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**UTILITARIANISM VS INDIVIDUAL RIGHTS:  
HAS THE MENTAL HEALTH (COMPULSORY  
ASSESSMENT AND TREATMENT) ACT 1992  
STRUCK THE RIGHT BALANCE?**

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*Word Count*

The text of this paper (excluding contents page, footnotes and bibliography) comprises approximately 15,000 words.

<sup>1</sup> Edmund Burke: Letter to the Sheriffs of Bristol, April 5, 1777.

<sup>2</sup> Section 2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

<sup>3</sup> Part VI of the Mental Health (Compulsory Assessment and Treatment) Act 1992.



*"Liberty must be limited in order to be possessed"*

Edmund Burke, 1777.<sup>1</sup>

## I. INTRODUCTION:

Mental Health law performs two main functions: protecting society from the mentally ill, and protecting the mentally ill from the exercise of excessive power by the state against them. This paper shall refer to the former as *utilitarianism*, and the latter as the protection of *individual rights*. There have been significant changes in mental health legislation in New Zealand in recent years, and it is the purpose of this paper to enquire whether these reforms have managed to properly balance the competing needs of utilitarianism and individual rights. The main focus of this paper shall be the Mental Health (Compulsory Assessment and Treatment) Act 1992, particularly the revised definition of 'mental disorder',<sup>2</sup> patients' rights,<sup>3</sup> and rights of review which, in the view of the writer, comprise the most fundamental and important changes in mental health law.

### *Word Count*

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<sup>1</sup> Jeremy Bentham: *An Introduction to the Principles of Morals and Legislation* (Clarendon Press, Oxford 1879).

<sup>2</sup> J.S. Mill: *Utilitarianism* (Dent, London 1910).

<sup>3</sup> Henry Sidgwick: *The Methods of Ethics* (Macmillan, London, 1890).

<sup>4</sup> Willy & Shalworthy: *Mental Abnormality and the Law* (NM Porter Lt., Christchurch, 1962).

<sup>1</sup> Edmund Burke: Letter to the Sheriffs of Bristol, April 3, 1777.

<sup>2</sup> Section 2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

<sup>3</sup> Part VI of the Mental Health (Compulsory Assessment and Treatment) Act 1992.



## II. UTILITARIANISM VS. INDIVIDUAL RIGHTS:

Utilitarianism encompasses many different theories, a comprehensive examination of which are outside the scope of this paper. In brief, however, all theories of utilitarianism require the maximisation of an important value in society. The classic utilitarian theories of Jeremy Bentham,<sup>4</sup> J.S.Mill,<sup>5</sup> and Henry Sidgwick<sup>6</sup> took as the fundamental basis of morality the requirement that overall happiness should be maximised. Later theories have replaced the requirement that "happiness" be maximised with other values, for example social welfare.

At a practical level, utilitarianism is a major focus of mental health law. Legislation is enacted to prevent mentally ill people interfering with the liberties of others in society. Historically, this was reflected in the institutionalising of mentally ill people - *an out of sight, out of mind response* - inmates in asylums were often incarcerated for very long periods of time, and as such were unable to interfere with the everyday lives of the rest of society thus maximising the total sum of happiness (welfare) of society at the expense of a few individuals.<sup>7</sup> Even though modern methods of psychiatric care are far less draconian, there is still a heavy emphasis in the legislation on the protection of society.<sup>8</sup> Utilitarian theories have been criticised for favouring the rights, or "happiness", of the masses at the expense of the individual, or as Rawls said, utilitarianism "ignores the distinctness of persons".<sup>9</sup> For example, a utilitarian would countenance slavery provided that the happiness accruing to the slave owner was greater than the pain suffered by the

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<sup>4</sup> Jeremy Bentham: *An Introduction to the Principles of Morals and Legislation* (Clarendon Press, Oxford 1879).

<sup>5</sup> J.S.Mill: *Utilitarianism* (Dent, London 1910).

<sup>6</sup> Henry Sidgwick: *The Methods of Ethics* (Macmillan, London, 1890).

<sup>7</sup> Wily & Stallworthy: *Mental Abnormality and the Law* (NM Peryer Lt., Christchurch, 1962) 8.

<sup>8</sup> See for example s.2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 which purports to protect society from people who are "dangerous".

<sup>9</sup> John Rawls: *A Theory of Justice* (Oxford University Press, 1972).



slaves.<sup>10</sup> Proponents of individual rights find this suggestion abhorrent because the pain and the pleasure accrue to different people.

A person going to the dentist to have a painful tooth extracted is in a position to weigh the pain of having the tooth removed against the "happiness" of being without toothache. She can make a decision according to the utility of the situation because both the pleasure and pain will accrue to *that individual* patient.<sup>11</sup> The utilitarian may not make such a calculation with regard to the slave owner as it is the slave owner who receives benefit at the expense of the slaves. Thus it could be said that mental health legislation should embrace the individual rights of mentally ill people as its central purpose, and protect the autonomy of the mentally ill from abuses of power by society in the exercise of its (utilitarian) right to be protected from harm.

Do the rights of society and the individual necessarily conflict? The writer suggests not. Even an examination of a classic utilitarian theory shows that a desire for general welfare maximisation can co-exist with a desire to protect the rights of the individual. J.S. Mill, a proponent of classic utilitarianism, developed a theory which embodied both respect for the individual and recognition of the need for society's protection:

"[T]he only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will make him happier, because, in the opinions of others, to do so would be wise, or even right... To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to

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<sup>10</sup> N.E. Simmonds: *Central Issues in Jurisprudence: Justice, Law and Rights* (Sweet and Maxwell, London, 1986) 39.

<sup>11</sup> Simmonds, fn 10, 40.



someone else. The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign."<sup>12</sup>

The essence of this passage is that the only reason which will ever justify interfering with liberty is to prevent interference with the liberty of another.<sup>13</sup> Thus, according to Mill, the only time one could ever justify the compulsory treatment of the mentally ill to maximise social protection would be when failure to treat in this manner would result in the infringement of the liberty of another person.

As an advocate of individual rights, Rawls in his first principle of justice attempted to balance the individual's rights against the rights of society. This principle states that:

"Each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others."<sup>14</sup>

Whilst this statement may seem essentially similar to Mill's utilitarian statement (above), it is less stringent because it is as much concerned with equality as it is with liberty.

Rawls is not, as it would prima facie appear, concerned with protecting liberty in general, but certain specific liberties, for example freedom from arbitrary arrest and freedom of speech.<sup>15</sup> The liberties which Rawls selects as being protected by the first principle are those which would be chosen by hypothetical persons (the original actors) acting behind

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<sup>12</sup> John Stuart Mill: *On Liberty* (Penguin Classics, London, 1985).

<sup>13</sup> Mill was, in this passage, specifically referring to the criminal law, but the principles apply equally well to mental health law.

<sup>14</sup> Rawls, fn 9, 60.

<sup>15</sup> Simmonds, fn 10, 49.



the "veil of ignorance". These fictitious people have their identities, social and economic positions, knowledge of their natural talents and abilities and knowledge of their individual views and preferences stripped from them, and are asked to come up with a set of principles which will govern the conduct of society. As these people do not know what place they will occupy in that society, they will select rules in accordance with the first principle - they will try to maximise the amount of liberty that each person possesses.<sup>16</sup>

It is possible that different rules will be chosen by the "original actors" in Rawls' theory as opposed to the rules which Mill might suggest. For example, it is possible that the original actors might accept the idea that mentally ill people should be compulsorily treated for their own good if there was a good prospect of recovery. Mill, however, would reject this as infringing the individual liberty of that person, unless, perhaps, non-recovery would impinge on the liberty of other members of society.<sup>17</sup> Thus it can be seen that although utilitarianism and individual rights theories have divergent focuses, it is possible to balance -- to a greater or lesser extent -- the theories' main concerns. It may indeed be surprising that Mill as a utilitarian would reject incursions on individual liberty for a patient's own good, whereas Rawls, a proponent of individual rights, might accept such an incursion. These are just examples of the many jurisprudential theories in this area, given to illustrate the fact that it will be virtually impossible to satisfy the competing aims of all theories. However, the writer considers that there is a middle ground where an acceptable level of social good (utilitarian aim) can be achieved whilst preserving individual rights. It is a delicate balance, and may involve weighing a plethora

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<sup>16</sup> Rawls, fn9, 11.

<sup>17</sup> It is possible to argue, however, that Mill would accept compulsory treatment for people who are truly incapacitated, i.e. those who are so mentally ill as to be unable to consent to treatment in a meaningful way.



of complexities. For example, both proponents of individual rights and most utilitarians<sup>18</sup> would accept that the rights of the individual should be maximised until they threaten to harm society. And conversely, society should be protected so long as individual rights are not affected. There are times, however, when it will not be possible to secure both of these ideals, and a balancing of interests must take place in the penumbra between these two largely uncontroversial poles of agreement. Considerations which must be taken into account when weighing the competing rights to social protection and individual autonomy will include, for example, the degree of impingement on individual rights/autonomy, the nature and gravity of the threat to society, and the imminence of the threat.<sup>19</sup>

The remainder of this paper shall focus on the mental health law in New Zealand, in particular the Mental Health (Compulsory Assessment and Treatment) Act 1992, hereafter referred to as the "Act", and shall examine whether this Act has achieved an appropriate balance between the needs of the individual and the needs of society.

### III. HISTORY OF MENTAL HEALTH LAW:

There has been a dramatic shift in recent years from viewing the mentally disordered as quasi-criminals who required incarceration to protect the public, to a sense that the mentally ill may on occasion require compulsory treatment as much for their own sake as for the protection of others.<sup>20</sup> New Zealand's original mental health laws were, as in most Commonwealth countries, imported from England. This, in turn, can be traced back to the *Statute de Prerogativa Regis* which is undated, and suspected to originate anywhere

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<sup>18</sup> For example, Rawls.

<sup>19</sup> See, for example, part V.C of this paper.

<sup>20</sup> The shift has been from a rigid utilitarian "protection of society" focus to a more rights focused regime which emphasizes rights to treatment and rights whilst being treated.



between 1275 and 1339.<sup>21</sup> This enactment deals with the lands of idiots and the lands of lunatics which were to be administered on their behalf by the King. This worked very harshly in effect, because even though financial allowance was made for the idiot or lunatic, no such provision was made for his or her family. Little was done to help treat the insane or even to lessen their distress. In later years, under the Poor Laws, houses were established where the mentally subnormal could be taken, but in many cases, they were just chained to the wall and kept in appalling conditions.<sup>22</sup> It wasn't until the end of the 18th Century when advances in medicine caused private hospitals to be formed where the mentally ill could be more appropriately cared for. This culminated in the passing of the Lunacy Act 1890 which was a first attempt at more liberal mental health legislation.

However, despite the fact that the mentally ill were receiving better attention, the derogatory terms such as lunatic, idiot and asylum used in society and in the legislation, demonstrate how the mentally ill were perceived. This began to change in New Zealand at the beginning of the 20th Century when the Lunacy Act 1908 was replaced by the Mental Defectives' Act 1911 which in turn was more suitably renamed the Mental Health Act 1954.<sup>23</sup>

A new Mental Health Act came into force in 1969 (MHA1969). The focus of the Act remained keeping the mentally ill out of society rather than treating them and helping them to lead normal lives in the community. The Act was characterised by a massive imbalance of power: the hospital staff, administration and the police with the law at their disposal versus the patient who could be detained, subdued with medication and who had very little legal recourse.<sup>24</sup> Under the Act, medical staff could provide whatever treatment

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<sup>21</sup> Wily and Stallworthy, fn 7, 14.

<sup>22</sup> Wily and Stallworthy, fn 7, 17.

<sup>23</sup> Wily and Stallworthy, fn 7, 17.

<sup>24</sup> John Dawson: "Mental Health Law Reform" [1986] NZLJ 323, 323.



they deemed necessary, without the consent of the patient, or even any attempt to determine whether the patient was competent to consent. Patients had no rights to their medical records, and furthermore, they had no right to legal information or legal representation, and in practice were not even represented at committal hearings. Additionally, s.124 MHA1969 proved a huge bar to bringing actions against employees of the mental health system, as it said that special permission had to be obtained from the High Court before any action could be brought against any person acting "in pursuance or intended pursuance of the Mental Health Act". Additionally, any action brought under this section was subject to a six month limitation period, as opposed to the normal six year period. Thus s.124 effectively prevented any successful action being brought by a psychiatric patient, and allowed the psychiatric profession to continue to operate behind closed doors. Indeed, the only accountability of mental health professional was to other doctors under the complaints procedure in the Medical Practitioners Act, and as John Dawson asks, "[w]hat psychiatric patient would have any confidence in complaining about a grievance to another group of doctors in a closed proceedings?"<sup>25</sup>

The 1969 Act was severely criticised by commentators as failing to recognise -- let alone protect -- the rights of the mentally ill, with too much emphasis on psychiatric expertise and with too little accountability. The process of law reform was kindled by the Gallen Report after the death of a patient in Oakley Hospital who had been give electroconvulsive treatment (ECT) without anaesthetic, muscle relaxant or even any attempt to explain the procedure to him.<sup>26</sup> The report highlighted serious breaches of procedure, but additionally stressed that there were "no adequate safeguards" for patients to complain of

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<sup>25</sup> Dawson, fn 24, 324.

<sup>26</sup> *Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters* (Government Printer, Wellington, 1983).



ill-treatment.<sup>27</sup> The Mental Health (Compulsory Assessment and Treatment) Act 1992 ("MHCAT") has been hailed by many as redressing a significant number of the shortcomings of the previous Act.

This paper shall now examine the MHCAT in detail and shall ask whether the Act really has embraced individual rights. Enquiry shall be made of the balance struck by the Act: whether the scales have moved towards respect for the individual whilst still maintaining a sufficient degree of social protection to satisfy utilitarian requirements.

#### **IV. SHIFT IN FOCUS: FROM DETENTION TO TREATMENT**

The long title of the MHCAT gives clear indication of the purpose of the Act:

"AN ACT to redefine the circumstances in which and the conditions under which persons may be subject to compulsory psychiatric assessment and treatment, to define the rights of such persons and to provide better protection for those rights..."

Many commentators have welcomed this Act as a significant change in mental health law recognising that the mentally ill have a right to proper treatment and recognition of their fundamental human rights just as society has the expectation that it will be protected from dangerous patients who are mentally ill.<sup>28</sup>

<sup>27</sup> Gallen Report, fn 26, para 8.1.14.

<sup>28</sup> Sylvia Bell: "Whose Rights are They Anyway? The Rights of The Mentally Ill, and Why they are Important." [1997] 2 Human Rights Law and Practice 232, 232.



Whereas the MHA1969 placed emphasis on the need for detention, the emphasis in the new Act is on consideration of the need for treatment.<sup>29</sup> Indeed, it has been suggested that the 1992 Act requires that its coercive powers should not be employed unless treatment affords a reasonable prospect of improvement or prevention of deterioration of mental health. This view is far beyond the scope of the 1969 Act (and arguably even beyond the new Act), and that this view can even be contemplated highlights the significant nature of the changes made by the new legislation.

The Act uses the language of rights and purports to make the mental health system more transparent and to enable legal redress for wrongs done to mental patients, but, seven years on, whether the Act has worked in practice is questionable. The remainder of this paper shall examine whether the Act really does adequately protect patients' rights, and whether the balance has slipped too far towards the individual rights approach to the exclusion of utilitarian considerations.

## V. "MENTAL DISORDER":

Fundamental to the 1992 Act is the new definition of "mental disorder" found in s.2:

**"Mental Disorder"**, in relation to any person means an abnormal state of mind (whether of a continuous or 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;"

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<sup>29</sup> *Trapsski's Family Law* (Brooker and Friend, 1993) Vol III, MHIntro.07(2).



This is both narrower and broader than the definition in MHA1969:

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

(a) Mentally ill -- that is, requiring care and treatment for a mental illness:

(b) Mentally infirm -- that is, requiring care and treatment by reason of mental infirmity arising from age or deterioration of or injury to the brain;

(c) Mentally subnormal -- that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of mind:"

#### **A. The First Limb:**

The 1992 definition may be seen as broader than the 1969 section: in the first part of s.2, there is a list of various symptoms which encompass a wide range of abnormalities.

Indeed, it would appear that this limb was intended to include all persons with a diagnosable psychiatric disorder of any kind.<sup>30</sup> That is not to say that a "mental disorder" must be a diagnosable mental illness before it will fall under this definition. Rather, this definition is a *legal* one; it takes a phenomenological approach which does not pinpoint a definite diagnosis, but merely lists observable symptomalogical indices which may be indicative of mental disturbance in a clinical context. Even though a very large number of people will fall under the first limb of the definition, the broad definition and the decision by Parliament against diagnostic labelling is sound because "psychiatric illness is too

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<sup>30</sup> *Trapsski's Family Law*, fn 29, MH2.13.04.



complex and insufficiently concrete to be subjected to ... a rigid analysis."<sup>31</sup> Thus, even though this section will encompass a great many people, such flexibility is needed because of the indeterminacy of psychiatric diagnosis.

It was originally thought that "abnormal" in the first limb added little to the definition of mental disorder. However recent developments have shown that the term may prove difficult. The term "abnormal" begs the question "in reference to what?" Do we determine normalcy subjectively, against what is normal for the individual, or is it to be determined objectively against what is normal for society? Inherent in the objective approach is the danger that different or non-conformist behaviour will be brought under the Act just because it can be termed "abnormal" in reference to what the majority of society construes as "normal". This could have huge impact upon individual liberty with eccentrics being compulsorily restrained and treated under the Act just because they do not rigidly conform to the status quo, and their eccentricity may not necessarily stem from a disorder of the mind, it may simply be evidence of a creative personality. Such an outcome would involve a shift towards utilitarianism at the expense of individual rights. In these circumstances, such a shift is not warranted. Subjecting non-conformists to mental health legislation may make society more uniform in behaviour, but it is at the expense of the individual's right to self-determination.

The objective approach has been adopted, in particular, to bring intellectually disabled offenders under the Act.<sup>32</sup> Intellectually disabled persons do not strictly speaking have an "abnormal state of mind", as their state of mind is normal for them. It was argued in *R v T* (*a mental patient*) that intellectual disability was a disorder of cognition and therefore an

<sup>31</sup>*Vernon v Bosley (no1)* (1997) 1 All ER 577, 610.

<sup>32</sup> S.Bell and W. Brookbanks: *Mental Health Law in New Zealand* (Brookers, Wellington, 1998).



abnormal state of mind.<sup>33</sup> There is an additional problem with the objective approach in that any person making a decision as to what is abnormal compared to social norms must to an extent rely on what his own perceptions of what those social norms are. This is quite unacceptable given the lack of consensus as to what "normality" is, and how little official guidance there is on the making of such determinations. It must be remembered that bringing people under the auspices of the Act has the result that they may be compulsorily deprived of their liberty and subjected to treatment without their consent. More stringent guidelines must be implemented if the objective approach is to be used. Indeed, the Ministry of Health has recognised that there is a danger in using the objective approach and has stated that clinicians should bear in mind both the objective and subjective approaches when determining a patient's state of mind.<sup>34</sup> There is, then, a danger that the objective standard could be extended in such a way that it becomes oppressive and is used by society as a tool against non-conformists. This, is clearly not the intention in the Act, which would seem to be an attempt at more liberal mental health legislation, and it can only be hoped that this part of the definition isn't abused for purposes of social control.

That a disorder may be "continuous or intermittent" also gives cause for alarm. It was included in the definition because some disorders have periods where the symptoms of the disorder are in remission, for example with schizophrenia and bi-polar disorder, there may be periods of lucidity, but it may be almost certain that the symptoms will return. It is fairly uncontroversial to say that when a person is continuously exhibiting symptoms covered by the first limb of the act (and satisfies the second limb) he may be compulsorily detained and treated. However, the same is not true when the symptoms are only intermittent. It was held in *In The Matter of T* that s.2 did not require the court to focus solely on the individual's *present* state of mind because the current state is necessarily

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<sup>33</sup> (1993) 10 FRNZ 195, 203.

<sup>34</sup> Mental Health Services, Ministry of Health: *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Wellington, June 1997).



linked to his psychiatric history. The court found that there was no doubt that the applicant would fail to take his medication if released from compulsory status and despite the fact that there were no outward signs of a mental disorder, and no tendency towards aggression, the Southern Mental Health Tribunal refused to release the patient from compulsory status.<sup>35</sup> This decision was not followed by the Northern Review Tribunal in *Re PH* who stated that where the symptoms are in remission, whether spontaneous or as the result of treatment, the patient is no longer fulfilling the criteria of exhibiting an "abnormal state of mind", and therefore must be released. The Act does not permit compulsory treatment on the basis that there may be some future deterioration.<sup>36</sup> The latter decision seems to be most in keeping with the liberal spirit of the Act, and fits with the definition in s.2. For a person to be deemed mentally disordered they must exhibit certain *symptoms*. If those symptoms are not present, for example in periods of remission, then they do not fit within the definition.

The writer suggests that even though this strict adherence to the definition may allow some people who could benefit from compulsory treatment to slip through the cracks, it is to be preferred because there is such a high value at stake -- a person's right to liberty and self-determination -- that the most narrow and literal reading of the section should be preferred until such a time as there is a clearer legislative intent to the contrary. As Mill said, the only reason for interfering with the liberty of a person is when he threatens to interfere with the liberty of others.<sup>37</sup> Where it is not clear that a person will interfere with the liberty of others, there is insufficient reason to favour a utilitarian approach ignoring the consequences for the individual. However, the Ministry of Health's guidelines list certain situations in which psychiatric history or a reluctance to continue with medication

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<sup>35</sup> [1994] NZFLR 946, 958.

<sup>36</sup> 20/12/94, NRT 294/94.

<sup>37</sup> See part II of this paper.



will be sufficient to allow a compulsory treatment order (CTO) to be made even if the symptoms are in remission.<sup>38</sup> Although clarification is to be welcomed, extreme caution should be used when ordering a CTO when symptoms are in remission otherwise there is a danger that people will be detained because of predicted dangerousness, which not only is notoriously difficult to predict, but also goes against the "western legal tradition [which] generally mandates the deprivation of liberty only after a crime has been committed -- not before."<sup>39</sup> There is a tension between the need to protect society from people who may become dangerous, and the need to protect the autonomy of persons. This tension will be difficult to resolve. The writer has suggested, however, that a narrow reading of this first limb so that individuals have their autonomy limited only in situations where they are in fact "dangerous" rather than supposed to be. In this way, society will be protected from the mentally ill when it becomes necessary to intervene, and additionally, individual liberty and autonomy is maximised.

### **B. The Second Limb:**

The second limb of the 1992 Act is much narrower in scope than any of the provisions in the 1969 Act and as such is able to constrain the definition to those mentally ill people for whom compulsory treatment under the Act is absolutely necessary. The second limb of s.2 is sometimes referred to as the "severity criteria", and it states that only when a mentally disordered person meets the "severity criteria" may he be brought under the Act for the purpose of compulsory treatment.<sup>40</sup> Effectively, there are five criteria in the second limb:

- (a) serious danger to the health of others,
- (b) serious danger to the health of oneself,

<sup>38</sup> Mental Health Guidelines, fn 34.

<sup>39</sup> Grant Amer: "Mental Disorder: "Serious Danger" – a minor faux pas or a serious mistake?" [1996] MHL 40, 42.

<sup>40</sup> Amer, fn 39, 41.



- (c) serious danger to others,
- (d) serious danger to oneself,
- (e) seriously diminished capacity for self-care.

This limb of the test has been the main focus of judicial decisions as it is the hardest part of the test to satisfy, and in this way, provides a limit to the seemingly open-ended definition in the first limb. The two limbs of the test are conjunctive: not until the first limb is satisfied, can the second limb come into play. There has, however, been considerable dispute as to what this second limb actually means.

### **C. Serious Danger:**

The requirement of "dangerousness" in a person is one of the most criticised aspects of the Act. It has been criticised by some medical practitioners as overly restrictive, preventing them from helping the mentally disordered to the best of their ability. Brent Doncliff, the Manager of the Community Mental Health Service in Timaru says:

"There have been times when I have been working with mentally ill people, some of whom have quite severe manifestations of mental illness. As a clinician I see that they are in need of what I may have to offer -- but they refuse my help! ....

To me, if I know that a person's mental state will eventually deteriorate as a result of their decision to discontinue maintenance of medication, and they lack the insight to be aware of this, then this is a serious danger to their health".<sup>41</sup>

He argues that waiting until a person is "dangerous" and thereby falling under the auspices of the Act is unsatisfactory as preventative medication is often more effective, and is certainly more cost-effective than waiting until a person's situation deteriorates to such an extent that they fall within the definition in s.2. There is also the additional benefit that a potentially dangerous person is not left in society until they chose to exhibit their

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<sup>41</sup> Brent Doncliff: "Personal Viewpoint: Mental Health (Compulsory Assessment and Treatment) Act 1992: The Decision - Law and Process or care?" [1996] MHL 7.



dangerous tendencies. This approach certainly satisfies the utilitarian criteria: society's safety and welfare is maximised at the expense of individual liberty. What this approach does not take into account, though, is that the individual is stripped of his autonomy because he is *predicted* to be dangerous. As mentioned above, detaining a person for predicted malfeasance would seem abhorrent in the context of criminal law, so why is mental health law any different?

Additionally, "dangerousness" is notoriously difficult to predict. research has demonstrated that psychiatrists cannot reliably predict dangerousness.<sup>42</sup> Grant Amer notes a study conducted in New York State following the case of *Braxstrom v Herold*<sup>43</sup>. Braxstrom was certified insane by a prison doctor and detained in a prison hospital following the completion of his sentence. He petitioned the court that he should be transferred to a psychiatric hospital if he was insane, and released if he was sane. The US Supreme Court released him, and about 1000 patients in similar circumstances were also released. Four years later, only 2.7% of those patients had behaved dangerously. Those who did behave dangerously showed no consistent signs which would have allowed a prediction of their dangerousness.<sup>44</sup> Thus it would seem that there is a great danger that predicted dangerousness may be used as a reason to deprive a person of their autonomy in situations where they would not have behaved dangerously. While this clearly upholds society's interest in protection, predicted dangerousness alone cannot be sufficient justification for depriving a person of his liberty and subjecting him to compulsory treatment.

Initially, it was thought that the term "serious" added little to the requirement of dangerousness and was just an indication that compulsorily treating a person against their

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<sup>42</sup> Crawford: "Problems with the Assessment of Dangerousness in England and Wales" [1984] 3 Med & Law 141.

<sup>43</sup> (1986) 383 US 107.

<sup>44</sup> Amer, fn 39, 41.



will was not a step to be taken lightly. However the term has been interpreted so that it is a valuable limitation on the indeterminate and unpredictable term "dangerous".

Given that it is so hard for clinicians to predict dangerousness, judges have tended to interpret "serious" as requiring imminence, thus preventing people being detained because at some indeterminate time in the future, they may cause harm.<sup>45</sup> Sylvia Bell and Warren Brookbanks recommend that imminence is just one of a number of factors which should be taken into account when determining the "seriousness" of the danger presented by a mentally disordered person. These factors should include:

- (1) Level (that is gravity) of the harm should it eventuate;
- (2) Likelihood of the harm occurring;
- (3) Imminence (that is the time-frame) of the harm;
- (4) Frequency of the harm;
- (5) Need to balance the nature of the harm against the proposed intervention."<sup>46</sup>

This is a sensible and practical scheme which would allow the danger presented by an individual to be meaningfully assessed, taking into account various relevant criteria, rather than having to stab in the dark as to what "serious danger" means.<sup>47</sup> Of particular importance is the fifth of the suggested criteria. It is this which would require a weighing of options: the judge would have to ask whether the nature and the imminence of the harm to society was to such a degree that it warranted the deprivation of liberty and autonomy of an individual. There is no such express requirement in the current Act which is unfortunate given that the balancing of these factors is the very purpose of mental health legislation.

The dangerousness criteria has also been criticised because it is not defined in the Act.

Whilst checklists like the one above may be of assistance, because the term is of such

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<sup>45</sup> See, for example, *Re JK [Mental Health]* (1994) 12 FRNZ 14; [1994] NZFLR 679.

<sup>46</sup> Bell and Brookbanks, fn 32, 2.5.

<sup>47</sup> See also WJ Brookbanks and AIF Simpson: "Restricted Patients in New Zealand: A Legal and Clinical Overview" [1996] 3 *Journal of Law and Medicine* 336, 361-377.



fundamental importance to the Act (only when the criteria has been satisfied may the powers under the Act be invoked) and because a determination that someone is sufficiently dangerous has such severe implications, it is unsatisfactory that this term is left undefined, or at least unrefined. That a checklists of factors have been used by the courts in recent years is to be welcomed, however, this definition is of such fundamental importance that the term should have been determined at the outset. When the focus of an Act is deprivation of liberty and autonomy, certainty should be a prerequisite. As has already been seen, it is hard enough to determine whether a person is mentally disordered. The level of dangerousness required before he can be compulsorily treated should be much more certain in order to avoid arbitrary results.

Furthermore, "dangerousness" is not a helpful term because it tends to encourage views in society that the mentally ill are always dangerous people. This may hamper efforts to treat the mentally disordered in the community and may increase the number of mentally disordered patients being returned to hospital. Other stigmatising words such as lunatic and asylum have been removed from mental health legislation: "dangerousness" conjures images of the mentally ill running wild and committing serious crime. In many cases, mentally disordered people subject to a CTO will only cause "anxiety" and "emotional distress to those around them." These minor effects have been held by the courts to amount to "dangerousness".<sup>48</sup> Thus, it is suggested, "danger" is too stigmatising and emotionally charged to enable a proper appraisal of the harm a mentally disordered person may cause. An alternative definition has been suggested by Amer:

"A clinically significant treatable behavioural, or biological, or psychological syndrome or pattern that occurs in an individual, which causes clinically significant distress or disability or impaired judgement, or impairment in social, occupational or other important areas of functioning."<sup>49</sup>

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<sup>48</sup> Amer, fn 39, 41.

<sup>49</sup> Amer, fn 39, 43.



The writer suggests that the non-judgemental language in this proposed section is to be preferred to the "dangerousness" criterion. It provides a relatively certain standard, because mental impairment must be "clinically significant" and therefore avoids the difficulties in predicting when a person will behave "dangerously". Additionally, it may enhance society's perceptions of the mentally ill, so that such persons are not viewed as necessarily "dangerous" but simply as people who suffer from diseases of the mind. The severity criteria are of the utmost importance as they limit the number of people who may be compulsorily detained under the Act. If the severity criteria still kept the majority of people with sufficiently serious mental disorders out of society, it would be possible to maximise the welfare of the individual by removing terms such as "dangerousness". In this way, those who are merely predicted to be "dangerous" would not be interfered with, and respect for the mentally ill may be increased, without prejudicing the utilitarian aim of social protection.

#### **D. Health and Safety:**

The second limb of the definition states that a person exhibiting symptoms listed in the first limb may be considered mentally disordered if they pose a "serious danger to the health or safety of that person or of others." There was initially some doubt as to whether "health" included mental as well as physical health. The courts concluded that had parliament wanted to limit the definition to physical health alone, some limiting wording would have been included. Doogue J found that mental, emotional and psychological health and well being were included in the ordinary meaning of the term, but that when dealing with non-physical effects, greater care must be taken because of the difficulty of assessment.<sup>50</sup> This holistic approach to health means that a person may be

<sup>50</sup> *In the Matter of D* [1995]NZFLR 28, 45. See also, *In the Matter of T* unreported, DC Auckland 13.2.95.



compulsorily treated for a mental disorder when his behaviour results in fear or anxiety or emotional stress to others.<sup>51</sup> Arguably, "serious danger to health" would also enable a person to be subjected to a CTO where their mental disorder adversely affects their capacity to care for dependants. This will be of special importance when the mentally disordered person is the primary care giver to children.<sup>52</sup> The writer suggests that if the degree of anxiety, distress or stress to others is properly monitored and weighed, and people are not compulsorily assessed just because their behaviour is non-conformist, "serious danger to health" is a useful and balanced requirement in the Act, and it is especially important when the people living with a mentally disordered person are children or infirm or elderly persons who have a diminished capacity for self-protection.<sup>53</sup>

More difficult, though, is the possible committal of a person because her mental disorder adversely affects her own mental health. Initially, the court found that "the danger posed must be shown as likely to be injurious to other aspects of the patient's physical integrity or well being [and not his mental health]"<sup>54</sup> However, a later decision concluded that the term also included danger to mental health, and to find otherwise would be to distort the legislative intent.<sup>55</sup> This argument is circular. A person's mental illness is necessarily a danger to their mental health.

To subject a person to a CTO just because they are mentally ill defeats the purpose of the Act which appears to require a level of "dangerousness" -- logically, this must be dangerousness over and above the mere presence of a mental disorder. The degree of

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<sup>51</sup> Amer, fn 39, 41.

<sup>52</sup> New Zealand Law Society Seminar: *The Mental Health (Compulsory Assessment and Treatment) Act 1992*. Leaders: John Dawson, Dr Jeremy Anderson, Stephen McCarthy. (Wellington, 1993).

<sup>53</sup> See *Decision 354 27/10/95* where the risk that a person posed to her child was considered an indicator of continued mental disorder and need for treatment and was taken into account when rejecting her application for release from a CTO.

<sup>54</sup> Per Ellis, J: *In the Matter of JK* (1994) NZFLR 678, 695.

<sup>55</sup> *In the Matter of T* (1994) NZFLR 946, 957.



deterioration which will amount to dangerousness is extremely difficult to assess, and there is no guidance in the Act. Indeed, it is not even clear that deterioration to mental health was even contemplated by the Act. Jane Hunter draws an analogy:

"if someone suffered from cancer and chose, on being appraised of their options, to refuse treatment, they would not, in law, be forced to submit to treatment, even if the ultimate outcome would mean their death. The consequences are serious, demonstrable, and potentially imminent."<sup>56</sup>

This is an interesting point, and further illustrates the flaws in the argument that deterioration of mental health can amount to dangerousness. The writer suggests that this does not accord with the phenomenological definition of mental disorder in the Act. Section 2 delineates mental disorder by reference to cause and effect -- the cause must be certain observable symptoms. It is illogical to allow those symptoms to also count as the required effect. In that case, what would be the point of the two stage test? The interpretation of "health or safety of that person" adopted by the courts is unsatisfactory. It accords too little weight to the requirement that a mental disorder must manifest itself as a symptom before the person may be subjected to a CTO. In this way, the interpretation does not seem to serve social utility or individual rights. If a person is capable of taking care of himself, he does not require detention for his own good, and if there is no necessary outward manifestation of dangerousness, then society does not need protection, and in that case, the individual is being deprived of liberty arbitrarily. This would appear to breach of s.22 of the New Zealand Bill of Rights Act 1990, which guarantees protection against arbitrary detention.

Furthermore, dangerousness to oneself has been taken to include suicidal risk, or risk of self mutilation. Accurate assessment of these risks is virtually impossible. The assessment is often extremely subjective.<sup>57</sup> Given that there is no reliable way of

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<sup>56</sup> Jane Hunter: "Don't Compel Patients Just Because they are Ill." [1996] MHL 57, 58.

<sup>57</sup> Amer, fn 39, 42.



determining the risk of suicide, it seems that there are insufficient guidelines for the clinician when determining the risk which should bring a person under the Act. Additionally, the patient may not currently be displaying symptoms, and therefore will not strictly satisfy the definition in s.2 because of a lack of symptoms. Therefore, it is suggested that this section requires further legislative clarification, and a set of guidelines to determine, for example, how recent the suicide attempt has to be, how effective the attempt was (did he take a few too many aspirin, or a whole bottle of sleeping pills?) and whether there is strong evidence of a wish to try again. It is suggested that in the absence of recent serious attempts, it is far too difficult to determine whether someone who professes to have suicidal intent is really a danger to himself. If in fact there is no 'danger', society's interest in protection is not being furthered, and there is no justification for removing the individual's right to autonomy.

### **E. Seriously Diminished Capacity for Self-Care:**

In part (b) of the second limb, it states that a person satisfying the first limb of the test may be detained under the Act if a mental disorder "seriously diminishes the capacity of that person to take care of himself or herself". This has been interpreted broadly by the tribunals as meaning more than a ability to care for oneself "in the narrow sense of eating and washing ... but in the wider sense of managing in the community."<sup>58</sup>

As was noted in the Law Society Seminar, there are two aspects to this part: firstly, capacity to take care of themselves, and secondly, the level of self care.<sup>59</sup> It is crucial that this distinction be made else, there is the possibility that people could be detained under the Act because of a life-style choice.

People may have their reasons for refusing medical treatment, eating poorly and choosing inferior accommodation, but so long as they are competent to make that decision, the law

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<sup>58</sup> *Re Decision 274 13/7/94, NRT 274/94.*

<sup>59</sup> Law Society Seminar, fn 52, 29.



should not interfere. Even more importantly, the law should not intervene and make persons subject to a CTO because they are mentally disordered and cannot afford to care for themselves in a better manner, because utilitarian goals would not be advanced, and there would be a severe incursion into individual liberty. Poverty should not be confused with a lack of capacity. The focus should be, and this seems to have been recognised by the courts, on capacity to make the decision, not the substance of that decision.<sup>60</sup> This provision does seem to have been interpreted by the courts, on the face of it, in a liberal manner. There is, however, danger that this provision may be misused; because it is so difficult to determine what part (a) actually means, there may be a temptation to try and force cases to fit under this head. This is clearly not desirable as precision is needed when deciding whether to commit a person under a CTO, and thus some redefinition in these sections would provide greater safeguards for individual liberty, whilst still providing adequate protection for society.

## **VI. DELUSIONS, DISORDERS OF MOOD, PERCEPTION, COGNITION OR VOLITION.**

As stated above, the definition of mental disorder in the first limb of s.2 is intentionally broad. The inclusion of delusions and disorders of mood and perception has caused relatively little difficulty as they have a recognised and accepted psychological meaning.<sup>61</sup> Disorders of volition and cognition, however are not precise clinical terms, and thus it has been very difficult for lawyers and psychiatrists to agree on a meaning. Clearly, this is cause for concern: the Act enables a person to be deprived of his liberty, so it is almost unthinkable that the symptoms he may be said to exhibit are not understood in any concrete or meaningful way.

<sup>60</sup> See McCormick J, in *Re CMC* [1995] NZFLR 538, 541.

<sup>61</sup> Bell and Brookbanks, fn 32, 2.8.



## A. Disorders of Volition:

In *Re A* the Northern Review Tribunal said that:

"as the term 'disorder of volition' has no medical or psychiatric significance it should be given its ordinary and natural meaning. ... [T]o literally apply the dictionary definition of volition which relates to wishing, willing, choosing and decision-making would result in the definition of mental disorder embracing an inordinately vast range of conditions. On the other hand to apply too narrow a definition of the term 'disorder of volition' would militate against the legislative intent to bring within the 'mental disorder' definition of conditions demanding of compulsory treatment."<sup>62</sup>

The definition of volition is unclear, imprecise and difficult to determine. In the above case, the applicant was held to be suffering from a disorder of volition because "to an abnormal extent he [failed] to learn to adjust and control his impulsive behaviour." The tribunal held that it was unnecessary to enquire whether the applicant's impulsive behaviour was involuntary or whether the behaviour was simply an impulse not resisted: it was the end result that was important. With respect, this is an alarming decision. Subjecting people to CTO's when they cannot control their behaviour is one thing, but forcing people to undergo treatment when they have simply made antisocial decisions is quite another matter.

It is possible that a person who has simply given in to an impulse should not fall under the definition of "mental disorder" at all, otherwise it would be tantamount to punishing people for crimes they *might* commit. As mentioned above, this is an odious result as it is oppressive towards the individual and removes personal responsibility for one's actions. The role of the criminal justice system includes the rehabilitation of people who cannot

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<sup>62</sup> *Re A* 1/6/95, NRT 320/95.



resist impulses to thief, commit arson, burglary etc, in addition to advancing the utilitarian goal of social protection. The role of the mental health system is to protect society and to rehabilitate the mentally disordered. If impulsive behaviour is merely a choice, then it is completely inappropriate to subject a person to a CTO because the mental health system is unlikely to be able to help them. A distinction must be made between people who are "mad" and people who are "bad".

There is additionally, the thorny problem of whether personality disorders are to be considered disorders of volition.<sup>63</sup> It was suggested that under the 1969 Act persons with personality disorders were excluded because they could not be treated or cured. This was clarified somewhat in relation to the 1992 Act by a decision of the District Court in 1996: *Re H*.<sup>64</sup> In that case, a patient suffered severe bulimia accompanied by frequent mood swings characterised by anger and despair. She frequently tried to eat poisonous or otherwise harmful substances and objects and had suicidal tendencies. She often fainted, suffered from anaemia and refused all medication, and tended to remove all IV apparatus from her body. An application was made for an extension of her CTO. There was some argument among the professionals that as the patient's problems couldn't properly be characterised as a specific "mental illness" or "mental disorder" the hospital could not compulsorily detain her, despite the risk she posed to herself and to others.<sup>65</sup> Judge Inglis QC made two distinctions. Firstly, the definition of "mental disorder" is a legal one, not a medical one, and as such is dependant on observable symptoms rather than any concrete "disorder" as such, and secondly "the expression 'mental disorder' is used simply as a

<sup>63</sup> See C.Elliot: "Puppetmasters and Personality Disorders: Wittgenstein, Mechanism and Moral Responsibility"[1994] 1 Philosophy, Psychiatry & Psychology 91.

<sup>64</sup> Family Ct, Palmerston North, CAT 054 03095, 29 July, 1996.

<sup>65</sup> See WJ Brookbanks: "Defining Personality Disorder" [1996] MHL 87.



convenient term to describe a combination of threshold characteristics which must be found to exist in a particular patient before that patient can be required to undergo compulsory assessment and treatment."<sup>66</sup>

Thus, the real question is whether there is an observable abnormality of mind *in law*. Judge Inglis QC said that regarding personality disorders, the wrong questions are being asked: it is not necessary that one should be able to say "personality disorders are mental disorders", one must instead look to the symptoms of the personality disorder (as with all other mental abnormalities) and determine whether those symptoms can be classed a disorder of mood, cognition volition or a delusion within the terms of s.2. In *Re H*, it was clear that the patient suffered a severe disorder of mood within the legal definition, and additionally suffered from a disorder of volition "in whatever sense that term is to be understood" because of her attempts to harm herself, commit suicide, and her inability to deal with food.

This is an extremely important decision: in effect, it establishes that personality disorders are not necessarily mental disorders under the Act, but that they may be, providing observable symptoms and the requisite "dangerousness" are present. This decision is in accordance with the spirit of the Act: that "dangerous" people with certain observable symptoms should be made subject to a CTO for the protection of themselves or society. It seemingly finds a sensible balance between individual rights and utilitarianism. Had the court ruled that personality disorders could not be mental disorders under the Act, society would have been put at risk with mentally disordered persons being outside help until they committed a crime and could be brought within the criminal justice system. In which case, the criminal justice system would be an inappropriate place for a person suffering from a mental illness as they would be held wholly responsible for their actions.

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<sup>66</sup> Brookbanks, fn 65, 88. See also: D.McCullum: "Law, Psychiatry & Anti-social Personality Disorder: A Problem of Government." [1998] Law in context 29.



Furthermore, although seemingly paternalistic, helping people for their own good in this circumstance is not an unjustified incursion into individual autonomy so long as the requisite "severity criteria" and observable symptoms are strictly observed. If people are truly incapable of recognising and promoting their own interests, their autonomy is not being violated if measures are taken for their own good, so long as their individual rights are protected to the maximum possible extent. In such situations, society's need for protection is arguably more pressing than the need to rigidly preserve individual autonomy at all costs, especially when a person is in no position to exercise that autonomy.

#### **B. Disorders of Cognition:**

Clinically, disorders of cognition are generally associated with organic brain stem dysfunction arising from for example, drug related delirium, head injury, severe depression, or dementia. Symptoms normally involve disruption of thought processes such as memory, judgement, insight and orientation.<sup>67</sup>

Although intellectual disability has been specifically excluded by s.4 as the sole indicator of a mental abnormality, the District Court has held that intellectual disability may fall within the definition of "disorder of cognition". It is important to note that to bring an intellectually disabled person within the Act, it is necessary that there is some other mental abnormality to satisfy the terms of s.2 when read with the exclusionary provision in s.4. Thus if an intellectually handicapped person *also* suffered from disorders of mood or disorders of cognition (over and above his intellectual handicap) then he could be brought within the scope of the Act. Whilst it is often asserted that there is no point in subjecting an intellectually handicapped person to a CTO as he cannot be treated (intellectual handicaps do not generally improve), this is an important provision from the point of social utility. If a person displays symptoms which would otherwise determine



him as having an abnormality of mind and presents a danger to himself or to society, it would be illogical for the Act to exclude him by virtue of s.4. For the protection of society, and for the protection of the intellectually handicapped, this is an important distinction.

## VII. PATIENTS' RIGHTS

Part VI of the Act contains provisions relating to patients' rights. This is the first reference to patients' rights in the New Zealand legislation, and as such, it must be welcomed as a step away from archaic mental health laws with emphasis on detention and social utility towards a more liberal and enlightened philosophy recognising the rights and autonomy of the individual regardless of their mental state. This Part was influenced to a large extent by international conventions, most particularly, the International Covenant on Civil and Political Rights which recognises certain basic, fundamental human rights, such as the right to freedom from cruel, inhumane and degrading punishment, freedom from arbitrary detention, and the right to humane treatment and respect for inherent human dignity, and also The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health care. This outlines the standard of treatment a person can expect to receive from a mental health system, and reiterates certain fundamental rights. A similar ethos is reflected in the 1992 Act, bringing New Zealand's legislation into line with international standards and approaches taken in other jurisdictions.<sup>68</sup>

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<sup>67</sup> *Trapsski's Family Law*, fn 29, MH2.13.13.

<sup>68</sup> See Zifcak: "United Nations Principles for the Protection of People with Mental Illness: Applications and Limitations" (1997)20International Journal of Law and Psychology 259.



It must be noted, however, that while part VI of the Act recognises the fundamental importance of patients' rights, only one of the rights is mandatory: the right to receive in writing a statement of one's rights "on becoming a patient".<sup>69</sup> The other rights in this part are expressed as entitlements only. One would hope, though, that even the use of the language of rights creates an obligation that mental health professionals will take seriously, recognising their inherent obligation to treat a patient with the respect accorded to him by this part of the Act.

This is an important part of the Act and clearly indicates the shift in focus in New Zealand mental health legislation. Provisions creating patients' rights do not generally affect the utilitarian goal of social protection, yet such provisions are of immense value to individuals as they will increase feelings of self-worth and empowerment. This part of the Act is central to striking the right balance between utilitarianism and individual rights.

#### **A. s.64 Written Acknowledgement of Rights:**

As discussed above, this is a mandatory right, but the written acknowledgement needs to be provided only on a person "becoming a patient". This means that a person may be held when they may not have even been examined by a specialist in psychiatry and thus may not be able to avail themselves of the provisions in part VI. This would be an unfortunate result of an otherwise helpful section, and to counteract potential problems with fundamental rights not being recognised, the Ministry of Health stated in its guidelines that the spirit of part VI of the Act should be taken to apply also to proposed patients.<sup>70</sup>

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<sup>69</sup> Section 64.

<sup>70</sup> Mental Health Services, Ministry of Health: *Guidelines to Mental Health (Compulsory Assessment and Treatment) Act 1992* (Wellington, June 1997) 31.



In many ways, this is a more stringent safeguard to rights than that adopted in other jurisdictions, for example under the Mental Health Act 1983 (UK) a patient needs only be informed of his rights as "soon as practicable"; such provisions add an element of discretion which could erode the strict requirement that patients are informed of their rights.

The right in this section is of special importance because it enables the effective functioning of other rights contained in the Act - without knowledge of one's right to judicial review, for example, it would be very hard for a patient to launch an appeal against his detention. Thus the individual is empowered without jeopardising the social good.

### **B. s.65 Respect for Cultural Identity:**

This is another important step by the legislature towards recognition of individual rights, and shows a sensitivity towards the needs of a multicultural society such as New Zealand's. Several reports by committees of inquiry highlighted a lack of sensitivity to cultural issues, and this section can be seen as an attempt to recognise the diverse attitudes to mental health issues that will be held by society.<sup>71</sup> This section has been used to promote connection with family and iwi to promote a patient's well being.<sup>72</sup>

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<sup>71</sup> See RG Gallen: *Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters* (Government Printer, Wellington, January 1983).

KH Mason: *Report of the Committee of Inquiry into Procedures Used in Relation to Admission, Discharge or Release of Certain Classes of Patients* (Government Printer, Wellington, August 1988).

JA Laurensen QC: *Report of the Committee of Inquiry into the Death at Carrington Hospital; of a Patient Manihere Watene and Other Related Matters*. (Government Printer, Wellington, 1991).

<sup>72</sup> Re PT 19/7/95, SRT 30/95: a patient was moved to a unit nearer his whanau so that he could be better assisted as a maori.



This section is vitally important, given the disproportionate number of Maori in psychiatric care, and the statistical imbalance appears to be increasing.<sup>73</sup> It can only be hoped that an increasing cultural awareness will help redress this balance and give appropriate and effective support to minorities.

One aspect of this provision that has not been tested is the question of culturally insensitive treatment.<sup>74</sup> It was recognised in the Gallen Report that ECT may be inappropriate for Maori because of the special significance they place on the head.<sup>75</sup> It may be that the need for cultural sensitivity will override an assessment that ECT, for example, would be an appropriate treatment.

Section 65 is a welcome addition to the 1992 Act. Although its effects have yet to be fully explored, it is likely that this provision will have significant and positive impact on the right of the individual to have his cultural beliefs respected. Even though the ruling out of certain treatments may reduce the likelihood of recovery of a patient and thus may affect his behaviour vis a vis society as a whole, this must be outweighed by the need for cultural sensitivity and the positive effects on individual (and almost certainly collective) welfare that appropriate contact with whanau and iwi may have.

### **C. s.66 The Right to Treatment:**

"Every patient is entitled to medical treatment and other health care appropriate to his condition."<sup>76</sup> The inclusion of this right illustrates that the right of society to be protected from mentally disordered persons carries with it a duty to provide appropriate care and treatment to those persons.

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<sup>73</sup> *Atawhaitia – The Maori Trustee Report on the Care of Maori under the Protection of Personal and Property Rights Act 1988 and part 4 of the Maori Affairs Act 1953* (Wellington, June 1991) 16.

<sup>74</sup> Bell and Brookbanks, fn 32, 9.6.

<sup>75</sup> See fn 71.

<sup>76</sup> Section 66 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.



This right has long been recognised in other jurisdictions, for example, in *Wyatt v Stickney* it was held that "involuntarily committed patients have a constitutional right to receive such treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition."<sup>77</sup> Without offering appropriate treatment, holding the mentally ill without their consent merely amounts to preventative detention and does not adequately recognise their individual rights and needs. This section, therefore, recognises that for utilitarianism to be just, certain individual rights must be recognised, thereby contributing to the balancing of these two apparently conflicting aims.

It has been argued that this section of the Act incorporates a de facto "treatability" criterion, that is, a person should not be detained under the Act unless she will benefit from treatment. If this is so, it would seem to further complicate the situation with regard to persons suffering from a personality disorder as it is widely believed that many such persons cannot be treated or "cured". This view is in keeping with the Mason report which said that "the right to treatment only extends to treatable patients. It does not require that those who are not treatable should have treatment forced upon them."<sup>78</sup> The report seems to suggest that in order to justifiably detain a person under the Act, he should be responsive to treatment, otherwise society is merely detaining him to prevent danger to society.

It is arguable, that in this case, such a person is best left to the criminal justice system after his dangerousness has manifested itself: "A compulsory treatment order cannot be upheld and continued simply for the purposes of detaining a person who otherwise might pose a serious danger to the public."<sup>79</sup> Is this apparent requirement of treatability really necessary?

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<sup>77</sup> 325 F Supp 781, 785.

<sup>78</sup> Mason report, fn 71, 224.

<sup>79</sup> *Re RR 9/7/93*, SRT93.



It does in one sense strengthen an individual's position against arbitrary detention, however, if a person suffering a personality disorder, for example, exhibits symptoms of a disorder of mood or a disorder of cognition/volition and poses a danger to the public and himself, it would seem contrary to the intention in the Act that he could not be made subject to a CTO. Society, in this case, is not being protected. Furthermore, for the individual to be left at large until his dangerousness manifests itself in criminal offending is not satisfactory for the individual either. Were he sent to prison, his mental disorder could place him at a serious disadvantage, and he may be open to abuse from other inmates. There is certainly no easy solution to this problem. To hold on to a mentally disordered person indefinitely because he shows no sign of improvement harks back to archaic asylums, but there seem to be few other ways to protect society from harm. Perhaps the drafters of the current Act chose to draft s.66 because it is the lesser of two evils: in an imperfect situation, the provision that maximises individual liberty is to be preferred.

#### **D. s.67 The Right to be Informed about Treatment:**

Again, this is further evidence that the mentally disordered are not to be viewed as thorns in the side of society, but, to the largest extent possible, they should be viewed as independent and autonomous beings. This provision should help foster helpful and sympathetic relationships between patients and mental health professionals so that even if a patient is being compulsorily treated against his will he should be given every opportunity to understand why, thereby minimising the incursion into his autonomy, whilst not affecting utilitarian goals.

#### **E. s.68 Further Rights in case of Visual or Audio Recording:**

This section requires that the patient (or his personal representative) consents before any audio or audio-visual recording is made of any treatment or interview of the patient. This, again, gives the patient an increased say in what may be done to him while he is being detained.



**F. s.69 The Right to Independent Psychiatric Advice:**

The inclusion of this section is another improvement to the previous legislative scheme. It enables a patient to get independent advice concerning his treatment. Independent in this case means independent of his treatment, it does not require that the psychiatrist be independent of the body providing the treatment. It has been suggested that this section may help relieve a patient's anxiety with regard to compulsory treatment, and as such may help foster a good relationship with his usual doctor.<sup>80</sup> However, this right may pose difficulties in practice as there is no obligation on the treating hospital to provide a second opinion. As such, it may be virtually impossible in some situations for a patient to arrange an independent psychiatrist, for example if he is subdued by medication, or has no family and few contacts.

The right to consult an independent psychiatrist is valuable because it increases individual rights without hampering the utilitarian goals of social protection.

**G. s.70 The Right to Independent Legal Advice:**

s.70 requires that a lawyer must be allowed access to his client, but again does not require the mental health authorities to provide a lawyer. Even though the Ministry of Health's guidelines recommend that arrangements are made with local lawyers to facilitate legal representation, this is in no way guaranteed.<sup>81</sup>

<sup>80</sup> Bell and Brookbanks, fn 32, 9.9.

<sup>81</sup> Ministry of Health's Guidelines, fn 67, para 19.7, 33.



For the rights in ss.69 and 70 to really protect the individual's interests, there should be an obligation on the mental health authority to provide an independent psychiatrist and legal representation if requested. No less is done for suspects when remanded in custody in the criminal justice system,<sup>82</sup> and it is arguable that the mentally disordered person is in a far more tenuous situation: he may be confused as a result of his disorder, he may be sedated by drugs, and he may be totally under-resourced. Although the rights in this section and in s.69 are laudable in intent, there must be an effective way of guaranteeing them. Guaranteeing such rights would not jeopardise society's right to protection, and would greatly improve the position of the individual.

#### **H. s.71 The Right to Company and Seclusion:**

The use of seclusion as a therapeutic tool has been limited to situations where the responsible clinician agrees that it is in the patient's best interests.

Because seclusion can be a further violation of liberty, strict guidelines have been laid down by the Ministry of Health as to when a patient can be placed in seclusion.<sup>83</sup> This is yet another improvement to the previous Act where no such guidance was available and seclusion was more readily used.

#### **I. s.72 - 74 Right to Communicate:**

These sections help to safeguard the right of the individual to communicate with the outside world. Naturally, this will often be beneficial to maintain relationships with family and friends and as such may speed recovery. The ability of the responsible clinician to withhold mail if he considers it beneficial to the patient has been defined and limited, thereby maximising the patient's liberty in this respect, without altering the level of protection available to society.

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<sup>82</sup> Section 10 of the Criminal Justice Act 1985.

<sup>83</sup> Ministry of Health: *Procedural Guidelines for the Use of Seclusion (revised edition)* (Wellington, 1995).



The language of rights used in part VI of the Act creates the impression of a more liberal and benevolent piece of legislation. However, these are not the only rights created by the Act, as there are other equally important entitlements provided for elsewhere. For example, the patient has the right to withdraw his consent,<sup>84</sup> and he has the right to instigate a judicial or clinical review of his treatment.<sup>85</sup> Significant in the protection of individual rights are the additional limits placed on mental health professionals when the patient is being given invasive treatment such as ECT or brain-surgery.<sup>86</sup> Furthermore the patient has certain basic rights that are so fundamental that there was no need to protect them in legislation, such as the right to food and shelter. As discussed, recognising such rights is vital to promoting an individual's sense of self-worth and empowerment. These rights are of fundamental significance to the mentally ill, and yet do not adversely affect society's right to protection. In this way, a significant step has been made towards redressing the imbalance in the previous legislative scheme.

This paper shall now consider whether these professed rights are mere tokens, or whether the Mental Health (Compulsory Assessment and Treatment) Act 1992 provides an effective framework for their protection.

### **VIII. RIGHTS OF REVIEW:**

Despite the apparent focus on individual rights in the 1992 Act, the rights-conferring provisions are rendered nugatory if there is no way to assert and enforce them. As mentioned above, the 1969 Act provided very little in the way of specific protection for

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<sup>84</sup> Section 57, s.63. The issue of consent is discussed below at part VIII.

<sup>85</sup> Section 16, s.18, s.76, s.77, s.83, s.84 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

<sup>86</sup> Section 58, s.59, s.60, s.61 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.



mentally disordered people's rights, and indeed, by virtue of s.124, reduced their rights to bring actions in tort vis a vis non-mentally disordered persons. The 1992 Act is certainly a great improvement on the previous scheme as it recognises that mentally disordered persons subject to a CTO need an enhanced method of review because of the tenuous position they may be in, and the great incursion into their liberty that a CTO will involve. The various methods of review shall now be examined.

### B. Reviews by the Mental Health Review Tribunal

#### A. Clinical Review:

Under s.76 of the Act, every patient subject to a CTO must undergo clinical review not less than three months after the initial order is made, and then at 6 monthly intervals. The responsible clinician must consult all persons involved in the patient's treatment to determine her condition. A certificate detailing the findings of this review is then sent to the Director of Area Mental Health Services. On performing a clinical review, the responsible clinician may himself declare that the patient is fit to be released from compulsory status, and thereby revoke the CTO.<sup>87</sup>

increased risk to society, it is to be welcomed that the Tribunal apply the letter of the

This is an important provision, because it is fundamental to the operation of the Act that a person should not be detained if he is not mentally disordered under s.2 of the Act. However, there is very little guidance in the Act as to when a patient is "fit to be released". It is merely said that a patient is fit to be released from a CTO when he is "no longer mentally disordered and fit to be released from the requirement of assessment or treatment under [the] Act." It has been argued that this section is flawed because the argument is circular: compulsory status can only apply to someone who is mentally disordered and requires assessment or treatment.<sup>88</sup> However, the circularity is not

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<sup>87</sup> Section 76(3)-(5).

<sup>88</sup> Bell and Brookbanks, fn 32, 8.6.

<sup>89</sup> Section 76.

<sup>90</sup> Section 79.

<sup>91</sup> Under s.2 of the Act.



problematic in and of itself, it is simply that if the definition in s.2 does not apply (that is, the patient does not exhibit any of the observable symptoms listed in the first limb, and or is no longer "dangerous" as required by the second limb) he is no longer mentally disturbed. Thus the only difficulties with the definition of "fit to be discharged" will be the same as those listed in relation to s.2.<sup>89</sup>

### **B. Reviews by the Mental Health Review Tribunal:**

The tribunals have jurisdiction over persons subject to Compulsory Treatment Orders and may act on receipt of a certificate of clinical review<sup>90</sup> or of its own motion.<sup>91</sup> In this way, the tribunal may be seen as a supervising body. Whilst the tribunal does not have jurisdiction to declare that the patient has been illegally detained, it does have the power to order the revocation of a CTO. The tribunal can only take into account the criteria for discharge determined by the Act<sup>92</sup> and cannot take into account other factors external to the patient's condition. Whilst this may, in some circumstances, mean that patients who would otherwise benefit from treatment are released and thus may pose a potential increased risk to society, it is to be welcomed that the tribunals apply the letter of the statute so rigidly. The writer suggests that it is preferable to have a patient released from compulsory status, and then, if necessary, readmitted, than it is to continue to detain such a person "just in case". Furthermore, for a tribunal to deem a patient fit to be released, he must no longer satisfy the criteria of s.2, in which case, he should not pose a danger to himself or society at all. In this way, the tribunal performs a highly important supervisory role, ensuring that the responsible clinician has properly applied the relevant *legal test*, and in this way, ensures that the autonomy of the individual is not overshadowed by the desire to protect society from perceived antisocial behaviour.

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<sup>89</sup> See above, part V of this paper.

<sup>90</sup> Section 76.

<sup>91</sup> Section 79.

<sup>92</sup> Under s.2 of the Act.



The tribunal has broader powers of review, however, when there is an alleged breach of a patient's rights under Part VI of the Act.<sup>93</sup> Under s. 75(4), the tribunal may "take all steps as may be necessary to rectify the matter". This section means that the rights conferred by Part VI of the Act may be adequately protected: a protection which mental health patients have never enjoyed before in New Zealand. However, as mentioned above, there are a great many other rights that are not specifically included in part VI or are deemed so fundamental that they are not included in the Act at all. With regard to these rights, the tribunal has no jurisdiction to intervene and cure perceived injustices, and may not intervene to say that a particular course of treatment should not be followed. This limits the tribunal's power of review, and prevents the tribunal from giving effect to *all* rights under the Act. It could be said that a wider power of review would enable the tribunal to better protect the individual against violations of his rights.

There is, though, an uneasy tension between psychiatrists and lawyers, and it could be said that each should observe their own fields of expertise: that is, the psychiatrists should be allowed to make appropriate diagnoses free from the interference of the tribunal (so long as there is sufficient provision for the patient to obtain a second opinion), while the tribunal's most appropriate role is to see that the correct legal procedures have been complied with.<sup>94</sup> In this way, not only is society being protected by patients being given appropriate treatment (as determined by those in the best position to evaluate the patient's condition) and the individual is being protected to some extent because the tribunal is enforcing procedural fairness. It is suggested, though, that the tribunal's

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<sup>93</sup> See part VI of this paper.

<sup>94</sup> Dr AIF Simpson: "Making the Mental Health (Compulsory Assessment and Treatment) Act work" [1996]MHL 51.



effectiveness could be extended by allowing it to review a violation of any right of the patient, not including an investigation of appropriate treatment.

### **C. Judicial Review:**

One of the first reviews a patient may be subject to is under s.16. This may occur in the first period of assessment and treatment<sup>95</sup> if requested by the patient.<sup>96</sup> An application is made to the District Court which enables the judge to release the patient from compulsory status if he deems that the patient is no longer mentally disordered within the terms of s.2. This section does not give the judge the power to determine the legality of the patient's detention, but it is an important layer of protection for individuals detained pursuant to the Act, nonetheless. In the first period of detention, the patient need not have yet been examined by a psychiatric specialist, and thus it is vital that there be some method of challenge to enable the patient to gain release if he is not actually mentally disordered.

Another important restriction on the invasive powers of the Act is s.18. This provides that a judge must examine a patient if an application for a CTO has been made before such an order is made.<sup>97</sup> The judge must consult the responsible clinician and at least one other health professional involved in the treatment of the patient, and if the judge is satisfied that the patient is no longer mentally disordered, he can order the patient's immediate

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<sup>95</sup> Under s.11, if the examining medical practitioner believes that the patient is mentally disordered he can be held for five days. This is the first period of assessment and treatment.

<sup>96</sup> Or any of the other persons listed in s.10(4)(a). The Judge cannot initiate an inquiry of his own motion.

<sup>97</sup> Section 14(4)(a).



release. Again, this step is a vital limitation to the powers of the Act, and demonstrates the vast improvement of the statutory regime. There is here an appropriate emphasis on the need to be absolutely sure before depriving a person of his liberty. In this way, society may also be protected: responsible clinicians may make preliminary assessments of people without subjecting them to the full force of a CTO and may be assured that the final decision to commit is not one they will have to take alone.

Even though the tribunals do provide a useful safeguard for individuals who are subject to a CTO, appeals of tribunal decisions to the district court are possible under s.83. The only purpose of this review is to determine whether a patient is fit to be released. This section may be problematic, as there is the possibility that a cycle of appeals may be started as neither the tribunal or the district court can bind the other with precedent. This has the unfortunate result that the legal status of the patient may remain unresolved and uncertain. It has been suggested by some writers that s.83 should be repealed and replaced by a right of appeal to the High Court.<sup>98</sup> The writer would agree with this: certainty in mental health law often proves elusive, but should be strived for because of the fundamental values at stake. For uncertainty to be created by a procedural system is not desirable, and thus a structure allowing an appeal to the High Court is to be preferred.

The most extensive power of review under the Act is contained in s.84. The judge may require that a report is written about a patient "as the Judge thinks fit".<sup>99</sup> This section is commonly invoked, and provides a final level of protection for those compulsorily detained under the Act. It is a marked improvement in contrast to the 1969 Act that those

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<sup>98</sup> See for example, Bell and Brookbanks, fn 32, 8.5.3.

<sup>99</sup> Section 84(1).



who feel they are being wrongly detained should have a set procedure to assert their rights rather than being hampered every step of the way by restrictive provisions such as s.124 of the 1969 Act.

It can be seen that there are very important procedural safeguards in place for protecting the rights laid down in the Act, and whilst there may be minor flaws in the review system, it is vital to protect individual rights from being overshadowed by societal desires for protection from perceived threats. In this way, the procedures for clinical, tribunal and judicial review under the Act help achieve a sensible balance between utilitarianism and individual rights by giving the individual a way to enforce his rights despite his relatively powerless position.

#### **D. The Mental Health Commission:**

Although it is not mentioned in the Mental Health (Compulsory Assessment and Treatment) Act 1992, the role of the Mental Health Commission is worth considering here. The Commission exercises a very wide and general supervisory role, across the whole mental health system, and thereby offers yet another level of support for individual rights. The Commission was founded as a result of the Mason Report which found that mental health services were being provided inconsistently across the country and at times were inhumane, and that there was a pressing need for leadership in the provision of mental health services.<sup>100</sup> The functions of the Commission include, providing advice to the Minister of Health, monitoring the provision of mental health services, and ensuring mental health needs are being met, and reducing the stigma and discrimination surrounding mental disorder.<sup>101</sup>

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<sup>100</sup> Mason Report, fn 71.

<sup>101</sup> See Sylvia Bell: "The Mental Health Commission" [1996] MHL 71.



Although the Commission is only a temporary statutory body, it has a potentially very useful role within mental health services. By investigating and reporting on the rights of individual patients, the Commission will make mental health services more transparent which in effect will make them more just.<sup>102</sup>

In reporting on the injustices and inadequacies of the mental health system, the Commission could be in a position to help strike the appropriate balance between utilitarianism and individual rights: to ensure that society is properly protected whilst enabling individuals to operate as autonomous beings to the maximum possible extent.

## **IX. SHOULD THERE BE A PRESUMPTION OF COMPETENCY?**

This paper has illustrated many of the reforms of mental health legislation which have promoted the rights of the individual to try to redress the inequality of the system so that the mentally ill have well established and protected rights to freedom from arbitrary detention, a right to human dignity and adequate rights of review. Some commentators, however, suggest that merely using the language of rights and putting judicial safeguards in place still does not place sufficient weight on individual rights, and continues to value social utility too highly. What is needed, they assert, is a presumption of competency.<sup>103</sup>

Even though a person is compulsorily detained under the Act, he has not necessarily lost his capacity to consent to treatment. Indeed, the Act states that as a basic principle, no-one should be treated without his consent.<sup>104</sup> This right is qualified in that non-consensual treatment is permitted for the period of assessment and for the first month of

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<sup>102</sup> See for example, Mental Health Commission: *Specialist Mental Health Services For Children and Youth* (Wellington, May 1999).

<sup>103</sup> See Denys Court: "Mental Disorder and Human Rights: the Importance of a Presumption of Competence." [1996] Auckland University Law Review 1.

<sup>104</sup> Section 57.



a CTO.<sup>105</sup> Additionally, if after the first month of treatment, the patient still refuses to consent, and the responsible clinician considers it in the patient's best interests to continue treatment, a second opinion will be obtained from a psychiatrist appointed by the Mental Health Review Tribunal.<sup>106</sup> Thus in theory, the patient's consent should be obtained for treatment to continue (unless a second opinion is obtained under the Act). However, the provisions in the Act do not amount to a presumption of competency to consent of the sort defined in the American case of *Rogers v Okin* where it was held that even though he is committed, a mental patient is to be presumed competent to consent to treatment in non-emergencies.<sup>107</sup>

It is argued that presuming a person competent has many important advantages, for example maintaining his self-esteem,<sup>108</sup> encouraging independence and useful functioning in society. However, it appears that there is almost a presumption of *incompetence* in New Zealand, which is not necessarily in line with the apparent desire in the Mental Health (Compulsory Assessment and Treatment) Act 1992 to make compulsory detention and treatment as uninvasive as possible and to maximise individual autonomy and wellbeing. In the case of *Re KS*, for example, a patient objected to being given ECT and applied for judicial enquiry under s.84 Act. The responsible clinician decided that it was in the patient's best interests under s.60 Act to have ECT and obtained a concurring opinion from a second psychiatrist under s.60(b). The court refused to exercise its powers under s.84 just because the patient objected.<sup>109</sup> Brookbanks has noted that:

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<sup>105</sup> Section 59.

<sup>106</sup> Section 59(2)(b).

<sup>107</sup> (1979) 478 F Supp 1342, 1367.

<sup>108</sup> This stems from the concept of "normalization", that it is of the utmost importance that the mentally ill be treated, as far as possible, in the same way as every other person. See D Court, fn 103, 6.

<sup>109</sup> [1993] NZFLR 845; (1993) 11 FRNZ 15. (cited by D.Court, fn 103, 14).



"[T]he decision appears to represent at some level a return to the presumption of 'global incompetence' in that it appears to imply that if a patient has been detained for treatment then any treatment that may seem to clinicians to be desirable may be administered irrespective of the wishes of the patient or his family ... [D]oes the decision mean that a refusal of consent even by a competent patient is ineffectual where the clinical decision to treat has been taken?"<sup>110</sup>

If the decision in *Re Ks* is taken to give clinicians *carte blanche* to administer any treatment to compulsorily detained persons under the Act, so long as they obtain a second opinion, it is a disturbing trend. Whilst it may be in society's interest that a person be treated and, if possible, "cured" of his antisocial disorder, it is also in society's interest that when that person is returned to society, he is a functioning, independent human being with a sense of self-worth. Presuming him incompetent is likely to achieve the opposite - he may begin to actually believe he is incompetent, and it is likely that compulsory treatment, especially of a highly invasive nature like ECT, is likely to render the patient extremely bitter. Additionally, it is arguable that a patient should have the right to withhold his consent from such invasive treatment. This, therefore, does not achieve the ends of either society or the individual. It is suggested, then, that a patient's right to refuse treatment under s.11 Bill of Rights Act 1990 should not be side-stepped just because s.60(b) 1992 Act.

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<sup>110</sup> Brookbanks: "Electro-Convulsive Therapy and the Mental Health (Compulsory assessment and Treatment) Act 1992 (NZ)" (1994) 1 Journal Law and Medicine 184, 190.



## **X. HAS THE RIGHTS FOCUS OVERSHADOWED OTHER ISSUES?**

The Mental Health (Compulsory Assessment and Treatment) Act 1992 has improved the relationship between the mental health system and mentally disordered persons at many junctures. It has been suggested in this paper that the Act constitutes a huge step forward towards a more enlightened mental health system with greater regard for individual autonomy and liberty and with adequate procedures to protect individual rights. It is now necessary to examine the operation of this rights-based approach in practice, to determine whether the Act has really helped mentally disordered persons, and additionally whether the Act has left society unreasonably exposed to the mentally disordered. That is, has the language of rights lulled proponents of individual rights into a false sense of security, and/or has the rights focus ignored the utilitarian goal of social protection.

The rights approach of the Act is in keeping with the trend originating in the 1960's which recognised the inappropriate and ineffective nature of compulsory hospitalisation for many mentally disordered persons and shifted the emphasis towards care of the mentally ill in the community.<sup>111</sup> This trend is reflected in the 1992 Act which contains a presumption that mentally disordered persons will be subject to the least invasive form of compulsory treatment, namely compulsory community care, rather than in-patient treatment.<sup>112</sup> When making a compulsory treatment order, the court has a discretion as to what type of order to make, but may only make a community treatment order if:

- (a) The Board provides, through the institution or service named in the order, care and treatment on an outpatient basis that is appropriate to the needs of the patient; and
- (b) The social circumstances of the patient are adequate for his or her care within the community.<sup>113</sup>

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<sup>111</sup> P Barham: *Closing the Asylum: The Mental Patient in Modern Society* (Penguin, London, 1992).

<sup>112</sup> Section 28(2).



The original policy of community care was intended to enable the closing of expensive, inefficient institutions, with the result that the money released could be channelled back into community services to better support the former patients of those institutions in a more appropriate manner.<sup>114</sup>

The end result, though has not been as successful as anticipated. The cost of running community services was severely underestimated, and the effect was that the lack of funding and resources left community services unable to care for many former patients who could not then be returned to their former hospitals because they had been downsized or shut-down altogether. For these people there was nothing to "afford them asylum.. in the most benevolent sense."<sup>115</sup> For these people, their position is an uncomfortable one -- they have been released from compulsory in-patient care, without appropriate support structures in place. As a result, their functioning in the community must necessarily be impaired. This is of great concern to both proponents of individual rights and those wary of letting the mentally disordered "loose" in society because of the potential harm to the community they exist in. The individual is severely disadvantaged: not only is he subject to a compulsory treatment order which can require him to live in a certain place and to accept certain medication, but society is not acting with any degree of reciprocity. He is not being given the support and treatment that he requires to help him function in the community, and arguably, this is failing to take seriously the obligations to provide "medical treatment and other health care appropriate to his condition".<sup>116</sup> The community is also at risk, because without sufficient support for mentally disordered

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<sup>113</sup> Section 28(4).

<sup>114</sup> Bell and Brookbanks, fn 32, 183.

<sup>115</sup> Bell and Brookbanks, fn 32, 183.

<sup>116</sup> Section 66.



persons living under compulsory treatment orders in the community, there is no guarantee that the patient will continue to take medication etc so as to reduce his risk to society. Clearly, without sufficient funding, the provisions in s.28 could harm both patients and the community.

There was originally a provision in the Mental Health Bill (which established the Mental Health Commission) to make the Commission responsible for purchasing mental health services. This would have enabled the Commission to channel all funding from former institutions back into community services. Unfortunately, this never materialised, and the Commission is now only able to monitor and evaluate, and is unable to act if money is being siphoned away from community services.

There have, however, been suspicions that the Community Treatment Order, despite being shrouded in the language of rights, may be used as an instrument of social control. If it is seen as a "soft-option", a way of dealing with mentally ill people who may cause social problems but are not felt to be dangerous enough to warrant compulsory detention in hospital, a system akin to plea bargaining may take place whereby mentally disordered persons may be subject to surveillance and control in the community.<sup>117</sup> This would be of great concern as community treatment orders may be almost as invasive as compulsory detention in hospital. Monitoring would have to take place by way of compulsory blood testing to see whether medication is being taken, and limits on lifestyle might be imposed such as whether the patient was allowed to drink, or whether he was allowed to meet certain people.<sup>118</sup> Such requirements impose huge restrictions on the lifestyle of the patient, yet the community has an easy conscience *knowing* that he is subject to a less restrictive type of treatment.

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<sup>117</sup> Dawson: "Community Treatment Orders" [1991] Otago Law Review 410, 413.

<sup>118</sup> Dawson, fn 117, 413.



The criteria listed in s.28(4) may provide a significant hurdle to the making of community treatment orders. As mentioned above, the lack of funding to community mental health services may mean that there are simply not the resources to place people in the community, so that they must remain in hospital. This does not reflect the liberal intentions in the Act which purports to reduce the incursion into the liberty of individuals. Indeed, it is possible that patients who might benefit from community care, but who are not of such danger to themselves that they must remain in hospital (for example, they have agreed to take their medication which suppresses their symptoms, but require occasional supervision to ensure their continued compliance). It could be argued that this is an unnecessary restriction on the liberty of the individual.

It would appear that the proper functioning of the Act is largely dependant on political will. The 1992 Act does not determine how mental health services are to be funded, and there is nothing to require funds from "deinstitutionalisation" to be re-routed to patients in the community.<sup>119</sup> If this funding was in fact happening, judges would be able to give community treatment orders more often, and be sure that the patients really were obtaining the most appropriate care in the least invasive of settings. The writer suggests that the Mental Health Commission is in the perfect position to be able to monitor and set funding for mental health services, and regrets that the Commission was not given a role in the purchasing of mental health services. The care of the mentally ill should not be subject to political whim diverting funds to other "good causes". A major effect of the 1992 Act was to engage public and political attention, to focus action on the rights of patients. There is no telling how long the spotlight will remain on the rights of the mentally ill, and when political attentions turn back to other unrelated policies, there are no guarantees that funding will be forthcoming.

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<sup>119</sup> See Dawson, fn 117.



Thus, it can be seen that the rights focus does not necessarily guarantee less invasive treatment. When the least invasive order, the community treatment order, could potentially be used as a form of social control, it is clear that the language of rights does not go far enough to countering the inadequacies of the system. Furthermore, that a less invasive form of treatment is unavailable because of a lack of funding is also unacceptable, and illustrates how the language of rights can appease the political and public conscience. Indeed, the writer would even suggest that using the language of rights alone, can often mask the deficiencies of a legislative system and lull those in power into a false belief that those at the receiving end are properly provided for. As Spencer Zifcak notes: "[p]olitical claims cloaked in the language of rights, may achieve short term success in shifting governmental priorities in favour of additional provision for people with mental illness. In the longer term, however, the fate of the mentally ill .... will ultimately depend upon the outcome of broader social arguments and conflicts."

Complacency towards the Act would be harmful; those receiving mental health services should not be content that they now have *rights* unless and until those rights are actually recognised and protected. The role of the Mental Health Commission could be crucial in this respect in focusing public and political attention towards the real deficiencies in the mental health system beneath the veneer of rights and entitlements. That role could be magnified, however, if the Commission were given responsibility for funding allocation. In this way, the Committee could be certain of political attention.

## **XI. CONCLUSION:**

This paper has illustrated some of the many improvements introduced to mental health law by the Mental Health (Compulsory Assessment and Treatment) Act 1992, and concludes that the less restrictive, rights-oriented approach is one to be welcomed.



The previous systemic imbalance has been significantly altered by this Act: the mentally ill are no longer individuals pitted against the system with no form of defence when compulsorily deprived of liberty and autonomy. Now, the mentally ill have a whole bastion of rights and have avenues for clinical and judicial protection to pursue that prevents the system removing their liberty arbitrarily. However, too much emphasis on the improvements in the Act, detracts from the failings of the legislation itself, and the mental health system as a whole. In order to gain a satisfactory balance between the competing demands of individual rights and social utility, an effort must be made to counteract the flaws in the system. For example, the definition sections of the Act, the bedrock of the whole piece of legislation and the yardstick against which people will be measured before being deprived of their liberty and autonomy, are unsatisfactorily vague. Greater certainty must be introduced so that decisions are not made arbitrarily, otherwise the scale will slip back towards ensuring social protection at the expense of the individual where not fully justified.

The emphasis on rights and least invasive methods of treatment in the Act also help to change public perceptions away from visions of the mentally ill as crazed "lunatics", towards a more sensitive view. However, the Act appears to give with one hand and take away with the other. It is at once trying to harmonise mental health services, but at the same time is setting the criteria for compulsory treatment at "dangerousness". This label is not helpful and appears to undo much of the good that the Act achieves. If a balance between utilitarianism and individual rights is to be achieved, society should feel that it is being adequately protected, otherwise it may call for harsher standards and cause the recent liberal changes to be undone. The "dangerousness" criteria seems at variance with the Act's purpose and should be replaced.<sup>120</sup>

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<sup>120</sup> See the suggested definition in part V.C of this paper.



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Furthermore, the mood of enlightenment surrounding the recent legislative changes may be hiding some fundamental problems which may put hurdles in the way of achieving a proper balance between the rights of the mentally disordered person and the expectations of the public at large. It must be realised that while the Act represents a massive step forwards, it does not cure all ills. There are basic and difficult issues such as funding and resource allocation to resolve before the Act can ever properly function as it was designed to.

Until these questions and issues are resolved, there is still the risk that the mentally disordered will be dealt with in an ad hoc manner -- as dependant on social mood and funding allocation as the existence of a mental disorder in the patient. It is the conclusion of this paper that uncertainty in this area is potentially hazardous. Questions of individual liberty and social protection are far too important to be left to chance.

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