of the case, such an order is necessary. This requirement has been described as the ". . .

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94 Section 66.

95 Gostin, L *A Practical Guide to Mental Health Law* (MIND, London, 1983) p 3 quoted in Legal Information Service/Mental Health Foundation Task Force on Revision of Mental Health Legislation *Towards Mental Health Law Reform* (December 1983) p 161.

96 See below Part Two, No 2.

ultimate protective screen against unjustified loss of liberty and other fundamental rights."[97] There is no statutory guidance provided and no statutory limits set as to what factors may be taken into account in determining an order's necessity.

The most obvious situation where a compulsory treatment order will be held to be unnecessary and, the writer suggests, one of the primary motivations for the inclusion of this additional criterion, is where the mentally disordered person is willing to undertake treatment on a voluntary basis. This is consistent with the use of the Act's compulsory powers as a last resort only.

In *Trapski's Family Law*,[98] it is suggested that a situation where an order may not be considered necessary ". . . may involve a patient who is medicated and indicates an intention to continue to take medication or, if their capacity to take care of themselves is diminished, somebody agrees to assume responsibility for them."[99]

Although the criteria for compulsory status contain no express treatability requirement, the writer suggests that one of the circumstances which may render an order unnecessary is a lack of effective treatment. As the name indicates, treatment is an important rationale for the imposition of a compulsory treatment order and, it is suggested, the only legitimate justification for detaining a person who has not committed an offence. It seems difficult to find a compulsory treatment order necessary when treatment can have no positive effect.

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97 *Butterworth's Family Law Service Commentary* (Butterworths, New Zealand, 1993) p 9080.

98 Above n 85.

99 Above n 85, p A-80.

## 6 Standard of Proof

The decision to impose a compulsory treatment order requires that the court be *satisfied* that the person concerned suffers from a mental disorder and that a compulsory treatment order is necessary in all the circumstances of the case.

An explanation of a requirement that a court be *satisfied* is contained in *R* v *White (David)*.[100] It means simply that the court must make up its mind and indicates a state where the court comes to a judicial decision on the evidence. Satisfaction beyond reasonable doubt is not required. Although such an explanation was made in the context of a section of the Criminal Justice Act 1985, there is no logical reason for it to be attributed a different meaning in the context of the MH(CAT) Act 1992.

[100] *R* v *White (David)* [1988] 1 NZLR 264.

# PART TWO

# THE REMOVAL OF A COMPULSORY TREATMENT ORDER

## 1 The Need For Review

Unlike offenders, mentally disordered persons are deprived of basic human rights due purely to the particular nature of their illness rather than due to any moral culpability on their part. Also unlike offenders, one determination of the legality of their detention is insufficient. The period for which they are subject to compulsory treatment does not have a fixed upper limit as does a prison sentence,[101] and the (sometimes rapidly) changing nature of mental illness means that appropriate use of the powers under the MH(CAT) Act 1992 can quickly become inappropriate. The fact that a compulsory treatment order expires after six months unless renewed and again after a further six months,[102] is some safeguard against this but two extensions only are required before an order achieves indefinite status.

To ensure that adequate grounds exist for the use of the Act's compulsory powers and that the right not to be arbitrarily detained in section 22 NZBORA is not being breached, regular and effective review of a patient's compulsory status is vital.

## 2 Section 22 New Zealand Bill of Rights Act 1990

Section 22 NZBORA provides: "Everyone has the right not to be arbitrarily . . . detained."

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[101] With the exception of those offenders serving sentences of preventive detention.

[102] Section 33.

The New Zealand courts have so far given a wide interpretation to the concept of 'detention'.

In *Re S*,[103] the applicant, a committed patient under the 1969 Mental Health Act, was released from hospital on leave under section 66 of that Act. The case concerned the availability of a section 74 inquiry into a patient's circumstances by a High Court judge. The Area Health Board concerned argued that no such inquiry was possible because S, as a patient on leave, was not 'detained or kept' as was required before the powers conferred by the section could be employed by the judge. Barker J rejected that argument and held that detention did not necessarily connote physical restraint or confinement and could encompass situations where a person is subject to involuntary supervision and/or perceives a lack of control over his/her actions. Although the court was concerned with the concept of 'detention' in the context of section 74 Mental Health Act 1969 rather than its use in section 22 NZBORA, one of the stated reasons for such an interpretation was the broad interpretation given by the Canadian courts to 'detention' in the Canadian Charter of Rights and Freedoms on which the NZBORA is based. The element of supervision has been held to override the need for physical constraint.[104]

Further, in *Herewini* v *Ministry of Transport*,[105] in the context of a different section of the NZBORA,[106] detention was held to mean any form of coercion, whether the coercion be physical, psychological or legal.

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[103] Temm J in *Re S* Unreported, 20 April 1993, High Court Auckland Registry M559/93.

[104] *R* v *Therens* 18 DLR 655, 678.

[105] *Herewini* v *Ministry of Transport* [1990-92] 3 NZBORR 113.

[106] Section 23.

The writer suggests that, given the generous interpretations of 'detention' by the courts to date, a person subject to a compulsory treatment order is 'detained' so as to be able to claim the protection of section 22 NZBORA whether he/she is being held as an inpatient in a psychiatric institution, is an inpatient on leave, or is subject to a community treatment order.[107]

The meaning of 'arbitrarily' in section 22 NZBORA has also been at issue before the courts. Gallen J in *Re M*,[108] held that 'arbitrary' in the context of personal freedom is normally interpreted in terms of whether or not the detention is justified by existing law. Detention is not arbitrary if the decision to detain or continue detention is made in observation of "principles which are imposed statutorily or which are accepted as being applicable within the system as a whole".[109] The fact that in following such principles different decision-makers may reach different results on the same facts does not render such decisions arbitrary. In summary, Gallen J concluded that something is arbitrary when it is not in accordance with the law or with the principles which the law regards as appropriate for a discretion to be operated within.

## 3 The Standard for Discharge

As will be seen below, the outcome of many of the forms of review under the MH(CAT) Act 1992 depends on whether the patient is or is not considered to be *fit to be released from compulsory status.* The availability of discharge, therefore, depends on a patient under a compulsory treatment order[110] meeting this standard. If a patient is considered fit to be released from compulsory status, then the compulsory treatment order is deemed to have

[107] See below Part Three for discussion of community treatment orders.

[108] Above n 23.

[109] Above n 23, p 41.

[110] This paper is not concerned with the review of the status of special or restricted patients to whom different sections apply.

expired. The person is then no longer subject to the Act and must be discharged.

The meaning of the phrase 'fit to be released from compulsory status' is, therefore, pivotal. It is defined in section 2 of the Act as:

- *no longer mentally disordered and*
- *fit to be released from the requirement of assessment or treatment under this Act.*

Admittedly, in most cases where a patient is deemed to be no longer mentally disordered, they will also be considered to be fit to be released from the requirement of assessment or treatment under the Act. It is, however, possible that there will exist patients who are no longer mentally disordered within that definition and yet continue to be subject to compulsory status on the basis that they are deemed not fit to be released from the requirement of treatment under the Act (that is, on the basis of the second limb of the definition of 'fit to be released from compulsory status').[111] These are persons who would not be placed under compulsory treatment orders if they were entering the system because they are not mentally disordered within the definition. A person who is considered a danger, but not a serious danger, to his/her own health is a possible example, so too is a person who no longer has the requisite abnormal state of mind but who has become 'institutionalised' due to long term detention.

[111] It is unclear whether the standard for discharge under the 1969 Act allow continued detention of a person who was no longer mentally disordered. Greig J in *Re M* above n 51 and Judge Unwin in *Report to the Minister under a s 73 Inquiry* Unreported, 22 November 1984 held that it was not implicit under the Mental Health Act 1969 that absence of mental disorder will determine the decision as to discharge. On the other hand, Ellis J in *In re M (a mental patient)* Unreported 17 April 1986, High Court Auckland Registry M1419/85 held that the discharge provisions did not authorise the detention of a person who was not mentally disordered.

Continued detention justified on the second limb may seem to be arbitrary and therefore a breach of the NZBORA. However, as stated above,[112] Gallen J in *Re M* held that detention is not arbitrary when it is justified by law.

The existence of both limbs would perhaps be more easily understandable if 'dangerousness' was not a component part of the definition of mental disorder but rather a second and separate criterion to be satisfied before compulsory status could be imposed. The possibility of danger could then be looked at under the second limb. The legitimacy of continued detention, even on the basis of potential dangerousness, would be questionable, however, if the person concerned is no longer mentally disordered. It would result in a sentence equivalent to preventive detention being imposed on a person who may not have committed any offences.

There is the possibility that this second limb was included to account for those persons whose mental illness is 'in remission' but who have a history of short periods of remission while undergoing compulsory treatment and who, therefore, continue to require compulsory status. However, as discussed above,[113] the definition of mental disorder provides that the abnormal state of mind may be continuous *or intermittent* and therefore those persons who are not displaying obvious signs of mental illness may still fall within the definition of mental disorder. The possibility of 'remission' does not, therefore, provide a justification for the existence of the second limb.

The limb may also have been included to account for those persons who are no longer mentally disordered *because* of the ongoing compulsory treatment but who it is predicted will become mentally disordered again within the definition if released from compulsory status and fail to continue treatment on a voluntary basis. The fact that an intermittent abnormal state of mind suffices

[112] Above Part Two, No 2.

[113] Above Part One, No 2B (i).

for the definition of mental disorder is not necessarily enough here. For example, a person may have a continuous abnormal state of mind but no longer pose a serious danger to health or safety or is able to take care of himself/herself adequately due to ongoing compulsory treatment.

It is suggested that detaining persons who are no longer mentally disordered is unacceptable notwithstanding the above possible justification. The dangers inherent in such widely-worded powers outweigh the benefits which may exist for a few patients who may require release from compulsory status only to have a compulsory treatment order re-imposed shortly afterwards.

The writer suggests two changes to the current standard for discharge. 'Fit to be released from the requirement of assessment or treatment under the Act' can only mean that a compulsory treatment order is not necessary in all the circumstances of the case. For the sake of clarity and consistency with the standard for the *imposition* of a compulsory treatment order,[114] therefore, it would be preferable to amend this second limb to 'a compulsory treatment order is no longer necessary in all the circumstances of the case'. Secondly, the word 'and' between limbs one and two should be replaced by the word 'or'. Both limbs must be satisfied before imposition and therefore, if either limb ceases to be satisfied, the person should be entitled to be released from compulsory status.

## 4 Clinical Review

Every person who is subject to a compulsory treatment order must have their condition formally reviewed by their responsible clinician (RC) no later than 3 months after the date of the order (this is recognition of the potentially rapid

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[114] Section 76(1).

stabilising effects of psychotropic drugs), and subsequently at intervals of not greater than 6 months.[115]

Such a review involves the RC examining the patient and consulting with other health professionals involved in the care and treatment of the patient. The RC must take the views of the other health professionals into account when assessing the results of his or her review of the patient's condition.[116] Findings must be recorded in a *certificate of clinical review* in the prescribed form,[117] which must state whether or not, in the opinion of the RC, the patient is fit to be released from compulsory status.[118]

If the RC is of the opinion that the patient *is* fit to be released from compulsory status, the patient must be released from that status, at which time the compulsory treatment order is deemed to have been revoked.[119] If, however, the RC is of the opinion that the patient is *not* fit to be released from compulsory status, he or she must send a copy of the certificate to certain listed persons and bodies[120] and, in addition, to some of them[121] a statement of the legal consequences of the finding and of the recipient's right to apply to the Mental Health Review Tribunal ("MHRT") for a further review.[122]

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115 Section 76(1).

116 Section 76(2).

117 See Appendix B for forms.

118 Section 76(3).

119 Section 76(5).

120 Section 76(7).

121 Section 76(8).

122 Above n 117.

Irrespective of the opinion of the RC, he or she must also send to the Director of Area Mental Health Services the certificate plus full particulars of the reasons for the opinion and any relevant reports from other health professionals involved in the case.[123]

No provision for mandatory automatic clinical review of psychiatric patients has previously existed in New Zealand.

## 5 Tribunal Review

### A Mental Health Review Tribunals

The Act provides for the establishment of MHRTs.[124] There are to be such number of MHRTs as the Minister of Health appoints from time to time.[125] Although new entities in New Zealand, MHRTs are well established in other jurisdictions. They have been in operation in the United Kingdom since 1959, and at present exist in Canada and in most states of Australia.[126] Their principal function[127] is the review of a patient's condition with a view to the revocation of the compulsory treatment order. They do, however, perform a number of secondary functions, for example, the investigation of complaints that the rights of a patient have been denied or breached.[128]

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[123] Section 76(4).

[124] Section 101.

[125] Above n 123.

[126] Bell, Sylvia (ed) *Legal and Consumer Issues in Mental Health Law - Volume One of the Edited Proceedings of the Mental Health Foundation's Conference '87* (1988, Mental Health Foundation of New Zealand, Parnell, Auckland), 16; Legal Information Service/Mental Health Foundation Task Force on Revision of Mental Health Legislation *Towards Mental Health Law Reform* (Dec 1983), 316.

[127] Stated as such in s102.

[128] Section 75.

## B Constitution

MHRTs consist of 3 persons appointed by the Minister of Health, one of whom must be a barrister or solicitor, and another a psychiatrist.[129] Unlike the UK tribunals, there is no statutory requirement in New Zealand that the third tribunal member be a layperson.[130] Deputies are able to be appointed by the Minister to replace members who are absent due to illness or other reasons.[131]

In contrast to clinical review, the MHRT as a decision-maker is independent from the detaining authority. Moreover, it is heralded to be superior to a fully judicial body in that it enjoys both legal and medical internal expertise and constitutes an attempt to strike a balance between 'medicalism' (the idea that psychiatry needs freedom from legal regulation to function effectively) and 'legalism' (the idea that psychiatry, unregulated, has too great a potential for abuse).[132] The presence of the lay member provides a further layer of knowledge and experience. "The legal, social and medical approach is . . . interwoven in the decision-making process."[133]

A MHRT is empowered by statute (or required if requested) to co-opt other persons as members for the purposes of the particular hearing when no

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[129] Section 101.

[130] They always are in practice, however - Interview with Catherine Coates, Mental Health Policy Section, Department of Health, August 1993.

[131] Section 105.

[132] Note, though, that research has indicated the domination of the medical perspective in MHRTs - Peay, Jill "Mental Health Review Tribunals and the Mental Health (Amendment) Act" [1982] Crim L R, 794, 803.

[133] Bridge, C and Bridge, G W K "Civil commitment: a multi-disciplinary analysis" (1984) 14 VUWLR 145, 153.

member of the MHRT is of the same ethnicity or gender as the patient.[134] MHRTs are also able to co-opt any person who may be of assistance to them due to the person's specialised knowledge or expertise.[135] These provisions exemplify the multi-disciplinary approach which currently prevails in relation to the care and treatment of mentally disordered persons.[136]

### C The Hearing

Patients may or may not be represented at MHRT hearings. Under section 70 of the Act, the patient is entitled to request a lawyer. The utility of such an entitlement depends, however, on its actual exercise by the patient. Even if patients do request and receive legal representation, the effectiveness of ordinary lawyers in such a specialised situation may be limited. In this context, a patient advocacy service specifically for psychiatric patients is desirable. No provision was made for such a service in the Act due to the proposed introduction of a Health Commissioner.

A MHRT review of a person subject to a compulsory treatment order may arise in the following ways:[137]

a) Of its own motion at any time (including after referral from a district inspector).[138]

b) Of its own motion after receiving a copy of the certificate of clinical review. In these cases, the MHRT must at least *consider* whether it should review the patient's condition.

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[134] Section 103(1).

[135] Above n 134.

[136] For example, the patient's RC need not be a psychiatrist - see s2.

[137] Section 79.

[138] Section 76(11).

c) On application from any person to whom a copy of the certificate of clinical review is sent.

d) On application from any person to whom a copy of the certificate of clinical review should have been sent (when the RC has failed to conduct such a review).

In the last two cases, the MHRT must conduct the review within 14 days of receipt of the application with two exceptions. The MHRT may refuse to consider an application for review of the patient's condition:

- *if it has considered an application for review within the preceding 3 months* and the certificate of clinical review states that the patient's condition is unchanged; or
- when the application is made by a relative or friend[139] and the MHRT is satisfied that the application is made otherwise than in the best interests of the patient.

If the section is to be workable, the words 'if it has considered an application for review within the preceding 3 months' must be read to mean 'if it has conducted a review of the patient's condition or considered whether it should review the patient's condition within the preceding three months'. This is because a MHRT cannot merely have 'considered an application for review' when it is mandatory to review an application. At some point, the MHRT would have had to have been able to merely *consider* an application for the first exception to take effect. The Department of Health publication "A User's Guide to the Mental Health (Compulsory Assessment and Treatment) Act 1992",[140] although not acknowledging any difficulty with the actual words of the statute, interprets 'if it has considered an application for review within

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[139] Who would, presumably, come under the category of principal caregiver which is itself defined in s2.

[140] Above n 75.

the preceding 3 months' to mean 'if it has considered the patient's condition within the preceding 3 months'.[141]

The MHRT, by reason of section 82, must follow the procedure set out in the First Schedule to the Act when reviewing a patient's condition.[142]

**D After-Care Facilities**

Before a judge can order that a person be subject to a *community* treatment order,[143] he or she must be satisfied that adequate facilities exist for the patient's care and treatment in the community.[144] There is, however, no statutory requirement that the *MHRT* consider after-care facilities when deciding on a patient's *discharge*. Further, a MHRT is not able to attach any conditions to the discharge of a patient.

The justification for the difference in requirements in the two situations lies in the fact that in the first case, the patient is ill to a point where compulsory status is still considered necessary, whereas in the latter, a decision is made to discharge because the patient no longer meets the criteria for compulsory status. Taking into account the availability of appropriate subsequent support facilities would shift the focus away from the person's condition.

The Government, however, has recently issued guidelines for clinicians to follow when a patient is discharged. The guidelines ". . . emphasise that each patient must have an identified key worker . . . where followup treatment and

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141 Above n 75, p 47.

142 See Appendix D for First Schedule.

143 Above n 107.

144 Section 28(4)(a).

care is needed. Each hospital or similar service that treats people with mental disorders is expected to put in place its own discharge planning protocol."[145]

## E Automatic Tribunal Review

After the operation of MHRTs for several decades in the UK, automatic MHRT review was introduced for those patients who did not apply for review or on whose behalf an application for review was not made.[146] Until then, patients eligible for review tended not to exercise that right. Automatic review was also recommended in New Zealand before the introduction of the current Act.[147] At present, if no application is made by the patient or on the patient's behalf, the undertaking of any MHRT review is left to the discretion of the MHRT. As long as the MHRT at least *considers* whether to review, they may never actually review a patient's status.

The existence of District Inspectors is helpful[148] but even if they refer the patient's case to the MHRT, the MHRT's decision to review remains discretionary.

Automatic review can be said to be superior to any other form of review because its occurrence does not depend on the initiative being taken by those whose initiative may be impaired.[149]

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145 Katherine O'Regan, Associate Minister of Health quoted in *The Dominion*, Wellington, New Zealand, 16 August 1993.

146 Above n 132, p 796.

147 Legal Information Service/Mental Health Foundation Task Force on Revision of Mental Health Legislation *Towards Mental Health Law Reform* (December 1983) p 161.

148 See below Part Two, No 6 for an outline of their role.

149 No automatic review exists in relation to personal or property orders made by the court under the Protection of Personal and Property Rights Act 1988. Under that Act, the decision to impose the order has been made by the court. The situation is different from that under the MH(CAT) Act 1992 in that although the initial decision to impose a compulsory treatment order is made by the court, the decision to continue it is made by a non-independent purely medical decision-maker.

If automatic MHRT review is not considered acceptable, the writer suggests that there should be ongoing renewal of the compulsory treatment order and that the order not be made indefinite, as it currently is, after two extensions. This may even be preferable to automatic review in that the burden for the continuation of the order falls on the party seeking to continue it.[150]

Once a MHRT review is concluded, the MHRT must complete a certificate of tribunal review in the prescribed form,[151] stating its opinion as to whether the patient is fit to be released from compulsory status. A copy of the certificate must be sent to those persons to whom a copy of the certificate of clinical review was sent. In addition, a copy must be sent to the Director of Mental Health and to the RC. The same persons to whom a statement of the legal consequences of the clinical review had to be sent must, under section 79 subsection 11, be sent the same in relation to the MHRT review. They must also receive notification of their right to appeal to the court against the MHRT's decision.

## F Reasons

At no stage is a MHRT required by statute to provide reasons for its decision.

Section 27 subsection 1 of the NZBORA provides:

> "Every person has the right to the observance of the principles of natural justice by any tribunal or other public authority which has the power to make a determination in respect of that person's rights, obligations or interests protected or recognised by law."

[150] The disadvantage of this is that such applications for extension are heard before the courts rather than before the MHRT and, therefore, the benefits of the MHRT are lost.

[151] Above n 117.

The writer suggests that natural justice requires that reasons be given for a statutory decision to continue a patient's compulsory status.

In the UK, reasons must be recorded in writing in all cases in a prescribed form and delivered within 7 days.[152]

The Task Force[153] recommended that reasons be required for a decision of a MHRT. Factors in favour of its recommendation included the following:

a) The applicant and/or patient can see that justice is being done; and

b) A requirement of reasoned decisions forces MHRT members to verbalise their thinking in a rigorous and disciplined manner.

Greenland[154] also suggested that reasons be given to provide guidance to patients as to their future behaviour.

The ability of any MHRT reasons to achieve these results depends on the willingness of the MHRT to do more than merely restate the legislation. For example, a statement that discharge is refused because the patient remains mentally disordered or because the patient is not considered fit to be released from the requirement of compulsory treatment would be inadequate. Adequate reasons assume real importance in the light of the scope for interpretation which still exists in the current definition of mental disorder.

Mere restatement of the legislation has occurred, on occasion, in the UK.

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[152] Mental Health Review Tribunal Rules, Rule 23 (UK).

[153] Above n 147.

[154] Greenland, C *Mental Illness and Civil Liberty: A Study of Mental Health Review Tribunals in England and Wales*, Occasional Papers on Social Administration No 38 (Willner Brothers Ltd, Birkenhead, England, 1970), p 115.

Donaldson M R in *Alexander Machinery Ltd* v *Crabtree*[155] held that the overriding test must always be whether the tribunal has provided both parties with the materials which will enable them to know that the tribunal has made no error of law in reaching its finding of fact.

Reasons should also be supplied to the patient after a clinical review. This would require very little effort because the RC is already required to send reasons for his/her decision to the Director of Area Mental Health Services with the certificate of clinical review.

The provision of reasons for a decision is also necessary to enable effective judicial review of that decision.

## 6 The Role of the District Inspector

The role of the district inspector, continued under the new Act with a few modifications, is the position under the Act most closely resembling a patient advocate for mentally disordered persons. District inspectors have been described as ". . . watchdog[s] for the rights of persons who have already become subject to the provisions of the Act or who appear likely to become subject to such provisions."[156]

As a result of the introduction of MHRTs, the functions of district inspectors have been expanded to include involvement on the patient's behalf in the review process. More specifically, under section 76 subsections 9 to 12, the district inspector who receives the copy of the certificate of clinical review must talk to the patient, ascertain his or her wishes in the matter and then consider whether an application should be made to the MHRT. If it is considered necessary, the district inspector must take whatever reasonable steps

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[155] *Alexander Machinery Ltd* v *Crabtree* [1974] ICR 120.

[156] Above n 12, p 30.

he or she thinks necessary to encourage or assist the patient or the patient's welfare guardian, principal caregiver or usual medical practitioner to make such an application. If neither the patient nor these other persons intend to make such an application and the district inspector considers that one should be made, he or she may report the matter to the MHRT. The MHRT may then review the patient's condition of its own motion. Note that the ultimate decision to review still lies with the MHRT.

The district inspector is empowered to arrange for the Official Visitor to instead perform these functions.

These provisions which apply to 'clinical review to MHRT stage' also exist, with appropriate modifications, in relation to the 'MHRT to Court' stage.[157]

## 7 Appeal to the Court

Certain persons[158] who receive a copy of the certificate of MHRT review stating that the patient is not fit to be released from compulsory status may appeal to the court against the decision of the MHRT within one month of that decision.[159] (There is no provision for the detaining authority to appeal against a decision of the MHRT that a person is fit to be released.)

The court must then review the patient's condition. This involves the judge examining the patient as soon as practicable,[160] consulting with the RC, at least one other health professional involved in the case and any other person

[157] Section 79(12) to (15).

[158] The patient, the patient's welfare guardian, principal caregiver and usual medical practitioner.

[159] Section 83.

[160] See s16(2) as to the form of the examination.



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the judge thinks fit. If the judge considers the patient is fit to be released from compulsory status, he or she must order accordingly.

There is a statutory presumption in favour of the review being conducted by a Family Court judge but, where not practicable, it may be conducted by a District Court judge.[161]

Although termed an 'appeal', it is really an inquiry into the patient's condition at the time of the proceedings rather than an appeal against or review of the MHRT's decision.[162]

## 8 Judicial Inquiry

Under section 84, any person may apply to a High Court judge to inquire into the circumstances of a person who is being detained as a patient in a hospital. Standing under this section is not, therefore, limited to those persons entitled to apply for a review before the MHRT or the court. An inquiry may also be made of the High Court judge's own motion.

The predecessor to section 84[163] in the Mental Health Act 1969 (now repealed) was the sole means under the previous regime by which a committed patient could gain a review of his or her position by an authority wholly independent of the hospital or the government.[164]

The purpose of such a section is ". . . to provide additional protection and an additional safeguard to those who may be detained . . . in a mental hospital.

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[161] Section 83(2) in conjunction with s16(6) and (7).

[162] In *Re C (a mental patient)* [1959] NZLR 529.

[163] Section 74 Mental Health Act 1969.

[164] Above n 147, p 313.

It is an important supervisory function of the Court and is a statutory expression of the inherent jurisdiction of the High Court to maintain a protective and supervisory function over those who are under a disability."[165]

The previous equivalent section applied to persons 'detained or kept as mentally disordered in any hospital, house or other place'.[166] This was held to include persons on leave in their own homes.[167] This generous interpretation was proffered because the court recognised that the objective of section 74 was to enable a High Court judge to review the condition and status of a person subject to compulsory powers under the Act at any time.

Therefore, the previous section applied to every person who was subject to the Act.

The possibility of a judicial inquiry under the current section clearly exists only for those patients 'detained in a hospital'. The arguments as to the interpretation of the concept of detention that were made in relation to section 22 NZBORA cannot be made in relation to section 84. This is because the possibility of a wide interpretation is removed by the use of the words 'in a hospital'.

It clearly does not exist, on the face of section 84, for those patients subject to community treatment orders. It would also seem to now exclude those patients on leave from a psychiatric institution. Unlike the previous section, it does not extend to all persons restricted by the Act's compulsory powers. Given the ability to interpret any compulsory status as effective detention, it is unfortunate that the new judicial inquiry section deprives a large number of compulsory patients of its protection.

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[165] Above n 51, p 15. Affirmed in *Re S*, above n 103.

[166] Above n 163.

[167] Barker J in *Re S* [1990-92] 1 NZBORR 239, 249.

If the judge is satisfied after an examination of the patient (by a district inspector or any other person(s) the judge may select) and on the evidence of medical or other witnesses that:

a) the person is detained illegally in the hospital as a patient; or

b) the person is *fit to be discharged from the hospital,*

the judge must order that the person be discharged from the hospital immediately.[168]

The phrase 'fit to be discharged from the hospital' in paragraph (b) does not correspond with the wording of the general standard for discharge in the Act which is 'fit to be released from compulsory status'. The former phrase arguably requires a lower standard than the latter.[169]

A person could continue to be mentally disordered within that definition[170] and therefore not be 'fit to be released from compulsory status' but could be considered by a judge to be fit to be discharged from hospital. This anomaly would be overcome if the writer's suggested amendments to the definition of 'fit to be released from compulsory status' were made.

Another potential problem with the section is the possibility that a judge may be satisfied that the person concerned is fit to be discharged from hospital but requires treatment in the community and is not therefore fit to be released from compulsory status altogether. The section does not, however, make provision for the conversion of an inpatient order to a community treatment order and seems to allow only outright discharge, that is, release from the provisions of the Act.

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[168] Note that under s84(8) the judge is also able to report to the Minister of Health with comments and recommendations.

[169] See definition of 'fit to be released from compulsory status' in above Part Two, No 3.

[170] See s2.

'Fit to be discharged' was the general standard for discharge in the 1969 Act[171] and it is possible that this is merely an inadvertent and unfortunate carrying over of that terminology. It has been suggested that 'fit to be discharged from the hospital' should be read as 'fit to be released from compulsory status'.[172] This suggestion assumes that 'discharge from the hospital' means outright discharge.

## 9 Habeas Corpus ('You Have the Body')

A writ of habeas corpus is a prerogative writ directed to a person who detains another commanding them to present the person before the court to test the legality of the detention.[173]

Section 23 NZBORA states that:

> "(1) Everyone who is . . . detained under any enactment
>
> (c) shall have the right to have the validity of the . . . detention determined without delay by way of habeas corpus and to be released if the . . . detention is not lawful."

Further, section 84 subsection 9 of the MH(CAT) Act 1992 expressly leaves open the possibility of ". . . any other remedy or proceeding available by or on behalf of any person who is or is alleged to be unlawfully detained, confined or imprisoned." The possibility of habeas corpus proceedings is, therefore, not ruled out.

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[171] Section 73 Mental Health Act 1969.

[172] Above n 85, p A-165.

[173] *The Australian Legal Dictionary* (Hargreave Publishing Coy, 1980) p 104.

Are these proceedings available to a person subject to compulsory powers under a community treatment order?

On their face, the above provisions appear to limit the availability of habeas corpus to those patients who are subject to an inpatient order, that is, those who are actually held in a psychiatric institution. Admittedly, section 28 NZBORA provides that existing rights are not abrogated or restricted merely because they are not included or are only included in part in the NZBORA. Section 84 subsection 9 MH(CAT) Act 1992 could, however, be argued as impliedly limiting the avenues for review to those contained in the Act itself for those persons who are subject to compulsory status but who are not 'detained'.

The broad interpretations of 'detention' being made by the courts have already been discussed.[174] The suggestion has been made that detention in relation to mentally disordered persons encompasses a broader concept than that normally contemplated by judges.[175] One judge has written that detention in this context means ". . . that the person is made subject to the will of other persons in respect of where he lives and how he lives and about whether and, if so, by what means his condition will be treated."[176]

If this is accepted, detention would clearly apply to those persons subject to community treatment orders.

Alternatively, it could be argued that the use of both 'confined' and 'detained' in section 84 subsection 9 implies that each word connotes a different standard and that one is actually something less than physical restraint.

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[174] See above Part Two, No 2.

[175] Above n 12, p 27.

[176] Above n 12, p 27.

Further, a distinction could be drawn between this subsection and subsection 1 of section 84 which specifically states 'detained in a hospital'.

There do not appear to be any reported New Zealand cases in which a psychiatric patient has challenged his or her detention by way of habeas corpus. This is probably due to the availability of a section 84 action ('judicial inquiry').[177]

## 10 Judicial Review

Judicial review is not expressly provided for in the Act. The 'appeal' to the court, the MHRT hearing, and the judicial inquiry under section 84 are not reviews of the earlier decisions.[178]

However, section 27 subsection 2 NZBORA provides:

> "Every person whose rights, obligations or interests protected or recognised by law have been affected by a determination of any tribunal or other public authority has the right to apply, in accordance with law, for judicial review of that determination."[179]

Any person may apply for the judicial review of the exercise or refused exercise of a statutory power of decision affecting their rights[180] on the grounds of unlawfulness, unfairness, irrationality or arbitrariness.[181] In the context of the MH(CAT) Act 1992, this may relate to such an exercise by any

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177 Above n 147, p 314.

178 Above n 9, p 70.

179 Section 27(2) affirms the right to judicial review provided in s4 Judicature Amendment Act 1972.

180 Section 4 Judicature Amendment Act 1972.

181 Above n 9, p 70.

of the persons or bodies who conduct a review of the patient's condition, for example, the interpretation of the definition of mental disorder by the MHRT.

It has been suggested that courts may be reluctant to interfere with difficult decisions in this area, particularly those with considerable clinical content.[182]

## 11 The High Court's Inherent Jurisdiction - "A Somewhat Murky Stream"[183]

Under section 17 of the Judicature Act 1980 the High Court of New Zealand has

> ". . . all the jurisdiction and control over the persons and estates of mentally disordered persons as the Lord Chancellor of England or any Judge or Judges of Her Majesty's High Court of Justice or of Her Majesty's Court of Appeal, so far as the same may be applicable to the circumstances of New Zealand, *has or have* in England under the Sign-Manual of Her Majesty or otherwise." (emphasis added)

There are no longer any English judges with jurisdiction assigned to them by Warrant under the Sign-Manual.[184]

The House of Lords held in *In re F (Mental Patient: Sterilisation)*[185] that the courts' inherent or parens patriae jurisdiction over mentally disordered adults was totally extinguished upon revocation of the Warrant in 1960 (it was

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[182] McCarthy P in *Re R* [1974] 1 NZLR 399, 406.

[183] Above n 182.

[184] Turner J in *Re P (A Mental Patient)* [1961] NZLR 1028, 1030.

[185] *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (HC).

replaced by comprehensive mental health legislation) and that it is the role of the legislature rather than the courts to breathe life into it again.

The fact that section 17 is in the present tense would indicate that that jurisdiction of the New Zealand courts was also extinguished. The New Zealand courts do, however, appear in the main to accept the continued existence of a wide parens patriae jurisdiction over mentally disordered adults.[186] This is despite the express statutory powers given to the High Court in section 84 MH(CAT) Act 1992 - the court's jurisdiction is not exhausted by wide powers given in a corresponding statute.[187] Its existence is not, therefore, dependent on section 84 subsection 9 of the Act.

In *Re S*[188] in the context of an application under section 84 of the MH(CAT) 1992 Act, Temm J in the High Court commented that the obligation imposed on a High Court judge by section 17 Judicature Act 1980 and ". . . to some extent, spelled out by the Mental Health (Compulsory Assessment and Treatment) Act 1992, is a very solemn responsibility, not lightly to be set to one side."[189]

Any exercise of the court's inherent powers is governed by the principle of the best interests of the person for whose benefit the powers exist.[190]

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[186] Above n 182, p 401.

[187] Above n 184, p 1031.

[188] Above n 103.

[189] Above n 103, p 4.

[190] W Atkin "The Courts, Family Control and Disability - Aspects of New Zealand's Protection of Personal and Property Rights Act 1988" (1988) 18 VUWLR 345, 362.

The only dissent from this acceptance of the continuation of the High Court's inherent jurisdiction can be found in *Re H*.[191] Judge Inglis QC held that ". . . there must be doubt whether, in New Zealand, the parens patriae jurisdiction remains available in the case of an intellectually disabled adult . . ."[192] The writer suggests that these comments, made in the Family Court, may indicate that the matter has not yet been settled authoritatively but do not override the High Court's earlier statements regarding the jurisdiction.

Given the limitation on the use of section 84 and the possibility that the right to habeas corpus in section 23 NZBORA may be construed narrowly, any inherent jurisdiction of the High Court may be a useful avenue for protection for those patients who are subject to compulsory status and who fall outside the scope of these other safeguards.

[191] *Re H* [1993] NZFLR 225.

[192] Above n 191, p 229.

# PART THREE

# COMMUNITY TREATMENT ORDERS

## 1 Introduction

Under the new Act, a compulsory treatment order may take the form of an inpatient order in which case the mentally disordered person is confined and treated in a psychiatric institution. Alternatively, it may take the form of a community treatment order (CTO) in which case the mentally disordered person is treated while living in the community.

This is the first time in New Zealand that a legal framework has been established which provides for alternatives to institutional care and treatment for those persons who need to be cared for and treated involuntarily. Courts have never before been equipped to order that a mentally disordered person be compulsorily treated outside the traditional confines of a psychiatric hospital and in his or her home or community.

The creation of the community treatment order is a result of an international trend in the last few decades away from the mental health ideology and practice which centred on the psychiatric hospital as the normal method to deal with those suffering from mental disorders. This process, commonly known as 'deinstitutionalisation', has coincided with increased attention being given to community mental health services as an alternative method. Community-based care and treatment have had an expanding role in New Zealand mental health practice for some time. They are, however, new concepts in New Zealand mental health law.

Before the community treatment orders themselves are discussed, the deinstitutionalisation process and the accompanying move towards community mental health services for mentally disordered persons will be examined to put

community treatment orders in their context and to outline the philosophical underpinnings of their provision.

## 2 Deinstitutionalisation

### A The "Sociological Phenomenon"[193]

The asylum as the normal way to deal with mentally disordered persons was the result of a nineteenth century movement by "humane men of conscience"[194] who believed they had found a solution to the problem of how to care for and cure the mentally disordered. It is at least claimed that it was originally thought to be in the patient's best interests to be secluded in that it ensured their protection from the harshness of the outside world.

Psychiatric institutions began to spring up in New Zealand soon after colonisation.[195] Numbers of psychiatric patients peaked here in 1944 when 0.5% of the population was resident in a psychiatric hospital. Since the middle of this century, however, the deinstitutionalisation which has been occurring in many countries has also been underway in New Zealand. The proportion of the population detained in psychiatric institutions has been declining steadily.[196] Psychiatric institutions have either undergone significant reductions in inpatient numbers or have closed down completely. This process

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[193] A phrase used in Robinson, David (ed) *Mental Health Care in the Community Seminar Report 10 September 1986* (Wellington Community Mental Health Services Group, Wellington, 1986) p 16.

[194] Murphy, Elaine "Community mental health services: a vision for the future" (1991) 302 British Medical Journal 1064, 1064.

[195] The first psychiatric institution opened in Karori in 1854. Haines, Hilary and Abbott, Max "Deinstitutionalisation and Social Policy in New Zealand: 1: Historical Trends" (1985) 1 Community Mental Health in New Zealand 44, 45.

[196] Above n 195, p 54.

is continuing. It was recently announced that Tokanui Psychiatric Hospital in the Waikato will be closed in June 1995.

A dramatic shift in mental health ideology has taken place. The emphasis is no longer on the confinement and seclusion of mentally disordered persons but rather on their care and treatment in the community. Mentally disordered persons who would previously have been institutionalised for considerable periods of time are now spending much, if not all, of this time in the community.

There is no typical community mental health service. They range from assistance in the mentally disordered person's own home to drop-in centres to supervised accommodation.

Standard hospitalisation of mentally disordered persons in New Zealand has been described as ". . . an era gone, an obsolete way of providing mental health services".[197]

### B Reasons for Change

The introduction and development of modern psychoactive drugs in the 1950s played a large role in moving patients out of institutions and back into the community.[198] The powerful behaviour-modifying effects of these drugs meant that, in many cases, long periods of hospitalisation were no longer necessary. These drugs were accompanied by new therapy techniques, for example, occupational therapy, which purported to provide patients with the skills necessary to survive in the community.

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[197] See Appendix C for diagram from above n 191.

[198] Tony Cull, Chief Executive, Waikato Crown Health Enterprise, quoted on Radio Pacific, Auckland, April 1993.

Deinstitutionalisation was propelled also by a growing recognition amongst mental health professionals of the detrimental effects of long-term hospitalisation.[199] It was increasingly accepted that institutionalisation was self-perpetuating. An institution by its nature removes a person's responsibility for his or her daily life. This conflicts with one of the expressed aims of therapy which is to enable patients to manage independently.[200]

> "The movement towards community psychiatry grew out of the realization that chances of discharge from mental hospitals are diminished by long-term residence, and that this occurs regardless of age or clinical condition . . . . The depressed surroundings, the enforced idleness, the loss of ordinary privileges, and the isolation from family, friends and developments in the outside world, all of which may be attendant features of institutional life, often result in loss of motivation, withdrawal, apathy, submissiveness and an inability to make decisions. Ultimately, the patient may conform to institutional life, which precludes his participation in the community."[201]

Proponents of deinstitutionalisation argue that not only are these negative effects of institutionalisation diminished by community-based services but so too is the stigma which accompanies the inpatient or ex-inpatient label.

Evidence that care and treatment in the community could be as, if not more, effective than hospitalisation for many patients also had an effect.[202] It came

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[199] Above n 195, p 47.

[200] Haines, Hilary and Abbott, Max (eds) *The Future of Mental Health Services in New Zealand: Deinstitutionalisation, Volume 1 of the Edited Proceedings of Mental Health Foundation of New Zealand's 1985 Conference* (1986, Mental Health Foundation of New Zealand, Parnell, Auckland) p 23.

[201] Gostin, L *A Human Condition Volume One* (MIND, London, 1975) p 13 quoted in above n 147, p 109.

[202] Above n 200, p (vi).

to be accepted that, to achieve its maximum potential, care and treatment had to be tailored to the individual. Hospitalisation, by its very nature, standardises the way in which patients are dealt with and, when compared to community treatment, is highly inflexible.

It has been suggested that the community is the traditional place for support in difficult times and therefore the appropriate place for the provision of mental health services.[203] Patients are more accessible and thus the community, and not only mental health professionals, are able to be involved in ensuring a patient's well-being.

This accords with the current multi-disciplinary approach to mental health care. (The problem with such a suggestion is that the 'community' in the sense of a supportive, geographically linked entity rarely exists today. Modern society has witnessed a fragmentation of the community and family support systems. Those most in need of mental health care are likely to be those who are least able to form support networks.)

There is little doubt that the strongest politically motivated force behind deinstitutionalisation was a desire to reduce State health expenditure. The cost of running psychiatric institutions is extremely high - in 1990 it was approximately $100,000 per inpatient per year.[204] Such costs are difficult to justify in light of a more attractive alternative and the negative effects of institutionalisation on patients.

In theory, at least, deinstitutionalisation and a move to community mental health services sounds like a good idea. The reality of deinstitutionalisation, as indicated by overseas experience,[205] is less positive. This experience has

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[203] Above n 193, p 14.

[204] John Dawson "Community Treatment Orders" (1991) 7 Otago Law Review 410, 412.

[205] For example, the USA, above n 193, p 15.

shown that the process has simply allowed the State to transfer responsibility for the mentally disordered to voluntary agencies or patients' families who may or may not be financially, emotionally or physically equipped to cope. This has had detrimental effects on both the mentally disordered and the communities into which they have been released. Of these effects, the most apparent are:

- mentally disordered persons being left homeless
- rest homes being used to cope with the mentally disordered
- mentally disordered persons being diverted into the criminal justice system[206]
- increased burden on women as the principal caregivers.

Although the extent of these effects in New Zealand is uncertain, there are indications that they are at least beginning to occur.[207]

### C Reasons for the Problems

There are a number of reasons for these problems. The most obvious of these is the severe shortage of funding available for mental health services. Adequate care and treatment in the community may not be as expensive as hospitalisation but it is certainly not inexpensive.[208]

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[206] Above n 193, p 15.

[207] For example, three psychiatrically disturbed convicted inmates in Auckland's Mount Eden prison attempted self-mutilation in one evening - *The Dominion*, Wellington, New Zealand, 20 April 1993, p 1. This was blamed on a lack of community mental health services.

[208] Above n 200, p (vi).

Some funding for community mental health services is available through the Departments of Health, Social Welfare, Housing, Labour, and Justice.[209] Apart from private donations, any other funding of such services is at present a matter left to the discretion of individual Regional Health Authorities.[210] There is no requirement that any proportion of their expenditure be tagged for community mental health services or even for mental health services in general. Money saved by the now obsolete Area Health Boards[211] in deinstitutionalisation does not have to follow patients into the community and generally does not.[212] This is illustrated by the drop in the proportion of the Auckland health budget given to mental health services in the last 5 years from 14% to 8%.[213] In this era of cuts to the State health budget, mental patients as the 'silent sufferers' are one of the groups most in danger of being pushed to the back of the queue.

It is not surprising that ad hoc, inadequate funding in this area has resulted in ad hoc, inadequate services. The issue has received a great deal of media attention recently and widespread dissatisfaction has been voiced over the state of these services.[214] It is consistently agreed that community mental health services in New Zealand are far from satisfactory.[215]

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[209] National Mental Health Consortium *The Tangata Whenua Report, The Consumer Report, The Consortium Report* (Department of Health, Social Welfare, June 1989) p 56.

[210] Interview with Catherine Coates, Mental Health Policy Section, Department of Health, May 1993.

[211] Abolished under s22 of the Health Reforms (Transitional Provisions) Act 1993.

[212] Above n 200, p 14.

[213] Quoted on Holmes show, Television New Zealand, Channel One, 11 May 1993.

[214] For example, the Public Service Association's hospital subgroup of psychiatric nurses have called for a Royal Commission on community mental health services in New Zealand.

[215] For example, above n 200, p (vi).

The success of the changing trend depends on the social setting in which the change occurs as well as on economic factors. Public attitudes towards the mentally disordered remain predominantly negative despite the change in practice. As stated above,[216] the number of mentally disordered persons who are potentially dangerous is frequently over-estimated. This fear can create a barrier to effective community mental health services.

The fact that mentally disordered persons do not fit a common mould and therefore have diverse needs also causes difficulties. If all patients are to benefit from the potential flexibility of community mental health services, a comprehensive system comprising many different levels of service is essential.

Some of the negative effects of deinstitutionalisation may be relieved if an effective nationwide monitoring system is put into place. The Disabled Persons Community Welfare Act 1975 provides for nationwide monitoring but only in relation to 'homes' intended to accommodate or provide for five or more disabled persons.[217] These must be registered with the Department of Social Welfare. At present, Regional Health Authorities have responsibility for monitoring the standards of mental health services in their regions.[218] Although proper monitoring would not ensure that sufficient community mental health services are available, it would help to ensure and maintain an appropriate standard amongst those that are available (conditional, of course, on appropriate sanctions being applied to those who fall below the standards required).

[216] Part One, No 2.

[217] The definitions of both 'home' and 'disabled person' are contained in the Disabled Persons Community Welfare Act 1975 (as amended by the Health Reforms (Transitional Provisions) Act 1993).

[218] Above n 145.

## 3 Pre-Law Practice

As mental health ideology changed in other countries, so too did the law.[219]

Reforms in Italy provide an extreme illustration of these changes.[220] In 1978 and 1979, the Italian Government closed its psychiatric hospitals to new admissions and required the steady discharge of existing inpatients. It directed local authorities to establish general community health centres which were to include mental health services and obliged general hospitals to provide small numbers of emergency psychiatric beds. Committals were to be for an absolute maximum of 30 days. These reforms were based on the belief that it is the responsibility of the community as a whole to look after the mentally ill.

In New Zealand, the change in ideology and then practice went unaccompanied by any relevant law reform. How, then, was it possible for community mental health practice to develop in the absence of any legal framework for its provision?

Section 66 of the now repealed Mental Health Act 1969 provided the Directors of Mental Health Services and Superintendents of psychiatric institutions with powers to grant (and revoke) leaves of absence to committed patients.[221] Leave could be granted for an initial period of up to two years and extended from year to year at the discretion of the Director or the Superintendent with

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[219] For example, the Community Mental Health Act 1963 (US).

[220] See J Schaverien "Italian Mental Health Services: A Personal View" (1984) 1 Community Mental Health in New Zealand 31.

[221] There was also provision in s38 Mental Health Act 1969 for a district court judge to order the detention of a mentally disordered person as a single patient in a house rather than a hospital but this was rarely, if ever, used - Dawson, John "The Development of Community Mental Health Services in New Zealand: Implications for Law Reform" (1984) 1 Community Mental Health in New Zealand 12, 15.

the approval of the Director. Alternatively, patients were rehospitalised for one night upon the expiry of the initial leave period and subsequently released for a further period of up to two years.[222]

The original purpose of this section was to permit a small number of committed patients to be granted limited periods of leave with a view to their eventual discharge.[223] The section was positive in that it facilitated rapid readmission when required and allowed the taking of medication to be enforced outside the hospital setting.

It was the 1969 Act's inadequacy in the light of the changing mental health ideology that resulted in this artificial and extensive use of section 66. The section was forced to become the mechanism by which community care and treatment was facilitated. At one point in the mid 1980s, patients on leave outnumbered those detained in psychiatric hospitals.[224]

The artificiality of this use of section 66 was not, however, its only criticism. There was a clear lack of procedural protection for patients on leave under section 66.[225] Leave could be granted on any conditions the Director or Superintendent deemed fit and could be revoked at any time without a formal hearing, reference to statutory criteria or reasons being supplied to the patient concerned. It has been suggested that this lack of protection provided potential for breaches of natural justice, for example, the right of detained persons to be advised of the evidence against them.[226]

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[222] Above n 221, p 16.

[223] Above n 221, p 16.

[224] Above n 204, p 415.

[225] Above n 204, p 415.

[226] Above n 221, p 16.

## 4 Community Treatment Orders - Description

There is a presumption in the Act that a compulsory treatment order shall be a community treatment order unless the court considers that the patient cannot be treated adequately as an outpatient.[227] No indication of what is meant by this qualification is provided.

In addition, section 28 states that, before ordering a community treatment order, the court must first be satisfied that care and treatment will be provided that is appropriate to the needs of the patient and that the social circumstances of the patient are adequate for his or her care within the community.[228] As with the requirement that the patient be able to be treated adequately on an outpatient basis, there is no indication as to what is meant by 'social circumstances'. It is the writer's view that both phrases are sufficiently broad so as not to require the presence of the other.

The CTO will specify the place of treatment and the institution or service which is to carry out that treatment.[229] The place of treatment may be the patient's home or some other specified place.[230] Employees of the institution or service stated in the order who are authorised to provide treatment to the patient are entitled to have access to the place of treatment at all reasonable times.[231]

If at any time while the CTO is in force the RC considers that the patient can no longer be treated adequately as an outpatient, the patient may again be

[227] Section 28(2). The writer suggests that s126 Health Act 1956 is inconsistent with the new regime, unnecessary and ought to be repealed.

[228] Section 28(4)(b).

[229] Section 29.

[230] Above n 229.

[231] Section 29(2).

required to undergo the assessment procedure and an inpatient order may be made by the court.

CTOs have an initial lifespan of six months.[232] This may be extended for a further six months upon application to the court.[233] If a further application is made and a second extension ordered, the CTO will remain in force indefinitely.[234] The RC may direct at any time that the patient be released from compulsory status at which time the CTO will expire.[235]

## 5 Community Treatment Orders - Objections

It has been suggested that rather than providing an alternative to inpatient care, CTOs may allow an expansion of the class of persons able to be subjected to compulsory care and treatment.[236] No data on the effect of CTOs is available at this stage. The power given to the courts to order CTOs is certainly not, however, intended to allow a widening of this net. As discussed above,[237] before a CTO may be considered, the court must be satisfied that the criteria contained in the definition of 'mentally disordered' are met and, further, that in all the circumstances of the case a compulsory treatment order is necessary.

As stated above, before ordering a CTO under section 28 the court must be satisfied that appropriate outpatient care and treatment is available to the patient. The section states that this care and treatment must be provided by the

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[232] Section 33.

[233] Section 34(2).

[234] Section 34(4).

[235] Section 35(1).

[236] Above n 204, p 412.

[237] See above Part One.

relevant Area Health Board.[238] At first sight, this appears to provide some measure of protection against the State relieving itself of responsibility for those mentally disordered persons requiring compulsory care and treatment in the community. It would seem, however, that the requirement that the Boards *provide* the service is being interpreted very loosely. Until the creation of Regional Health Authorities and the abolition of Area Health Boards,[239] Boards arranged with community mental health agencies in the particular area to provide the service. (This role will now be undertaken by Regional Health Authorities or by a person declared to be a purchaser for the purposes of section 20 Health and Disability Services Act 1993.) There is no limitation on who the community mental health agencies are into whose care the mentally disordered person may be sent. Further, the 1992 Act imposes no statutory obligation on Boards to fund those agencies and formal acceptance by the agency is not a pre-condition of a CTO.

Even if section 28 is a sufficient safeguard against inadequate community care and treatment for those subject to CTOs under that section, that safeguard does not extend to all mentally disordered persons under CTOs. There are 2 other possible ways (other than an application under section 28) in which a CTO may originate or may have already originated. These are:

a) Under section 30 subsection 2 of the 1992 Act, the RC may, during an inpatient order, direct that the patient be discharged and treated as an outpatient. The inpatient order will then be deemed to have effect as a CTO.

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[238] Section 28(4)(a). This section was not included in the amendments to the MH(CAT) Act 1992 made by the Health Reforms (Transitional Provisions) Act 1993. Therefore, the discussion of the section will employ the old terminology.

[239] Above n 211.

b) Any patient who was on leave under section 66 Mental Health Act 1969 for more than 3 months when the new Act came into force was deemed to be subject to a CTO.[240]

There is no statutory requirement that adequate outpatient services be available for mentally disordered persons who become subject to CTOs by means of either of these 2 methods.

A fundamental objection raised in relation to community treatment orders is that they are unenforceable, that those mentally disordered persons for whom compulsory care and treatment is deemed necessary will not attend a specified place and/or accept treatment. This may well be true (although the absence of data at this early stage of the new regime means that, so far, only speculation is possible). The success of community treatment orders is dependent on the premise that a mentally disordered person under an order in the community, and under the implicit threat of being admitted or re-admitted to a psychiatric institution, will be more likely to decide that the community treatment order should be complied with.[241]

## 6 Leave Provisions

The leave provisions have been re-enacted alongside the CTOs. These are unchanged except that the leave period is now limited to a maximum of six continuous months.[242] These were retained to cater for those patients who are capable of and will benefit from spending periods of time in the

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[240] Section 144 MH(CAT) Act 1992.

[241] James, Dr Basil "The New Mental Health Act" in above n 126, p 15.

[242] Section 61.

community but who are in need of a higher level of care than the community is able to provide.[243]

Patients on leave under the new system are as deprived of procedural protection as were those under the old. The Parliamentary Select Committee recommended that reasons be supplied to the patient being recalled but that recommendation was not implemented in the legislation.

There is nothing preventing the new leave provisions being manipulated in the same manner as the old. Institutions are still technically able to re-admit patients for one night. The only difference is that that will now have to be after a period of six months rather than two years. The presumption in favour of a community treatment order for a person entering the system for the first time will, however, prevent the leave provisions being used in this way as frequently as previously.

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[243] Above n 210.

# CONCLUSION

There is little doubt that the Mental Health (Compulsory Assessment and Treatment) Act vastly improves New Zealand's mental health laws. The current definition of mental disorder represents a serious attempt to define more precisely those persons on whom the Act's powers are intended to be used.

The new and extensive review procedures and, in particular, the establishment of the entity called the Mental Health Review Tribunal, are also to be welcomed. Admittedly, the efficacy of many of these avenues for review currently depends on their accessibility to individual patients. Any inherent merit they may have is detracted from if the persons for whose protection they are devised are not able to take full advantage of them. This is, however, a problem which may best be resolved by an effective psychiatric patient advocacy service and is not a result of defects within the review provisions themselves.

Community treatment orders are positive innovations which have given legal foundation to what was rapidly becoming mental health practice and which ensure the least possible restrictions on a mentally disordered person's rights. If they are to achieve their full potential, adequate funding is imperative.

Notwithstanding the benefits of the new regime, real difficulties which have been indicated throughout the paper exist within the confines of the Act itself. These may or may not be resolved by the courts but at present they jeopardise fulfilment of the least restrictive alternative doctrine.

Compatible with the doctrine of the least restrictive alternative is the shift in focus which the Act embodies from the confinement of mentally disordered persons to their treatment. In this context, the absence of an express requirement that persons be treatable before a compulsory treatment order may

be imposed is notable. Arguably, such a requirement is implicit throughout the Act. The Act sets down a *right* to treatment which seems to assume that a patient is treatable. A community treatment order cannot be imposed unless the patient can be *treated* adequately in the community. The courts may interpret the requirement that a compulsory treatment be necessary in all the circumstances of the case to mean that effective treatment is possible. Nevertheless the writer suggests that satisfaction of an express treatability requirement before imposition of a compulsory treatment order is preferable. A finding that it is no longer satisfied would require the removal of the order. A requirement of this nature would resolve a number of the uncertainties which currently exist such as the positions of the personality disordered and the mentally retarded.

The use of a compulsory treatment regime cannot be justified without some benefit to the mentally disordered person and some prospect of a change in status. Through the innovations canvassed, the Act attempts to limit as much as possible the breaches of the rights which inevitably occur under such a regime. A treatability requirement would go some distance to compensating for the residual loss of rights.

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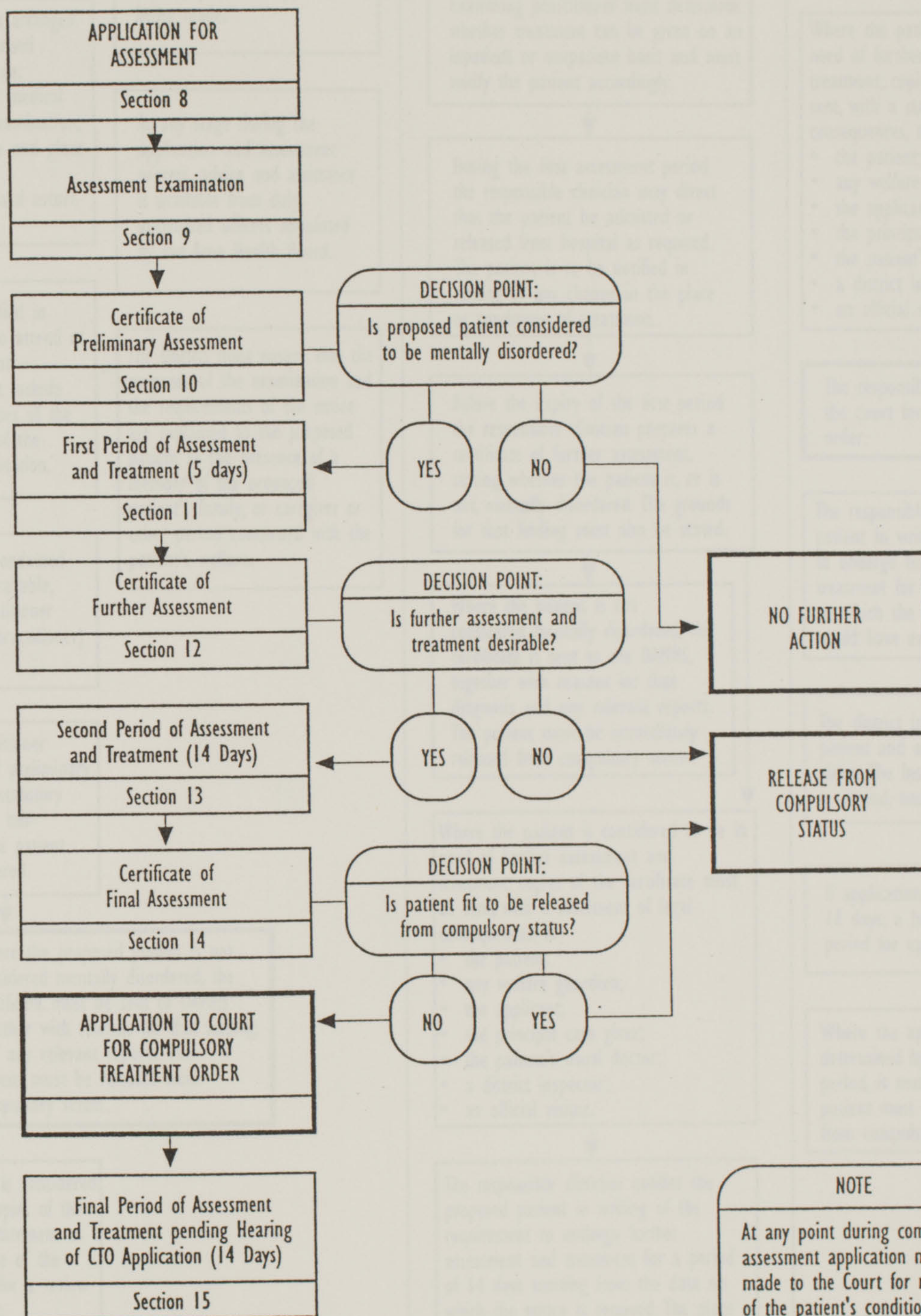
# COMPULSORY ASSESSMENT AND TREATMENT
## - KEY POINTS -

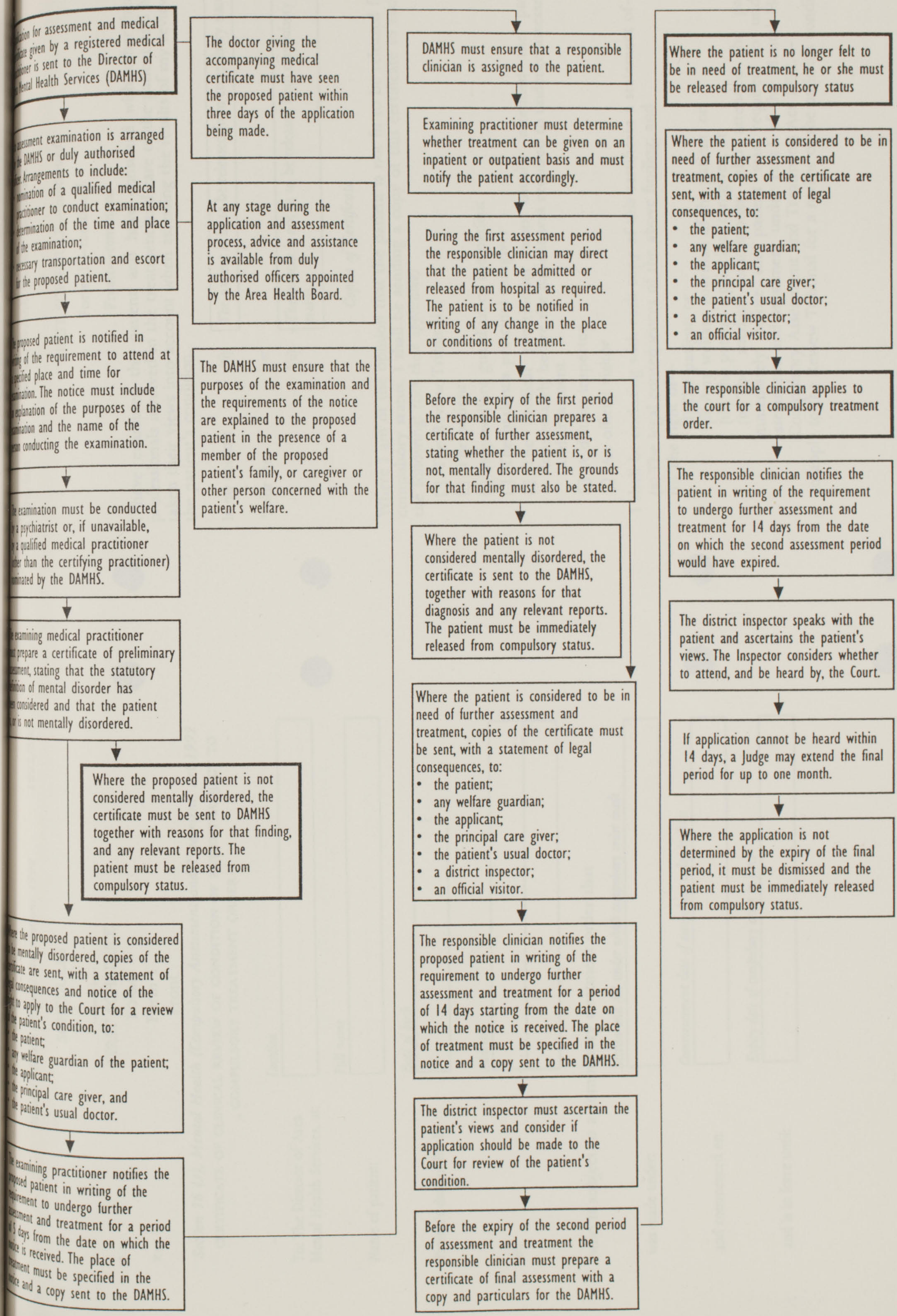
Appendix A (from Department of Health A User's Guide to the MH (CAT) Act 1992).




NOTE

At any point during compulsory assessment application may be made to the Court for review of the patient's condition.

# COMPULSORY ASSESSMENT AND TREATMENT
# - PROCEDURES -



SCHEDULES

FIRST SCHEDULE

FORMS

Reg. 3

Form 1

Front

*Section 76 (3), Mental Health (Compulsory Assessment and Treatment) Act 1992*

CERTIFICATE OF CLINICAL REVIEW OF CONDITION OF PATIENT SUBJECT TO COMPULSORY TREATMENT ORDER

To: The Director of Area Mental Health Services, at: *Location* [ ]

Name of patient: *Full name* [ ]

Patient's date of birth: *Date of birth* [ ]

of: *Address* [ ]

who is subject to a compulsory treatment order that

was made under: *Section and Act under which compulsory order made* [ ]

and commenced on: *Commencement date of compulsory order in force* [ ]

and is in force until: *Expiry date of compulsory order in force* [ ]



FIRST SCHEDULE—*continued*

Form 1—*continued*

Front—*continued*

I have examined the patient and have consulted with other health professionals involved in the treatment and care of the patient and have taken their views into account when assessing the results of my review of the patient's condition.

In my opinion: *(i) The patient is fit to be released from compulsory status.

*Delete one *or*

*(ii) The patient is not fit to be released from compulsory status.

*Copies of Certificate*

Where I am of the opinion that the patient is not fit to be released from compulsory status, I shall be sending a copy of this certificate to each of the following: *(tick those applicable)*

- ☐ The Review Tribunal
- ☐ The patient
- ☐ Any welfare guardian of the patient
- ☐ The patient's principal caregiver
- ☐ The medical practitioner who usually attended the patient immediately before the patient was required to undergo assessment and treatment
- ☐ A district inspector
- ☐ An official visitor

I shall be enclosing with each copy of this certificate a statement of—

(a) The legal consequences of the above finding; and

(b) The right of—

(i) The patient; or

(ii) Any welfare guardian of the patient; or

(iii) The patient's principal caregiver; or

(iv) The medical practitioner who attended the patient immediately before the patient was required to undergo assessment and treatment under Part I of the Mental Health (Compulsory Assessment and Treatment) Act 1992,—

to apply to the Review Tribunal for a review of the patient's condition.

Appendix B.

FIRST SCHEDULE—*continued*

Form 1—*continued*

Front—*continued*

*Reasons and Reports*

I shall be sending to the Director of Area Mental Health Services, with this certificate, full particulars of the reasons for my opinion of the patient's condition and any relevant reports from other health professionals involved in the case.

*Name of responsible clinician who conducted the review*

This certificate is issued by: ____________________

*Business address and telephone number of responsible clinician*

of: ____________________

____________________

/ /

*Signature of responsible clinician* *Date*



FIRST SCHEDULE—*continued*

Form 1—*continued*

Back

**Statement of Legal Consequences of Finding that Patient is not fit to be released from Compulsory Status and Statement of Right to Apply to Review Tribunal**

*Legal Consequences*

Where, on a clinical review under section 76 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 of the condition of a patient, the responsible clinician is of the opinion that **the patient is not fit to be released from compulsory status**, that patient will be required to continue to undergo treatment under that Act.

*Application to Review Tribunal*

There is however a further step that may be taken.

Each of the following persons, namely,—

(a) The patient:

(b) Any welfare guardian of the patient:

(c) The patient's principal caregiver:

(d) The medical practitioner who usually attended the patient immediately before the patient was required to undergo assessment and treatment under Part I of the Mental Health (Compulsory Assessment and Treatment) Act 1992,—

may apply to the Review Tribunal for a review of the patient's condition.

If any such person wishes to apply to the Review Tribunal, that person may seek help from—

(a) A district inspector:

(b) An official visitor:

(c) His or her lawyer:

(d) The patient's responsible clinician:

(e) A patient advocate (if one is available).

*Steps to be taken by District Inspector*

The district inspector who receives a copy of this certificate (or an official visitor acting under an arrangement with that district inspector) must, after talking to the patient and ascertaining the patient's wishes in the matter, consider whether or not an application should be made to the Review Tribunal for a review of the patient's condition.

If that district inspector or any such official visitor considers that such an application should be made, that district inspector or that official visitor is required to take whatever reasonable steps he or she thinks necessary to encourage or assist the patient, or any of the other persons entitled to apply to the Tribunal, to make such an application

FIRST SCHEDULE—*continued*

Form 1—*continued*

Back—*continued*

If that district inspector or any such official visitor considers that an application should be made to have the patient's condition reviewed by the Review Tribunal, but neither the patient nor any other person intends to make such an application, the district inspector or any such official visitor may report the matter to the Review Tribunal; and, in such a case, the Review Tribunal may, of its own motion, review the patient's condition under section 79 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 as if an appropriate application for such a review had been made to the Review Tribunal.

*Finding of Review Tribunal*

The Review Tribunal, on conducting such a review, may find that—

(a) The patient is fit to be released from compulsory status; or
(b) The patient is not fit to be released from compulsory status.

*Further Information*

For further information about the Review Tribunal, see sections 79, 82, and 101 to 107 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.



FIRST SCHEDULE—*continued*

Form 2 Reg. 4 (1)

Front

*Section 77 (3), Mental Health (Compulsory Assessment and Treatment) Act 1992*

CERTIFICATE OF CLINICAL REVIEW OF CONDITION OF SPECIAL PATIENT FOUND TO BE UNDER DISABILITY AND DETAINED PURSUANT TO ORDER MADE UNDER SECTION 115 (1) (a), CRIMINAL JUSTICE ACT 1985

To: The Director of Area Mental Health Services, at: *Location* [ ]

Name of patient: *Full name* [ ]

Patient's date of birth: *Date of birth* [ ]

of: *Address* [ ]

who was found to be under disability and who is detained pursuant to an order made under section 115 (1) (a) of the Criminal Justice Act 1985 and dated:

*Date of court order* [ ]

I have examined the patient and have consulted with other health professionals involved in the treatment and care of the patient and have taken their views into account when assessing the results of my review of the patient's condition.

FIRST SCHEDULE—*continued*

Reg. 6

Form 5

Front

*Section 79 (7), Mental Health (Compulsory Assessment and Treatment) Act 1992*

CERTIFICATE OF TRIBUNAL REVIEW OF CONDITION OF PATIENT SUBJECT TO COMPULSORY TREATMENT ORDER

To: The Director of Area Mental Health Services, at: *Location* [ ]

The Review Tribunal has reviewed the condition of

Name of patient: *Full name* [ ]

Patient's date of birth: *Date of birth* [ ]

of: *Address* [ ]

who is subject to a compulsory treatment order that

was made under *Section and Act under which compulsory order was made* [ ]

and commenced on *Commencement date of compulsory order in force* [ ]

and is in force until: *Expiry date of compulsory order in force* [ ]



FIRST SCHEDULE—*continued*

Form 5—*continued*

Front—*continued*

The review of the patient's condition was conducted by the Review Tribunal: *(i) Of its own motion

*or*

**Delete one* *(ii) On the application of

.............................................................
*Name*

In reviewing the patient's condition, the Review Tribunal has complied with the provisions of the First Schedule to the Mental Health (Compulsory Assessment and Treatment) Act 1992.

In the opinion of the Tribunal: *(i) The patient is fit to be released from compulsory status.

**Delete one* *or*

*(ii) The patient is not fit to be released from compulsory status.

*Copies of Certificate*

Where the Review Tribunal is of the opinion that the patient is not fit to be released from compulsory status, the convener of the Review Tribunal will send a copy of this certificate to each of the following: *(tick those applicable)*

- ☐ The Director of Mental Health
- ☐ The responsible clinician
- ☐ The patient
- ☐ Any welfare guardian of the patient
- ☐ The patient's principal caregiver
- ☐ The medical practitioner who usually attended the patient immediately before the patient was required to undergo assessment and treatment under Part I of the Mental Health (Compulsory Assessment and Treatment) Act 1992
- ☐ A district inspector
- ☐ An official visitor

FIRST SCHEDULE—*continued*

Form 5—*continued*

Front—*continued*

The convener of the Review Tribunal will enclose with each copy of that certificate a statement of—

(a) The legal consequences of the Review Tribunal's decision; and

(b) The right of—

(i) The patient; or

(ii) Any welfare guardian of the patient; or

(iii) The patient's principal caregiver; or

(iv) The medical practitioner who attended the patient immediately before the patient was required to undergo assessment and treatment under Part I of the Mental Health (Compulsory Assessment and Treatment) Act 1992,—

to appeal to a District Court against the decision.

| | / / |
|---|---|
| *Signature of Convener of Review Tribunal* | *Date* |



FIRST SCHEDULE—*continued*

Form 5—*continued*

Back

**Statement of Legal Consequences of Decision of Review Tribunal that Patient is not fit to be released from Compulsory Status**
**and**
**Statement of Right to Appeal to a District Court**

*Legal Consequences*

Where, on a review under section 79 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 of the condition of a patient, the Review Tribunal finds that **the patient is not fit to be released from compulsory status**, that patient will be required to continue to undergo treatment under that Act.

*Right to Appeal to a District Court*

There is however a further step that may be taken.

Each of the following persons, namely,—

(a) The patient:

(b) Any welfare guardian of the patient:

(c) The patient's principal caregiver:

(d) The medical practitioner who usually attended the patient immediately before the patient was required to undergo assessment and treatment under Part I of the Mental Health (Compulsory Assessment and Treatment) Act 1992,—

may, within 1 month after the date of the Review Tribunal's decision, appeal to a District Court against that decision.

If any such person wishes to appeal to a District Court against the decision, that person may seek help from—

(a) A district inspector:

(b) An official visitor:

(c) His or her lawyer:

(d) The patient's responsible clinician:

(e) The staff of the nearest District Court.

*Steps to be taken by District Inspector*

The district inspector who receives a copy of this certificate (or an official visitor acting under an arrangement with that district inspector), must, after talking to the patient and ascertaining the patient's wishes in the matter, consider whether or not an appeal should be made to a District Court against the Review Tribunal's decision.

If the district inspector or any such official visitor considers that such an appeal should be made, that district inspector or that official visitor shall take whatever steps he or she thinks necessary to encourage or assist the patient, or any of the other persons entitled to appeal, to make such an appeal.

FIRST SCHEDULE—*continued*

Form 5—*continued*

Back—*continued*

If that district inspector or any such official visitor considers that an appeal against the Review Tribunal's decision should be made, but neither the patient nor any other person intends to make such an appeal, the district inspector or any such official visitor may report the matter to a District Court; and, in such a case, a District Court Judge may, of his or her own motion, review the patient's condition as if an appropriate appeal had been made to the District Court.

*Determination of District Court*

On any such appeal, the District Court shall review the patient's condition to determine whether or not the patient is fit to be released from compulsory status.

*Further Information*

For further information about the review of a patient's condition on an appeal, see sections 16 and 83 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

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Appendix C

**Psychiatric Hospital Population — Average Number Resident: Rates, 1876-1982**

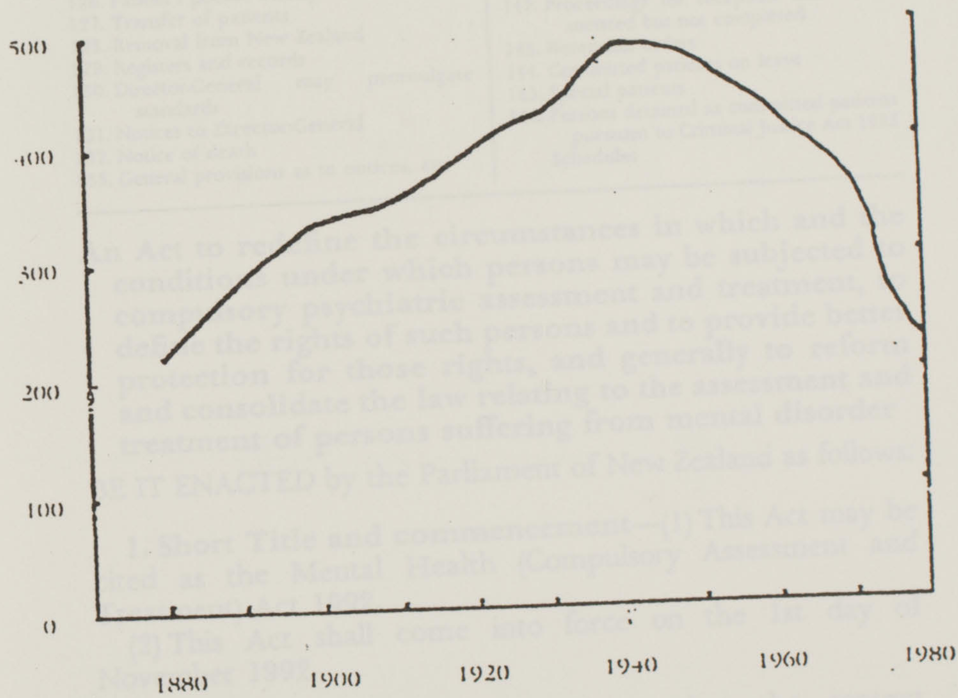


**Figure One**
**(From *Mental Health Data*, 1982)**

Appendix D.



119. Further offences involving false or misleading documents, etc.
120. Offences punishable on summary conviction
121. General penalty
122. Matters of justification or excuse

PART XI
MISCELLANEOUS PROVISIONS
123. Vetting of incoming mail
124. Vetting of outgoing mail
125. Procedure where letter withheld
126. Patient's pocket money
127. Transfer of patients
128. Removal from New Zealand
129. Registers and records
130. Director-General may promulgate standards
131. Notices to Director-General
132. Notice of death
133. General provisions as to notices, etc.
134. Fees of medical practitioners
135. Regulations
136. Application of other Acts
137. Repeals and consequential amendments
138. Savings
139. Criminal Justice Act 1985 amended
140. Armed Forces Discipline Act 1971 amended

PART XII
TRANSITIONAL PROVISIONS
141. Persons detained under section 19 of Mental Health Act 1969
142. Proceedings for reception order commenced but not completed
143. Reception orders
144. Committed patients on leave
145. Special patients
146. Persons detained as committed patients pursuant to Criminal Justice Act 1985
Schedules

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**An Act 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**

BE IT ENACTED by the Parliament of New Zealand as follows:

**1. Short Title and commencement**—(1) This Act may be cited as the Mental Health (Compulsory Assessment and Treatment) Act 1992.

(2) This Act shall come into force on the 1st day of November 1992.

**2. Interpretation**—(1) In this Act, unless the context otherwise requires,—

"Board" means an area health board:

"Clinician" means a person who holds a professional qualification relevant to the assessment, treatment, and care of patients with mental disorder:

"Court" means a District Court:

"Deputy Director" means the person who for the time being holds the office of Deputy Director of Mental Health pursuant to section 91 of this Act:

"Director" means the person who for the time being holds the office of Director of Mental Health pursuant to section 91 of this Act:

"Director of Area Mental Health Services", in relation to a Board, means the person appointed by the Board pursuant to section 92 of this Act to be the Board's Director of Area Mental Health Services for the purposes of this Act:

"District inspector" means a person appointed pursuant to section 94 of this Act to be a district inspector; and includes a person appointed pursuant to that section to be a deputy district inspector:

"Duly authorised officer" means a person who is designated and authorised by a Board under section 93 of this Act to perform the functions and exercise the powers conferred on duly authorised officers by or under this Act:

"Fit to be released from compulsory status", in relation to a patient, means no longer mentally disordered and fit to be released from the requirement of assessment or treatment under this Act:

"Hospital" means—

(a) A hospital managed by an area health board; and

(b) A private hospital licensed as a psychiatric hospital pursuant to Part V of the Hospitals Act 1957; and

(c) An institution that was, immediately before the commencement of this Act, a licensed institution under section 9 of the Mental Health Act 1969:

"Medical officer" means a medical practitioner, other than a medical superintendent, employed by a Board:

"Medical practitioner" means a person registered as a medical practitioner under the Medical Practitioners Act 1968:

"Mental disorder", in relation to any person, means 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;—

and "mentally disordered", in relation to any such person, has a corresponding meaning:

"Minister" means the Minister of Health:



"Official visitor" means a person appointed pursuant to section 94 of this Act to be an official visitor:

"Patient" means a person who is—

(a) Required to undergo assessment under section 11 or section 13 of this Act; or

(b) Subject to a compulsory treatment order made under Part II of this Act; or

(c) A special patient:

"Penal institution" has the same meaning as it has in section 2 of the Penal Institutions Act 1954; and in section 45 of this Act includes a police station while it is deemed by section 14 of that Act to be a penal institution:

"Principal caregiver", in relation to any patient, means the friend of the patient or the member of the patient's family group or whanau who is most evidently and directly concerned with the oversight of the patient's care and welfare:

"Psychiatric security institution" means a hospital, or part of a hospital, declared under section 100 of this Act to be a psychiatric security institution:

"Psychiatrist" means a medical practitioner registered as a psychiatric specialist under regulations made pursuant to section 39 of the Medical Practitioners Act 1968:

"Registrar" means the Registrar of a District Court:

"Responsible clinician", in relation to a patient, means the clinician in charge of the treatment of that patient:

"Restricted patient" means a patient who is declared to be a restricted patient by the Court under section 55 of this Act:

"Service" means a service for the treatment and rehabilitation of persons with mental disorder, being a service provided by, or managed by,—

(i) A board; or

(ii) A private hospital licensed as a psychiatric institution pursuant to Part V of the Hospitals Act 1957; or

(iii) An institution that was, immediately before the commencement of this Act, a licensed institution under section 9 of the Mental Health Act 1969:

"Special patient" means a person who is—

(a) Subject to an order made under section 115 or section 121 of the Criminal Justice Act 1985, or to an

(a) Apply to the Court for the making of a compulsory treatment order under Part II of this Act; and

(b) Send a copy of the certificate of final assessment to each of the following persons:

(i) The patient:

(ii) Any welfare guardian of the patient:

(iii) The applicant for assessment:

(iv) The patient's principal caregiver:

(v) The medical practitioner who usually attended the patient immediately before the patient was required to undergo assessment and treatment under this Part of this Act:

(vi) A district inspector:

(vii) An official visitor.

(5) To each of the persons specified in subparagraphs (i) to (v) of subsection (4) (b) of this section, the responsible clinician shall also send a statement of the legal consequences of the finding set out in the certificate of final assessment, and of the recipient's right to appear before the Court and be heard in respect of the application for a compulsory treatment order.

(6) The district inspector who receives a copy of the certificate of final assessment shall, subject to subsection (7) of this section, after talking to the patient and ascertaining the patient's wishes in the matter (where that can be done), consider whether or not to appear before the Court to be heard in respect of the application for a compulsory treatment order.

(7) Instead of performing personally the functions specified in subsection (6) of this section, the district inspector may in any particular case arrange for an official visitor to perform them.

**15. Status of patient pending determination of application**—(1) Where the responsible clinician applies to the Court for the making of a compulsory treatment order, the patient shall remain liable to assessment and treatment in accordance with the terms of the notice given under subsection (1) of section 13 of this Act and the succeeding provisions of that section until the expiry of a period of 14 days after the date on which the second period of assessment and treatment would otherwise have expired.

(2) If, after examining the patient under section 18 of this Act, the Judge is of the opinion that it is not practicable to determine the application within the period of 14 days referred to in subsection (1) of this section, the Judge may, by interim order, extend that period for a further period not exceeding 1 month.



(3) If the application is not finally determined before the expiry of the period of 14 days referred to in subsection (1) of this section, or within the last extension of that period ordered under subsection (2) of this section, the application shall be dismissed, and the patient shall be released from compulsory status (but without prejudice to the making of a further application under section 8 of this Act in respect of the patient at some time in the future).

**16. Review of patient's condition by Judge**—(1) Where an application is made to the Court under section 11 (7) or section 12 (7) or section 12 (12) of this Act for a review of the patient's condition, a Judge shall examine the patient as soon as practicable.

(2) The examination shall be conducted—

(a) At the patient's place of residence, the hospital, or the other place where the patient is undergoing assessment and treatment; or

(b) Where that is not practicable, at the nearest practicable place.

(3) Before examining the patient, the Judge shall (wherever and so far as practicable)—

(a) Identify himself or herself to the patient; and

(b) Explain to the patient the purpose of the visit; and

(c) Discuss with the patient the patient's situation, the proposed course of assessment and treatment, and the patient's views on these matters.

(4) As well as examining the patient, the Judge shall consult with the responsible clinician, and with at least 1 other health professional involved in the case, and may consult with such other persons as the Judge thinks fit, concerning the patient's condition.

(5) If the Judge is satisfied that the patient is fit to be released from compulsory status, the Judge shall order that the patient be released from that status forthwith.

(6) Every review under this section of a patient's condition shall, wherever practicable, having regard to the time in which that review is required to be conducted, and to the availability of Judges and other personnel and resources, be conducted by a Family Court Judge.

(7) Where it is not practicable for a review under this section of a patient's condition to be conducted by a Family Court Judge, that review may be conducted by any District Court Judge.

**75. Complaint of breach of rights**—(1) Where a complaint is made by or on behalf of a patient that any right conferred on the patient by this Part of this Act has been denied or breached in some way, the matter shall be referred to a district inspector or an official visitor for investigation.

(2) If, after talking with the patient, the complainant (where that is not the patient), and everyone else involved in the case, and generally investigating the matter, the district inspector or official visitor is satisfied that the complaint has substance, the district inspector or official visitor shall report the matter to the Director of Area Mental Health Services, together with such recommendations as the district inspector or official visitor thinks fit, and the Director of Area Mental Health Services shall take all such steps as may be necessary to rectify the matter.

(3) On concluding any investigation under this section, the district inspector or official visitor shall also inform the patient or other complainant of his or her findings.

(4) If the patient or other complainant is not satisfied with the outcome of the complaint to the district inspector or the official visitor, he or she may refer the case to the Review Tribunal for further investigation; and, in any such case, the provisions of subsection (2) of this section, with any necessary modifications, shall apply.

## PART VII

### REVIEWS AND JUDICIAL INQUIRIES

**76. Clinical reviews of persons subject to compulsory treatment orders**—(1) The responsible clinician shall conduct a formal review of the condition of every patient, other than a restricted patient, who is subject to a compulsory treatment order—

(a) Not later than 3 months after the date of the order; and

(b) Thereafter at intervals of not longer than 6 months.

(2) For the purposes of any such review, the responsible clinician shall—

(a) Examine the patient; and

(b) Consult with other health professionals involved in the treatment and care of the patient, and take their views into account when assessing the results of his or her review of the patient's condition.

(3) At the conclusion of any such review, the responsible clinician shall record his or her findings in a certificate of clinical review in the prescribed form, stating—



(a) That in his or her opinion the patient is fit to be released from compulsory status; or

(b) That in his or her opinion the patient is not fit to be released from that status.

(4) The responsible clinician shall send to the Director of Area Mental Health Services—

(a) The certificate of clinical review; and

(b) Full particulars of the reasons for his or her opinion of the patient's condition, and any relevant reports from other health professionals involved in the case.

(5) If the responsible clinician is of the opinion that the patient is fit to be released from compulsory status, the patient shall be released from that status accordingly, and the compulsory treatment order shall be deemed to have been revoked.

(6) Notwithstanding anything in subsection (5) of this section, if the patient is a special patient he or she shall be dealt with in accordance with subsection (1) of section 47 of this Act, and subsections (3) and (5) of that section shall apply.

(7) If the responsible clinician is of the opinion that the patient is not fit to be released from compulsory status, that officer shall send a copy of the certificate of clinical review to—

(a) The Review Tribunal; and

(b) Each of the following persons:

(i) The patient:

(ii) Any welfare guardian of the patient:

(iii) The patient's principal caregiver:

(iv) The medical practitioner who usually attended the patient immediately before the patient was required to undergo assessment and treatment under Part I of this Act:

(v) A district inspector:

(vi) An official visitor.

(8) To each of the persons specified in subparagraphs (i) to (iv) of subsection (7) (b) of this section the responsible clinician shall also send a statement of the legal consequences of the finding set out in the certificate of clinical review, and of the recipient's right to apply to the Review Tribunal for a review of the patient's condition.

(9) Subject to subsection (12) of this section, the district inspector who receives a copy of the certificate of clinical review shall, after talking to the patient and ascertaining the patient's wishes in the matter, consider whether or not an

application should be made to the Review Tribunal for a review of the patient's condition.

(10) If the district inspector considers that such an application should be made, the district inspector shall take whatever reasonable steps he or she thinks necessary to encourage or assist the patient, or any person specified in subparagraphs (ii) to (iv) of subsection (7) (b) of this section, to make such an application.

(11) If, in any case to which subsection (9) of this section applies, the district inspector considers that an application should be made to have the patient's condition reviewed by the Review Tribunal, but neither the patient nor any person specified in subparagraphs (ii) to (iv) of subsection (7) (b) of this section intends to make such an application, the district inspector may report the matter to the Review Tribunal; and, in such a case, the Review Tribunal may, of its own motion, review the patient's condition under section 79 or section 80 of this Act as if an appropriate application for such a review had been made to the Review Tribunal.

(12) Instead of performing personally the functions specified in subsections (9) to (11) of this section, the district inspector may in any particular case arrange for an official visitor to perform them.

**77. Clinical reviews of certain special patients**—(1) The responsible clinician shall conduct a formal review of the condition of every special patient who is detained in a hospital pursuant to an order of a court made under section 115 of the Criminal Justice Act 1985—

(a) Not later than 3 months after the date of the order; and

(b) Thereafter at intervals of not longer than 6 months.

(2) The provisions of subsections (2), (4), and (8) to (12) of section 76 of this Act shall apply in respect of every review under this section as if it were a review under that section.

(3) In the case of a special patient who was ordered to be detained following a finding of disability, the following provisions shall apply to any review of that patient's condition under this section:

(a) At the conclusion of the review, the responsible clinician shall record his or her findings in a certificate of clinical review in the prescribed form, stating—

(i) That in his or her opinion the patient is no longer under disability; or

(ii) That in his or her opinion the patient is still under disability but it is no longer necessary that the patient should be subject to the order of detention as a special patient; or

(iii) That in his or her opinion the patient is still under disability and should continue to be subject to the order of detention as a special patient:

(b) In every case, the responsible clinician shall send a copy of the certificate of clinical review to—

(i) The Review Tribunal; and

(ii) The Director; and

(iii) Each of the persons specified in section 76 (7) (b) of this Act:

(c) In any case where the responsible clinician is of the opinion that the patient is no longer under disability, or that the patient is still under disability but it is no longer necessary that the patient should be subject to the order of detention as a special patient, that clinician shall also send a copy of the certificate of clinical review to the Attorney-General for the purposes of section 116 of the Criminal Justice Act 1985:

(d) Notwithstanding anything in section 116 of the Criminal Justice Act 1985, on receiving a copy of the certificate of clinical review pursuant to paragraph (c) of this subsection, the Attorney-General may, instead of exercising the powers conferred by that section, apply to the Review Tribunal for a review of the patient's condition.

(4) In the case of a special patient who was ordered to be detained following acquittal on account of insanity, the following provisions shall apply to any review of that patient's condition under this section:

(a) At the conclusion of the review, the responsible clinician shall record his or her findings in a certificate of clinical review, stating whether or not, in his or her opinion, the patient's condition still requires, either in the patient's own interest or for the safety of the public, that he or she should be subject to the order of detention as a special patient:

(b) In every case, the responsible clinician shall send a copy of the certificate of clinical review to—

(i) The Review Tribunal; and

(ii) The Director; and

(iii) Each of the persons specified in section 76 (7) (b) of this Act:

(c) In any case where the responsible clinician is of the opinion that the patient's condition no longer requires, either in the patient's own interest or for the safety of the public, that he or she should be subject to the order of detention as a special patient, that clinician shall also send a copy of the certificate of clinical review to the Minister of Health for the purposes of section 117 of the Criminal Justice Act 1985:

(d) Notwithstanding anything in section 117 of the Criminal Justice Act 1985, on receiving a copy of the certificate of clinical review pursuant to paragraph (c) of this subsection, the Minister of Health may, instead of exercising the powers conferred by that section, apply to the Review Tribunal for a review of the patient's condition.

**78. Clinical reviews of restricted patients**—(1) The responsible clinician shall conduct a formal review of the condition of every restricted patient—

(a) Not later than 3 months after the date of the order declaring the patient to be a restricted patient; and

(b) Thereafter at intervals of not longer than 6 months.

(2) The provisions of subsections (2), (4), and (8) to (12) of section 76 of this Act shall apply in respect of every review under this section as if it were a review under that section.

(3) At the conclusion of the review, the responsible clinician shall record his or her findings in a certificate of clinical review, stating—

(a) That in his or her opinion the patient is fit to be released from compulsory status; or

(b) That in his or her opinion the patient is not fit to be released from compulsory status but it is no longer necessary that the patient should be declared to be a restricted patient; or

(c) That in his or her opinion the patient is not fit to be released from compulsory status and should continue to be declared to be a restricted patient.

(4) The responsible clinician shall send a copy of the certificate of clinical review to—

(a) The Review Tribunal; and

(b) The Director; and



(c) Each of the persons specified in section 76 (7) (b) of this Act.

(5) In any case where the responsible clinician is of the opinion that the patient is fit to be released from compulsory status, the Director shall either—

(a) Direct that the patient be released from that status forthwith; or

(b) Apply to the Review Tribunal for a review of the patient's condition.

(6) In any case where the responsible clinician is of the opinion that the patient is not fit to be released from compulsory status but it is no longer necessary that the patient should be declared to be a restricted patient, the following provisions shall apply:

(a) The responsible clinician shall send a copy of the certificate of clinical review to the Minister of Health:

(b) The Minister of Health shall, after consultation with the Attorney-General, either—

(i) Revoke the declaration that the patient shall be a restricted patient; or

(ii) Apply to the Review Tribunal for a review of the patient's condition.

**79. Tribunal reviews of persons subject to compulsory treatment orders**—(1) Any person to whom a copy of a certificate of clinical review is sent under section 76 of this Act may apply to the Review Tribunal for a review of the patient's condition.

(2) Without limiting anything in subsection (1) of this section,—

(a) The Review Tribunal may at any time, of its own motion, review the condition of any patient who is subject to a compulsory treatment order:

(b) On receiving a copy of a certificate of clinical review under section 76 of this Act, the Review Tribunal shall consider whether or not it should, of its own motion, review the patient's condition.

(3) Where it appears that for any reason a formal review of a patient who is subject to a compulsory treatment order has not taken place as required by section 76 of this Act, the Review Tribunal may review the patient's condition, either of its own motion or on application by any person to whom a copy of a certificate of clinical review would have been required to have been sent if the review had been held.

(4) Every application to the Tribunal under this section shall be addressed to the convener of the Review Tribunal.

(5) Subject to subsection (6) of this section, on receipt of such an application the convener shall arrange for the Review Tribunal to review the patient's condition as soon as practicable and in no case later than 14 days after the receipt of the application.

(6) Notwithstanding any of the preceding provisions of this section, the Review Tribunal may refuse to consider an application for review—

(a) If it has considered an application for review of the patient's condition within the preceding 3 months, and the certificate of clinical review states that there has been no change in the patient's condition in the intervening period; or

(b) In the case of an application made by a relative or friend of the patient, the Tribunal is satisfied that the application is made otherwise than in the interests of the patient.

(7) At the conclusion of any such review, the Review Tribunal shall set out its findings in a certificate of Tribunal review in the prescribed form, stating whether or not, in its opinion, the patient is fit to be released from compulsory status.

(8) If the Review Tribunal considers that the patient is fit to be released from compulsory status, the patient shall be released from that status accordingly.

(9) Notwithstanding anything in subsection (8) of this section, if the patient is a special patient he or she shall be dealt with in accordance with subsection (1) of section 47 of this Act, and subsections (3) and (5) of that section shall apply.

(10) If the Review Tribunal considers that the patient is not fit to be released from compulsory status, the convener shall send a copy of the certificate of Tribunal review to each of the following:

(a) The Director:

(b) The Director of Area Mental Health Services:

(c) The responsible clinician:

(d) The patient:

(e) Any welfare guardian of the patient:

(f) The patient's principal caregiver:

(g) The medical practitioner who usually attended the patient immediately before the patient was required to undergo assessment and treatment under Part I of this Act:



(h) A district inspector:

(i) An official visitor.

(11) To each of the persons specified in paragraphs (d) to (g) of subsection (10) of this section, the convener shall also send a statement of the legal consequences of the decision, and of the recipient's right to appeal to the Court against the decision.

(12) Subject to subsection (15) of this section, the district inspector who receives a copy of the certificate of Tribunal review shall, after talking to the patient and ascertaining the patient's wishes in the matter, consider whether or not an appeal should be made to the Court against the Review Tribunal's decision.

(13) If the district inspector considers that such an appeal should be made, the district inspector shall take whatever steps he or she thinks necessary to encourage or assist the patient, or any person specified in paragraphs (e) to (g) of subsection (10) of this section, to make such an appeal.

(14) If, in any case to which subsection (12) of this section applies, the district inspector considers that an appeal against the Review Tribunal's decision should be made, but neither the patient nor any person specified in paragraphs (e) to (g) of subsection (10) of this section intends to make such an appeal, the district inspector may report the matter to the Court; and, in such a case, a Judge may, of his or her own motion, review the patient's condition as if an appropriate appeal had been made to the Court.

(15) Instead of performing personally the functions specified in subsections (12) to (14) of this section, the district inspector may in any particular case arrange for an official visitor to perform them.

**80. Tribunal reviews of certain special patients**—(1) Any person to whom a copy of a certificate of clinical review is sent under section 77 of this Act may apply to the Review Tribunal for a review of the patient's condition.

(2) Without limiting anything in subsection (1) of this section, the Review Tribunal shall review the patient's condition on the application of the Attorney-General pursuant to subsection (3)(d) of section 77 of this Act or of the Minister of Health pursuant to subsection (4)(d) of that section.

(3) The provisions of subsections (2) to (6) of section 79 of this Act shall apply in respect of every review under this section as if it were a review under that section.

(a) The convener of the Review Tribunal shall send a copy of the certificate of Tribunal review to the Minister of Health:

(b) The Minister of Health shall, after consultation with the Attorney-General, either—

(i) Revoke the declaration that the patient shall be a restricted patient; or

(ii) Decline to revoke that declaration.

**82. Procedural provisions**—The provisions set out in the First Schedule to this Act shall apply in respect of a review of a patient's condition by a Review Tribunal under this Part of this Act.

**83. Appeal against Review Tribunal's decision in certain cases**—(1) Where, on a review under section 79 of this Act, the Review Tribunal considers that the patient is not fit to be released from compulsory status, any person specified in paragraphs (d) to (g) of subsection (10) of that section may, within 1 month after the date of the Review Tribunal's decision, appeal to the Court against that decision.

(2) On any such appeal, the Court shall review the patient's condition to determine whether or not the patient is fit to be released from compulsory status; and the provisions of section 16 of this Act shall apply, with any necessary modifications, to every such appeal.

**84. Judicial inquiry**—(1) A Judge of the High Court may whenever the Judge thinks fit, whether of the Judge's own motion or on the application of any person, make an order directing a district inspector or any one or more persons whom the Judge may select in that behalf to visit and examine any person who the Judge has reason to believe is being detained in a hospital as a patient and to inquire into and report on such matters relating to that person as the Judge thinks fit.

(2) A Judge of the High Court may whenever the Judge thinks fit, whether of the Judge's own motion or on the application of any person, and whether any order under subsection (1) of this section has been made or not, make an order directing the responsible clinician to bring any person who is being detained as a patient in the hospital before the Judge in open Court or in Chambers, for examination at a time to be specified in the order.



(3) If, on the examination of the person so ordered to be brought before the Judge, and on the evidence of any medical or other witnesses, the Judge is satisfied—

(a) That the person is detained illegally in the hospital as a patient; or

(b) That the person is fit to be discharged from the hospital,—

the Judge shall, unless the person is a special patient or is legally detained for some other cause, order that the person be discharged from the hospital forthwith.

(4) If the person has been found to be under disability and is detained as a special patient by virtue of section 115 of the Criminal Justice Act 1985, and it appears to the satisfaction of the Judge that the person is capable of being tried or committed for trial on the charge or indictment against him or her, the Judge shall (without prejudice to subsection (5) of this section) have the same powers as the Attorney-General has under section 116 of that Act to direct that the person be brought before a Court under that section.

(5) If the person has been found to be under disability and is detained as a special patient by virtue of section 115 of the Criminal Justice Act 1985, the Judge may, if in the circumstances of the case the Judge considers it proper to do so and if the interests of justice so permit (whether or not the person is capable of being tried or committed for trial), direct that the charge or indictment be dismissed.

(6) On giving any direction under subsection (5) of this section, the Judge may order that the person be released from compulsory status; but if it appears to the Judge that the person is not fit to be released from that status, the Judge shall order that the person be further detained in a hospital under this Act, and the last-mentioned order shall have effect as an inpatient order made under Part II of this Act.

(7) For the purposes of any examination under this section, the Judge shall have power—

(a) To summon any medical or other witnesses to testify on oath in respect of any matter involved in the examination, and to produce any relevant documents; and

(b) To call for any report on the person's condition by the Review Tribunal.

(8) The Judge may in any case, if the Judge thinks fit, report his or her opinion to the Minister, with such comments and recommendations as the Judge thinks fit.

**(9) Nothing in this section shall prevent the exercise of any other remedy or proceeding available by or on behalf of any person who is or is alleged to be unlawfully detained, confined, or imprisoned.**

(6) The Director may at any time amend or revoke any such delegation, and no such delegation shall prevent the exercise or performance of any power, duty, or function by the Director.

(7) Without limiting any of the preceding provisions of this section, the Director-General of Health may exercise and perform all or any of the powers, duties, and functions conferred or imposed on the Director by this Act.

Cf. 1969, No. 16, s. 3; 1987, No. 10, s. 6

**92. Directors of Area Mental Health Services**—(1) For the purposes of this Act, every Board shall appoint a Director of Area Mental Health Services.

(2) Every Director of Area Mental Health Services shall have the powers, duties, and functions conferred or imposed on the holder of that office by this Act.

**93. Duly authorised officers**—(1) For the purposes of this Act, every Board shall—

(a) Designate and authorise sufficient health professionals to perform at all times the functions and exercise the powers conferred on duly authorised officers by or under this Act; and

(b) Maintain an appropriate directory listing of a telephone number to ring when information or assistance is required under this Act.

(2) No person shall be so designated and authorised under this section by a Board unless the Board is satisfied that the person has undergone appropriate training and has appropriate competence in dealing with persons who are mentally disordered.

(3) Every person so designated and authorised under this section shall be issued with a document that identifies the holder and states that the holder is a duly authorised officer for the purposes of this Act.

(4) Persons so designated and authorised under this section shall carry out their duties under the general direction of the Director of Area Mental Health Services.

**94. District inspectors and official visitors**—(1) For the purposes of this Act, the Minister shall appoint such number of persons as the Minister thinks fit to be—

(a) District inspectors or deputy district inspectors; or

(b) Official visitors—



in respect of such Board or Boards as the Minister may specify in the instruments of appointment.

(2) No such person shall be a member or an employee of the Board or any of the Boards in respect of which the person is appointed.

(3) The Minister shall appoint as district inspectors or as deputy district inspectors only persons who are barristers or solicitors.

(4) The Minister may from time to time, with the concurrence of the Minister of Finance, fix the remuneration of district inspectors, deputy district inspectors, and official visitors, either generally or in any particular case, and may, with the like concurrence, vary the amount or nature of such remuneration.

(5) Every person appointed under this section shall hold office for a term of 3 years, but shall be eligible for reappointment from time to time.

(6) Every district inspector, deputy district inspector, and official visitor shall have the powers, duties, and functions conferred or imposed on holders of those offices by this Act, and such other powers, duties, and functions as may be conferred or imposed on them by the Director in writing in, and for the purpose of dealing with, situations of urgency.

Cf. 1969, No. 16, s. 5; 1982, No. 84, s. 2 (2)

**95. Inquiries by district inspector**—(1) Every district inspector on any visit to any hospital or other service may, and shall if so required by the Director, inquire as to—

(a) Any breach of this Act or of any regulations made under this Act, or any breach of duty on the part of any officer or other person employed in the hospital or other service; and

(b) Such other matters as the district inspector or the Director thinks fit to be inquired into respecting any patients, or the management of the hospital or other service.

(2) For the purpose of conducting any inquiry under this Act, a district inspector shall have the same powers and authority to summon witnesses and receive evidence as are conferred upon Commissions of Inquiry by the Commissions of Inquiry Act 1908; and the provisions of that Act, except sections 11 and 12 (which relate to costs), shall apply accordingly.

(3) A full report of every such inquiry shall be sent as soon as practicable by the district inspector to the Director.

Cf. 1969, No. 16, s. 58

*Review Tribunals*

**101. Review Tribunals**—(1) For the purposes of this Act, there shall be such number of Review Tribunals as the Minister may from time to time determine, each of which shall be appointed in respect of one or more specified Boards.

(2) Every Review Tribunal shall comprise 3 persons appointed by the Minister, of whom 1 shall be a barrister or solicitor, and 1 shall be a psychiatrist.

(3) No person shall act as a member of a Review Tribunal in any case where, given the identity of the patient, a conflict of interest may arise.

(4) Subject to section 104 (2) of this Act, a Review Tribunal shall not be affected by any vacancy in its membership.

**102. Functions and powers of Review Tribunals**—(1) The principal function of a Review Tribunal shall be to consider the condition of a patient who has applied for such a review, or in respect of whom an application for such a review has been made, under section 79 or section 80 of this Act.

(2) A Review Tribunal may at any time, and shall whenever required by the Director to do so, report to the Director on any matter relating to the exercise or performance of its powers and functions under this Act.

(3) A Review Tribunal shall have all such other functions as are conferred on it by this Act or any other enactment.

**103. Co-opting suitable persons**—(1) A Review Tribunal may, for the purposes of any particular case, co-opt—

(a) Any person whose specialised knowledge or expertise would be of assistance to the Review Tribunal in dealing with the case; or

(b) Any person whose ethnic identity is the same as the patient's, where no member of the Review Tribunal has that ethnic identity; or

(c) Any person of the same gender as the patient, where no member of the Review Tribunal is of that gender.

(2) Notwithstanding anything in subsection (1) of this section, where in any case no member of the Review Tribunal has the same ethnic identity as the patient, or is of the same gender as the patient, the Review Tribunal shall co-opt a suitable person pursuant to paragraph (b) or paragraph (c) of that subsection if the patient or the applicant requests it to do so.



(3) A person who is co-opted under this section shall be deemed for all purposes to be a member of the Tribunal in respect of the case for which he or she is co-opted.

**104. Meetings and powers**—(1) Meetings of a Review Tribunal shall be held at such times and places as the Review Tribunal or the convener appoints.

(2) No business may be transacted at any meeting of a Review Tribunal unless each member, or his or her deputy, is present.

(3) Every Review Tribunal shall have the same powers and authority to summon witnesses and receive evidence as are conferred upon Commissions of Inquiry by the Commissions of Inquiry Act 1908; and the provisions of that Act, except sections 11 and 12 (which relate to costs), shall apply accordingly.

*Further Provisions Relating to Review Tribunals*

**105. Deputies of members**—(1) The Minister shall from time to time appoint persons to be deputies of members of each Review Tribunal.

(2) The deputy of each member who is a barrister or solicitor shall also be a barrister or solicitor, and the deputy of each member who is a psychiatrist shall also be a psychiatrist.

(3) Every deputy may act for the member for whom he or she is appointed during any period when that member is incapacitated by illness, absence from New Zealand, or other sufficient cause from performing the duties of office, or during the absence of that member from any place at which a meeting of the Review Tribunal is to be held.

(4) No deputy may act for more than 1 member at the same time.

(5) Every deputy shall, while acting as such, be deemed to be a member of the Review Tribunal.

(6) No acts done by a deputy as such, and no acts done by the Review Tribunal while any deputy is acting as such, shall in any proceedings be questioned on the ground that the occasion for the deputy to act had not arisen or had ceased.

**106. Terms of office**—(1) Every member of a Review Tribunal, and every deputy of any such member, shall hold office for such term, not exceeding 3 years, as may be specified in the instrument of appointment, but may from time to time be reappointed.

# SCHEDULES

Section 82

## FIRST SCHEDULE

### PROCEDURAL PROVISIONS RELATING TO REVIEW TRIBUNALS

**1. Examination of patient**—Where a Review Tribunal is to review the condition of any patient under any of the provisions of Part VII of this Act, the convener, or some other member of the Tribunal nominated for the purpose by the convener, shall, as soon as practicable, examine the patient at the hospital, or the other place where the patient is undergoing treatment, or at such other suitable place as the convener or other member may determine, and may consult with such other persons as the convener or the member thinks fit concerning the condition of the patient.

**2. Attendance of patient and other persons**—(1) The patient shall be present throughout the hearing by a Review Tribunal of an application for a review of the patient's condition unless—

(a) The convener or other member who examines the patient in accordance with clause 1 of this Schedule certifies that it would be in the best interests of the patient to excuse the patient from attending the hearing; or

(b) The patient is excused or excluded by the Tribunal under subclause (2) or subclause (3) of this clause.

(2) The Tribunal may excuse the patient if it is satisfied that the patient wholly lacks the capacity to understand the nature and purpose of the proceedings, or that attendance or continued attendance is likely to cause the patient serious mental, emotional, or physical harm.

(3) The Tribunal may exclude the patient if it is satisfied that the patient is causing such a disturbance that it is not practicable to continue with the hearing in the presence of the patient.

(4) The Tribunal may exercise, at any stage of the hearing,—

(a) The discretion conferred on it, by subclause (2) of this clause, to excuse a patient; or

(b) The discretion conferred on it, by subclause (3) of this clause, to exclude a patient.

(5) The patient shall be present while the Tribunal makes any order upon the application unless—

(a) The patient has been excused or excluded under subclause (2) or subclause (3) of this clause; or

(b) There are exceptional circumstances justifying the Tribunal making an order in the absence of the patient.

(6) Any other person to whom a copy of the certificate of clinical review is sent under section 76 (7) (b) or section 77 (3) (b) of this Act shall be entitled to be present throughout the hearing, except as the convener may otherwise order.

**3. Right of patient and other persons to be heard and call evidence**—(1) The patient, and any person referred to in clause 2 (6) of this Schedule, shall be entitled to be heard by the Tribunal, whether in person or through a barrister or solicitor, and to call witnesses, and to cross-examine any witness called by any other party to the proceedings.

(2) Without limiting anything in subclause (1) of this clause, where the patient is present and appears capable of addressing the Tribunal, the

FIRST SCHEDULE—*continued*

Tribunal shall give the patient an opportunity to do so; and, in any such case, the Tribunal may, if it thinks it desirable to do so, require any parent or guardian of the patient, or any other person with whom the patient is living, or any barrister or solicitor representing any such parent, guardian, or other person, to withdraw from the Tribunal while the patient is addressing the Tribunal.

**4. Tribunal may call for report on patient**—(1) A Review Tribunal may, if it is satisfied that it is necessary for the proper review of a patient's condition, request any person whom it considers qualified to do so to prepare a medical, psychiatric, psychological, or other report on the patient.

(2) In deciding whether or not to request a report under subclause (1) of this clause, the Tribunal may ascertain and have regard to the wishes of the patient and any other party to the proceedings.

(3) A copy of any report obtained under this section shall be given by the convener of the Tribunal to the barrister or solicitor for the patient and for each of the other parties to the proceedings or, if any party is not represented by a barrister or solicitor, to that party.

(4) The Tribunal shall order that a copy of a report given to a barrister or solicitor under subclause (3) of this clause shall not be given or shown to the person for whom the barrister or solicitor is acting if the Tribunal has reason to believe that such disclosure of the contents of the report may pose a serious threat to the health or safety of the patient or of any other person.

(5) Where any person prepares a report pursuant to a request under subclause (1) of this clause, the fees and expenses of that person shall be paid by such party or parties to the proceedings as the Tribunal shall order or, if the Tribunal so decides, shall be paid out of public money appropriated by Parliament for the purpose.

(6) Any party to the proceedings may tender evidence on any matter referred to in any such report.

(7) The Tribunal may call the person making the report as a witness, either of its own motion or on the application of any party to the proceedings.

**5. Evidence**—For the purposes of any review of a patient's condition, a Review Tribunal may receive any evidence that it thinks fit, whether it is admissible in a court of law or not.

**6. Power of Tribunal to call witnesses**—(1) Without limiting anything in clause 5 of this Schedule, for the purposes of a review of a patient's condition, a Review Tribunal may, of its own motion, call as a witness any person whose evidence may, in its opinion, be of assistance to the Tribunal.

(2) A witness called by the Tribunal under this clause shall have the same privilege to refuse to answer any question as the witness would have if the witness had been called by a party to the proceedings.

(3) A witness called by the Tribunal under this clause may be examined and re-examined by the Tribunal, and may be cross-examined by or on behalf of any party to the proceedings.

FIRST SCHEDULE—*continued*

(4) Sections 20, 38, and 39 of the Summary Proceedings Act 1957, so far as they are applicable and with the necessary modifications, shall apply with respect to every person called as a witness by the Tribunal under this clause as if that person had been called by a party to the proceedings.

(5) The expenses of any witness called by the Tribunal under this clause shall be paid in the first instance, in accordance with the prescribed scale of witnesses' expenses, out of public money appropriated by Parliament for the purpose.

**7. Proceedings not open to public**—(1) No person shall be present during any proceedings before a Review Tribunal except the following:

(a) Members and staff of the Tribunal:

(b) Parties to the proceedings and their barristers and solicitors:

(c) Witnesses:

(d) Any person referred to in clause 2 (6) of this Schedule:

(e) Any other person whom the convener permits to be present.

(2) Any witness shall withdraw from the Tribunal if asked to do so by the convener.

**8. Restriction of publication of reports of proceedings**—(1) No person shall publish any report of proceedings before a Review Tribunal except with the leave of the Tribunal.

(2) Nothing in subclause (1) of this clause shall apply to the publication of any report in any publication that—

(a) Is of a bona fide professional or technical nature; and

(b) Is intended for circulation among members of the legal or medical professions, employees of the Health Service or the Department of Health, psychologists, or social workers.

**9. Tribunal may dispense with hearing in certain circumstances**—Notwithstanding any of the preceding provisions of this Schedule, a Review Tribunal may review a patient's condition without a formal hearing if it is satisfied that no person wishes to be heard in respect of the review.

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