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THE RIGHT TO REFUSE TREATMENT IN SECTION 11 OF THE NEW ZEALAND BILL OF RIGHTS ACT 1990, AND COMPULSORY PSYCHIATRIC TREATMENT UNDER THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992

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I INTRODUCTION

Ahakoa te momo mate, whakanuia tangata[1]

A The Central Dilemma

The scene can be set by drawing on first, the statement of the dilemma, as the drafters of the Mental Health Bill in 1987 saw the issue:

"In what circumstances should a civilized society insist on treating a mentally disordered citizen who is incapable of giving consent, or worse still, is capable of giving consent but refuses to do so?"[2]

The wide statement of the right in section 11 of the New Zealand Bill of Rights Act 1990 (the BoRA) suggests the retort to the second question is a clear "never!"

"11. Right to refuse to undergo medical treatment-
Everyone has the right to refuse to undergo any medical treatment".

But enter section 5 of the BoRA in the character of "justification", and the scene is set:

"5. Justified limitations –

Subject to section 4 of the Bill of Rights, the rights and freedoms contained in this Bill of Rights may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society".

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[1] Ministry of Health *Te Rau Hinengaro: The New Zealand Mental Health Survey: Summary.* Wellington 2006. The Whakataukī translates as "regardless of illness or disease, people deserve dignity and respect and the opportunity to become well again."
[2] Explanatory Note to the Mental Health Bill 1987 No. 18-1

A touch of suspense hangs in the air, as to what the effect of section 4 of the BoRA may be. If justification fails to make its case, will section 4 prevail or will it be re-empted?

"4. Other enactments not affected –

No court shall, in relation to any enactment (whether passed or made before or after the commencement of this Bill of Rights),-

(a) Hold any provision of the enactment to be impliedly repealed or revoked, or to be in any way invalid or ineffective; or

(b) Decline to apply any provision of the enactment –

by reason only that the provision is inconsistent with any provision of this Bill of Rights."

B Thesis

(i) This Paper examines the purpose of the right to refuse medical treatment. If it is correct that the purpose is to preserve human dignity and individual autonomy and, so that a person is not made the object of the actions of a heath-care provider, then the right should not be limited to "every person who is competent", but must have wider scope.

(ii) Limitations on the right must be only such as meet the standard of section 5 of the BoRA, as that test was set out in Hansen's case.[3]

(iii) The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MH (CAT) Act) limits the right to refuse of those who are found to be "mentally disordered".

(iv) The Court of Appeal in the Waitemata Health case defined the test for whether a person is "fit to be released from compulsory status" in terms of whether a person is "mentally disordered".[4] The Court ruled that "mentally disordered" is the only test provided in the Act for exit from compulsory treatment.

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[3] *R v Hansen* [2007] 3 NZLR 1.

[4] *Waitemata Health v Attorney-General* (2001) 21 FRNZ 216.

(v) One study, cited by the Mental Health Commission, has found that New Zealand has a high rate of community compulsory treatment compared to a range of other countries surveyed.[5] It is suggested that this would not be the case if the right to refuse treatment was given effect on a basis which recognised a person's decisional capacity.

C General Purposes of the BoRA and the MH (CAT) Act

The Long Title to the BoRA places it in the role of safeguarding the rights of the individual; its task being:

"(a) to affirm, protect and promote human rights and fundamental freedoms in New Zealand; and
(b) to affirm New Zealand's commitment to the International Covenant on Civil and Political Rights".

The BoRA is, in some senses, an ordinary statute, in that it was enacted as an ordinary act of Parliament. It does not give the courts power to strike down an enactment which breaches it, nor does it even give an explicit power to declare an enactment to be inconsistent with the Bill of Rights. At the same time, it is recognised as being part of New Zealand's constitutional canon.[6] One of the reasons is on account of section 6, the final voice to speak:

"6. Interpretation consistent with Bill of Rights to be preferred –
Wherever an enactment can be given a meaning that is consistent with the rights and freedoms contained in this Bill of Rights, that meaning shall be preferred to any other meaning."

The Courts have recognised that the BoRA is to make a difference to the way in

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[5] S Lawton-Smith *A Question of Numbers: The Potential Impact of Community-based Treatment Orders in England and Wales* (King's Fund, London, 2005), cited by the Mental Health Commission in *No-Force Advocacy by Users and Survivors of Psychiatry* (Wellington, November 2005), 9.
[6] Paul Rishworth and others *The New Zealand Bill of Rights* (Oxford University Press, Melbourne, 2003).

which other enactments are interpreted.[7] In the case of the MH (CAT) Act, if an analysis of the constraints on the right to refuse psychiatric treatment finds that the limits are not justified by the natural meaning, the next step is to seek another possible meaning which is consistent with the right to refuse treatment.[8]

One of the reasons why the BoRA is of constitutional status is that it is a statute which has as its purpose, the protection of individual and civil liberties against the power of the State. The BoRA applies to the acts of the 3 branches of government and to those carrying out statutory duties.[9] Many of the rights take the form of statements of rights to be enjoyed by "everyone", as for example, section 11. However, the Supreme Court in Hansen's case has stated the rights in terms of justified rights.[10]

The MH (CAT) Act sets out some specific rights for patients in Part 6.[11] Section 57 also provides that a patient may refuse consent to treatment, except as specified. The Act sets out procedures to be followed before compulsory treatment can be imposed, that is, it provides for protection by way of due process.[12] However the Act is also concerned to strike a balance in protecting individuals and the public from the dangers and inconvenience which people suffering from mental disorder can pose.[13] The MH (CAT) Act has procedures to ensure patients receive care and treatment.[14] The Act sets up a presumption that mental health patients will be treated in the community.[15]

The MH (CAT) Act imposes compulsory treatment on those who are within the definition of "mentally disordered".[16] This appears to be a direct inconsistency with the right to refuse medical treatment provided by section 11 of the BoRA. In *R v Hansen* the Supreme Court has provided guidance as to the way the courts in New Zealand are to

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[7] *Ministry of Transport v Noort* [1992] 3 NZLR 260 (CA), 270.
[8] *R v Hansen*, above n 3.
[9] S 3 of the New Zealand Bill of Rights Act 1990.
[10] *R v Hansen*, above n 3.
[11] The rights of patients in Part 6 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 include the right in section 66 to medical and other health treatment appropriate to the patient's condition.
[12] Parts 1and 2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
[13] S 110A of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
[14] S 28(4)(a) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
[15] For example section 28(2) and section 29(3) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
[16] S 11(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

deal with such inconsistencies.[17]

II APPLYING A BORA ANALYSIS TO COMPULSORY TREATMENT UNDER THE MH (CAT) ACT

A The Supreme Court Decision in Hansen

In *R v Hansen* the Supreme Court set out the most authoritative guidance to date as to the approach the New Zealand courts are to take in applying the BoRA to other legislation.[18] The starting point is to ascertain, by applying normal interpretation rules including section 5(1) of the Interpretation Act 1999, the extent to which a person who is subject to the MH (CAT) Act has the right to refuse psychiatric treatment.

If the provisions in the MH (CAT) Act are inconsistent with the right to refuse treatment, the next step in the analysis is to consider whether the apparent inconsistencies are justified in terms of section 5 of the BoRA. In *Hansen's case* the Supreme Court developed and applied the test initially used by the Canadian Supreme Court in *R* v *Oakes*.[19] A key similarity between the Canadian Charter of Rights and Freedoms and the BoRA is that both precede the rights with a justification clause allowing reasonable limits.[20] Provided the limitations are justified then there is no breach of the BoRA. If the limitations are considered not justified under section 5, the response required by s 6 is to seek an alternative consistent meaning. If no consistent meaning can be found, the justified meaning must be applied under section 4.

In *Hansen's case* McGrath J found it useful, by way of background, to consider

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[17] *R v Hansen*, above n 3.

[18] *R v Hansen*, above n 3.

[19] *R* v *Oakes* (1986) 26 DLR (4th) 200 (SCC).

[20] Constitution Act, 1982, Schedule B, Part 1, Canadian Charter of Rights and Freedoms, section 1.

the importance of the right, setting out the purpose and also the scope of the right.[21] A discussion of the purpose and scope of the right follows.

B Purpose of the Right to Refuse Medical Treatment

1 History of the right to refuse medical treatment

To uncover the purpose of the right, it is useful to look at the antecedents which give background to the choice of wording for section 11. This includes ascertaining any limits on the right and how the right may interact with other rights.

(a) White Paper on the draft Bill of Rights for New Zealand[22]

The White Paper on the Draft Bill of Rights for New Zealand noted that the proposed section 11 had no direct equivalent in the International Covenant on Civil and Political Rights (ICCPR).[23] Paul Rishworth notes that sections 9, 10 and 11 were grouped together in the original draft Bill which would have linked section 11 to Article 7 of the ICCPR which is the right not to be subject to torture or to cruel, inhuman treatment.[24] Sections 9, 10 and 11 were separated out in the version which became the BoRA. Rishworth comments that section 11 is typically conceived as a protection for liberty and security of the person, which links to Article 9(1) of the ICCPR.[25]

Rishworth makes the point that although there are protections for patients in tort and criminal assault, and in the Code of Health and Disability Services Consumers' Rights, placing the right to refuse treatment in the BoRA constitutionalises the right.[26] Rishworth considers this should be significant because Bill of Rights issues should be given prominence in decision-making.[27]

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[21] *R v Hansen*, above n 3 [193] to [199].
[22] Ministry of Justice "A Bill of Rights for New Zealand: A White Paper" [1984-1985] AJHR A6, 10.166.
[23] International Covenant on Civil and Political Rights (19 December 1966) 999 UNTS 171.
[24] Paul Rishworth and others, above n 6.
[25] Paul Rishworth *The New Zealand Bill of Rights*, above n 6, 252.
[26] Paul Rishworth *The New Zealand Bill of Rights*, above n 6, 251.
[27] Paul Rishworth *The New Zealand Bill of Rights*, above n 6, ibid.

The White Paper states, section 11 "...enacts a general principle that everyone has the right to refuse to undergo any medical treatment."[28]

(b) Section 11 of the BoRA and the common law right

Presumably the general principle referred to in the White Paper is the common law right of a person to control his or her own body. "Basically any intentional nonconsensual touching which is harmful or offensive to a person's reasonable sense of dignity is actionable.[29] Normal day-to-day unavoidable contact will not be actionable, but this does not include medical procedures. Margaret Brazier and John Murphy in *Street on Torts* say "Any physical contact with a patient without his consent to that contact is prima facie a battery".[30] Providing there is informed consent this will be a defence.[31] *Street on Torts* comment that the law's requirement for consent to treatment also recognizes and enforces the right to self-determination, to autonomy.[32]

The common law protects the right however unreasonable, foolish or risky the patient's decision may appear in the eyes of the medical profession or the community.[33] For the freedom to be meaningful, people must have the right to make choices that accord with their own values, regardless of how unwise those choices may appear to others.[34]

The United States Courts have recognized that a patient's right to determine the course of his medical treatment was paramount to what might otherwise be the doctor's obligation to provide medical care.[35]

The case law illustrates the limitations on the right to control ones own body. Emergency situations are an exception to the right,[36] necessity is another.[37] Two

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[28] Ministry of Justice, above n 23, 10.166 .
[29] *Malette v Schulman* (1990) 67 DLR (4th) 321 (Ont CA).
[30] Margaret Brazier and John Murphy *Street on Torts* (10th Edition, Butterworths, London, 1999), 85.
[31] Margaret Brazier, ibid.
[32] Margaret Brazier and John Murphy "Street on Torts" (10th Edition, Butterworths, London, 1999), 85.
[33] *Malette v Schulman* (1990) 67 DLR (4TH) 321 (Ont CA).
[34] *Smith v Auckland Hospital Board*[1965] NZLR 191, Gresson J at 219.
[35] *Rivers v Katz* 504 NYS 2d 74 (1986), citing the case of Storar, 78.
[36] *Malette v Schulman* (1990) 67 DLR (4TH) 321 (Ont CA).

limitations are expressed in the classic statement by Cardozo J that "Every human being of adult years and sound mind has a right to determine what shall be done with his own body";[38] namely that the right might not apply to children, or to mental patients. A child can give consent, but refusal by a child can be overridden in the child's best interests.[39] The court may also make an order in the best interests of an adult who is incapable of giving consent.[40]

It should be noted that the courts have been involved in developing the limitations on the right, and in overseeing the limitations. In *F v West Berkshire Health Authority and another (Mental Health Act Commission intervening)* the House of Lords ruled that it was lawful to operate on a patient who was incapable of consenting, but the operation had to be in the best interest of the patient, and commented that in practice a declaration should be obtained as to the patient's best interests.[41]

(c) A purpose of protecting dignity and autonomy

Referring to the common law source of the right to refuse treatment, Paul Rishworth endorses the purpose of section 11 as being to protect the interest in bodily integrity.[42] He also draws on the North American jurisprudence and argues that the right protects human dignity and autonomy in the making of decisions about treatment and investigation.[43]

There is support in New Zealand case law for the view that protection of human dignity and autonomy is the purpose for the right, including in the context of mental health. In *Re K [mental health]* Judge Inglis QC acknowledged the danger of a paternalistic approach which, in the guise of the patient's own good, denies the patient's

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[37] *Re F (a mental patient: sterilization* [1990] 2 AC 1.
[38] *Schloendorff v Society of New York Hospital* 105 NE 92 (1914) 93, cited by Rishworth, above n 26, 251.
[39] Margaret Brazier and John Murphy *Street on Torts* (10th Edition, Butterworths, London, 1999), 86.
[40] *Re CMC* [1995] NZFLR 538; *Re MB (Medical Treatment)* [1997] 2 FLR 426 (CA).
[41] *F v West Berkshire Health Authority and another (Mental Health Act Commission intervening)*[1989] 2 All ER 545, HL.
[42] Paul Rishworth, above n 6, 252.
[43] Paul Rishworth, ibid.

refusal and therefore her right to the dignity of self-determination.[44]

Butler and Butler consider that the purpose of sections 10 and 11 is to prevent a person from being made a non-consensual object of the actions of a scientist or health-care provider.[45] Their statement of the purpose is consistent with the location of the right as a security of the person right, and consistent with the wider purpose which runs through the Bill of Rights, of protecting the autonomy and dignity of the person. Butler and Butler's statement of the purpose usefully places the right in the healthcare context.

(d) Purpose of the right to refuse in the context of the MH (CAT) Act

On the basis that the purpose of section 11 is to protect the patient's human dignity, autonomy and right to self determination in the course of care and treatment, it may be asked whether the right is relevant in the MH (CAT) Act context where patients may lack the mental ability to exercise autonomy and any sense of self determination.

In *Secretary, Department of Health v JWB and SMB* Brennan J emphasized the breadth of the law's protection, saying that it rests on the unique identity of each person which the law respects and will protect, and that this applies regardless of the person's age or mental state.[46]

The right will always have a role in protecting the dignity of the patient, no matter how seriously mentally ill he or she may be. This important point is illustrated by the case law in the United States challenging the use of antipsychotic drugs on constitutional and due process grounds. In *Rivers v Katz* the court ruled that even involuntarily committed mental patients had the right to test the state's right to impose treatment.[47]

In the mental health context, in particular, the weak state of the patient's mind makes him or her vulnerable to coercion in treatment. To fulfill the purpose of protecting

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[44] *Re K [mental health]* 22 FRNZ 349, 356.
[45] Andrew Butler and Petra Butler *The New Zealand Bill of Rights Act: A Commentary* (LexisNexis NZ Limited, Wellington, 2005), 257.
[46] *Secretary, Department of Health v JWB and SMB* (1992) 66 ALJR 300, Brennan J, 317 – 318.
[47] *Rivers v Katz,* above n 35.

the patient from being made an object, the right needs to be given the fullest scope possible. This calls for more judicial oversight of treatment decision-making processes under the MH (CAT) Act.

If the right is to be the pathway to recovery for the person suffering mental illness, the treatment provided must be directed to improving the patient's condition, if possible to the point where the patient is competent to determine their own course of treatment.

The right to refuse, even if never exercised, gives the patient the sense of autonomy which is central to recovery.

(e) Informational content to the right

The right to make an informed and voluntary choice depends on having sufficient information to make an informed decision, and so supports an informational content to the purpose. Having information about the treatment proposed, its possible benefits, risks and side effects, tends to redress the power imbalance between the patient and medical professionals. It puts the patient on a more equal footing and so promotes the patient's sense of autonomy and dignity.

In *Wilkinson's case* the importance of access to information and the opportunity to challenge the basis of the medical professionals' approach was recognized as important in protecting the patient's Convention right not to be subject to degrading treatment.[48] The Court of Appeal ruled that the claimant was entitled to require the attendance of the doctors to give evidence and be cross examined on the medication being prescribed without the claimant's consent.[49]

C Scope of the Right to Refuse Medical Treatment

Having identified the purpose for the right as protecting the autonomy and dignity

[48] *Regina (Wilkinson) v Broadmoor Special Hospital Authority and others* [2001] EWCA Civ 1545.
[49] *Regina (Wilkinson) v Broadmoor Special Hospital Authority and others,* ibid.

of the patient from arbitrary and overbearing actions by the health care provider, this informs the scope which should be given to the right. The scope is also determined by the text and relevant case law.

1 Definitional limits

In *Re S* Barker J stated the right as applying to "every person who is competent to consent", thereby reading down the scope of the right.[50] The same approach was taken by Inglis QC in *Re K [mental health].*[51] This in not surprising considering that Cardozo's classic statement of the common law right is in terms of the right applying to those of sound mind.[52] Rishworth cautions that the common law rules around competency have the potential to undermine the protection afforded by section 11.[53] Rather than limiting the beneficiaries of the right, it is preferable to consider whether there are definitional limits to the right.[54]

In section 11 the definitional limits are better seen as being around refusal. The question being whether the patient has expressed a clear statement of will to which the law will give effect. Focusing on the nature of the refusal goes to the exercise of the right which is concerned with the person's decisional capacity.

(a) Refusal and decisional capacity

The American psychiatrist Meisel, [55] points to a distinction between decisional capacity and competence. "Decisional-capacity" is a functional and factual concept referring to a person's actual decision-making ability. Decisional-capacity also is in relation to a specific decision-type, and is time specific. Decisional capacity can vary

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[50] *Re S [1992] 1 NZLR 363.*
[51] *Re K [mental health],* above n 44.
[52] Cardozo J in *Schloendorff 's case,* above n 38.
[53] Paul Rishworth *The New Zealand Bill of Rights*, above n 6, 258.
[54] Ibid.
[55] Meisel, "Making Mental Health Care Decisions: Informed consent and Involuntary Civil Commitment (1983) 1 Behav Sci and Law, 73 at 80, referred to by Denys Court "Mental Disorder and Human Rights: The Importance of a Presumption of Competence" (1996) 8 AULR 1, 5.

depending on the person's situation, mental illness, even fatigue.[56]

Competency, in contrast, is a legal concept involving a conclusion applied to a person who has been determined, in accordance with legal requirements, to lack decisional capacity. Labeling a person as incompetent for all purposes or indefinitely should be avoided because of the variability of decisional capacity.

The relevance of the distinction to the right to refuse is that it suggests that as well as regular assessment of the patient's decisional capacity by health professionals in the course of treatment, the patient should have the opportunity to place evidence before a judicial body where he or she wishes to refuse treatment. A finding of incompetence by a judicial body should not prevent a further determination of the patient's competence where there is evidence of a change in the patient's condition or a different decision involved.

In *Rivers v Katz* the court cited medical authority to the effect that many patients, despite their mental illness, are capable of making rational and knowledgeable decisions about their medication.[57] The court ruled that the determination as to whether the patient lacked capacity was a uniquely judicial, not medical, function.[58]

Likewise the court in *Re K [mental health]* considered that it is for the Court to determine whether the patient is competent to refuse.[59]

(b) The test for competence or decisional capacity

Kennedy and Grubb phrase the question as being what factors does the law regard as important before attaching significance to an expression of will by the patient?[60] The content of the patient's decision has been a factor in some cases. That the patient refused

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[56] Denys Court "Mental Disorder and Human Rights: The Importance of a Presumption of Competence" (1996) 8 AULR 1.

[57] *Rivers v Katz*, above n 35, 79.
[58] *Rivers v Katz*, above n 35, 75.
[59] *Re K [mental health]* above n 44, 357.
[60] Ian Kennedy and Andrew Grubb *Medical Law* (3 ed, Butterworths, London, 2000), 597.

treatment appeared to be relevant to the finding of incompetence in *Re K [mental health]*.[61] The status of the patient has been a factor, such as whether the person is a committed patient. This approach was criticized in the United States case *Rivers v Katz*.[62]

Kennedy and Grubb make the point that any test which is not individual-orientated undermines their identified purpose of the right, which is individual autonomy.[63] Meisel and his colleagues have noted that there is no single right test for competency, and that in reality, judgments of competence reflect social considerations and societal biases.[64]

The test currently applied by the courts is as stated in *Re MB (Medical Treatment)*.[65] The test involves the ability to understand, retain and weigh in the balance information relevant to the decision, especially as to likely consequences of having or not having the treatment, and using the information in the process of coming to a decision.[66] The test is individual-orientated, focuses on the understanding and use of information, and supports the purpose of the right to refuse.

2 *"Ad hoc balancing"*

A right may potentially conflict with other rights including community and public rights, which may be the case with section 11. One way of achieving compatibility is to limit the scope of a right so the right is not so broad as to impinge upon and limit other rights.[67] The expression "ad hoc balancing", used to describe this approach, has been attributed to Professor Hogg.[68]

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[61] *Re K [mental health],* above n 44.
[62] *Rivers v Katz* 504 NYS 2d 74 (1986), above n 35.
[63] Ian Kennedy and Andrew Grubb *Medical Law*, above n 60, 598.
[64] Ibid, 603
[65] *Re MB (Medical Treatment) [1997] 2 FLR 426 (CA).*
[66] *Re K [mental health]* above n 46.
[67] *Re J (An Infant): B and B v Director-General of Social Welfare* [1996] NZLR 134, Gault J, 146.
[68] Paul Rishworth *The New Zealand Bill of Rights*, above n 6, 53.

Under the BoRA, limiting the scope of the rights is done as part of the section 5 justification. The limiting takes place in the particular context and should be only to the extent needed to allow competing rights to operate as appropriate. In the United States case *Rivers v Katz* this balancing was expressed as balancing the individual's liberty interest against the state's asserting compelling need on the facts of each case.[69]

The right of a mental patient to refuse treatment may be justified to the extent needed to give effect to other competing rights. It is suggested that factors which would be relevant to an "ad hoc" balancing of the rights include the significance of the treatment decision, the degree of competence of the patient, and whether the person poses imminent danger to themselves, or to others.

In the mental health context it could be suggested that the limiting of the right to refuse treatment has already been provided for in the MH (CAT) Act and that there is no further room for ad hoc balancing to give rights more or less scope.

3 Other aspects of the right to refuse

(a) Refusal to Undergo Treatment, Contrasted with a Requirement for Consent

Section 11 of the BoRA is phrased in terms of a right to refuse. This is in contrast to section 10 under which consent is required for medical experimentation.

Rishworth is one writer who doubts that anything should be read into the difference in wording between sections 10 and 11. He considers that on a purposive interpretation section 11 embraces not just a right to refuse treatment but also a right not to be treated without informed consent.[70]

The right not to be treated without consent and the right to refuse may not always mean the same thing. Section 59(2) of the MH (CAT) Act provides an example in that

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[69] *Rivers v Katz*, above n 35, 75.
[70] Paul Rishworth *The New Zealand Bill of Rights, above n 6,* 256.

under paragraph (a) a person is not required to accept treatment unless the person has given informed consent, but in the alternative paragraph (b), the patient must accept treatment prescribed by the Review Board's psychiatrist. At a conceptual level the right to refuse is foundational and provides the basis for genuine consent.

(b) The test for consent or refusal

The comment has also been made that there is a more stringent standard for refusal because it involves being able to assess and come to a contrary view on the information available.[71]

If this is so then it is suggested it arises from the authoritative nature of the power of the medical profession. The right to refuse treatment is intended to be a counter-weight to the advantage which the professional doctor or scientist has over the patient or layperson. An informed choice resulting in informed consent is a stringent standard to meet, or should be.

(c) To whose Acts does the Right to Refuse Medical Treatment Apply?

By section 3 the Bill of Rights is limited in its application to acts done by state health providers, and to private providers carrying out a public function under statute. Specifically, in the context of the MH Act, section 11 potentially applies to responsible clinicians, psychiatrists appointed by the Review Tribunal, the Review Tribunal, District inspectors, official visitors and the courts.

(d) Medical Treatment

The White Paper takes a broad view of what is covered by the word "medical" and says it should be used in a comprehensive sense, including psychiatric and

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[71] Sylvia Bell and Warren J Brookbanks *Mental Health Law in New Zealand* (Brooker's Limited, Wellington, 2005) 12.7, 241

psychological treatment.[72]

One question is whether this includes the assessment phase? It would be surprising if the right does not include assessment because diagnosis, which is what the assessment is, is closely related to treatment. If assessment was not covered this would amount to a gap in the protection because assessment is the basis for classification as mentally disordered and for choice of treatment. The view has been expressed that as assessment is closely associated with treatment throughout the MH (CAT) Act, it should be considered covered by the right. [73]

E Natural Meaning of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and whether it is Consistent with section 11 of the BoRA

1 Introduction

Having considered the purpose and the scope of section 11, the next step in the analysis required by *Hansen's case* is to identify the ordinary meaning of the provisions of the MH (CAT) Act to determine whether they allow decision makers to give effect to a person's refusal to accept the psychiatric treatment prescribed.[74]

If the provisions of the MH (CAT) Act are found to be inconsistent with the right to refuse treatment, the next step is to consider whether the imposition of compulsory psychiatric treatment can be justified at each phase of the Act's process. If it can be there is no breach of the BoRA. If not justified, it may be that another meaning can be applied to the MH (CAT) Act.

The MH (CAT) Act's provisions are considered around 6 phases in the Act; namely:

- The assessment phase under Part 1 and s 58;
- The making of a compulsory treatment order (CTO) under s 27(3);

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[72] Ministry of Justice "A Bill of Rights for New Zealand, above n 22.
[73] Ministry of Justice Advice to the Attorney-General dated 5 October 1998 on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill 1998.
[74] *R v Hansen*, above n 3.

- The first month under a CTO and s 59(1);
- A CTO of indefinite duration made under s 34(4);
- On-going treatment under s 59(2);
- Review under section 79 and appeal under section 83.

The two key definitions in the MH (CAT) Act are first considered as to whether they exclude a person who has decisional capacity and refuses to undergo treatment, from the Act's compulsion. The two definitions are "mental disorder" and fit to be released from compulsory treatment". [75]

2 "Mentally disordered"

At the various phases of the process of committal and treatment under a CTO, a person is entitled to be free from assessment and treatment if found to be not within the definition of "mentally disordered".[76]

"Mental disorder" is defined in s 2 as:

"mental disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—

(a) poses a serious danger to the health or safety of that person or of others; or

(b) seriously diminishes the capacity of that person to take care of himself or herself;—

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

The definition has two limbs with the first describing the patient's abnormal state

[75] S 2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
[76] Examples of instances where a patient may be released for the reason that he or she is not "mentally disordered" are sections 10(3) (in relation to a proposed patient), 12(1)(b)(i), 12(3), 123(4), 27(1), 27(3).

of mind, and the second limb setting out the consequences of the abnormal state of mind. Given the role of the definition in entry to and exit from compulsory psychiatric treatment in New Zealand, it is necessary to consider whether the definition would exclude those who have decisional capacity or are competent.

Under the descriptive limb the abnormal state of mind may be continuous or intermittent, which allows the possibility that the patient may have decisional capacity at times. Under the second limb, which describes consequences, the abnormal state of mind has to pose a serious danger or seriously diminish the person's capacity for self-care.

It is doubtful that a person with an abnormal state of mind posing the dangers identified in the second limb of the definition of mentally disordered, would be competent to make a decision to refuse treatment. It is likely that in the absence of medication the person's judgment would be impaired and they would lack decisional capacity. However, take for example a patient has been on medication for some time and is in partial recovery.[77] The patient is still likely to be within the definition of "mental disorder" because of their underlying condition, but could have decisional capacity, possibly sufficient to make decisions about his or her course of treatment. As Judge Inglis QC said in *Re K [mental health]*, it should not be assumed that they are not competent.[78]

The current definition of "mental disorder", on a natural meaning, potentially covers both patients who are decisionally capable and those who are not, and those who refuse and those who consent to treatment.

This appears to be the view of the scheme of the MH (CAT) Act taken in *Waitemata Health v Attorney General.*[79] The Court of Appeal ruled that the only basis on which a person can be released from compulsory status is that they have ceased to be "mentally disordered" and as a consequence are "fit for release". [80] That this interpretation could

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[77] This is given by Nigel Dunlop as the first example in his article "Compulsory Psychiatric Treatment and "Mental Disorder" [2006] NZLJ] 225, 226.
[78] *Re K [mental health],* above n 44, *357.*
[79] *Waitemata Health v Attorney General,* above n 4.
[80] *Waitemata Health v Attorney General,* above n 4, [93].

be a prescription for never-ending compulsory treatment is noted by Nigel Dunlop.[81]

The conclusion is that the natural meaning of mentally disordered, which effectively determines coverage by the MH (CAT) Act, is not aligned with a right to refuse treatment.

3 "Fit to be released from compulsory status"

The term "fit to be released from compulsory status" is defined as follows:

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

It should be noted that the term "mentally disordered", which has already been discussed, is a component of the definition of "fit to be released from compulsory status". The relationship between "mentally disordered" and "fit to be released" is open to a number of interpretations and these are set out by Tipping J in his judgment in the Court of Appeal, as that the patient is:

- No longer mentally disordered *and also* fit to be released;
- No longer mentally disordered *and therefore* fit to be released;
- No longer mentally disordered *or fit* to be released.[82]

The Court of Appeal ruled that the second or consequential meaning was the correct one on a natural interpretation of the MH (CAT) Act.[83]

The Court rejected the first interpretation for the reason that it requires an additional judgment of "fitness" and that the MH (CAT) Act contains no criteria for

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[81] Nigel Dunlop "Compulsory Psychiatric Treatment and "Mental Disorder", above n 77, 228.
[82] *Waitemata Health v Attorney General*, above n 4, [93].
[82] Ibid, [117].
[83] Ibid, [82].

making such an assessment.[84]

Waitemata Health was one of the parties which argued for the third or disjunctive meaning which is based on reading "and" as allowing "or".[85] The Health Board's argument included the therapeutic and other advantages of the practice of allowing discharge of patients who come within the definition of "mentally disordered" but who are clinically assessed as being able to be treated or managed without a compulsory treatment order.[86] The interpretation is also taken by the Guidelines issued by the Director-General under section 130 of the MH (CAT) Act.[87]

The Court of Appeal considered that it would be overstepping legitimate interpretation to allow discharge from compulsory status where the person remains mentally disordered but the clinician is of the view that the danger inherent in the mental disorder can be contained by a voluntary rather than compulsory regime.[88] The Chief Justice noted that the Act contains no guidance as to the criteria for "fitness" as a ground for release or detention, and that the scheme of the MH (CAT) Act is that those disordered to the extent that they are still within the definition of "mentally disordered" remain subject to compulsory status.[89]

At this point, it should be noted that the interpretation which gives the word "and" a consequential meaning, and which the Court of Appeal considered to be the natural meaning, does not allow for release from compulsory status on the basis that the patient has decisional capacity and refuses treatment.

4 Phases of the MH (CAT) Act

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[84] Ibid, [81].
[85] Ibid, [82].
[86] Ibid.
[87] Ministry of Health "Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992", Wellington, 1 April 2000.
[88] *Waitemata Health v Attorney General*, above n 4, [93].
[89] *Waitemata Health v Attorney General*, above n 4, [94].

(a) Compulsory Treatment during the Part 1 Assessment Phase – the Natural Meaning and consistency with s 11

The main provision imposing treatment during the assessment phase is section 58. It is as follows:

"58 Treatment while undergoing assessment
Every patient who is undergoing assessment pursuant to section 11 or section 13 of this Act shall be required to accept such treatment for mental disorder as the responsible clinician shall direct."

The medical practitioner making the necessary assessment of the patient must determine whether in terms of s 10(1)(b)(ii)-
"there are reasonable grounds for believing that the proposed patient is mentally disordered and that it is desirable that the proposed patient be required to undergo further assessment and treatment."

"Mentally disordered" is defined in section 2 and has been set out above.

There is an argument that the words "and that it is desirable" add a further element to the criteria for compulsory assessment and treatment. However in the face of the clear words of section 58 and section 11(1) which obliges the medical practitioner to require the patient to undergo further assessment and treatment, these words express the consequence of the finding of reasonable grounds that the patient is "mentally disordered". The natural meaning is that there is no allowance for a patient, even one who shows decisional capacity, to refuse treatment at this stage.

The other aspect of the Part I process which should be considered is that the patient, and those who have concerns for him or her, may, under sections 11(7) and 12(12) apply to the district court to have the patient's condition reviewed under section 16. This review requires a Judge to visit the patient and discuss with the patient, his or her views on the proposed course of assessment and treatment. Again, in the face of

section 58, even if the court considered that the patient had decisional capacity, and refused treatment, release from compulsory treatment is not a possibility.

Indeed the only basis for release of a patient from the Part I process is that he or she is not "mentally disordered", or is "fit to be released from compulsory status", as these terms are defined in section 2.

The conclusion is that patients in respect of whom there are reasonable grounds for a finding of "mentally disordered" are required to undergo treatment during the assessment and treatment phase under Part I of the Act, and so the natural meaning is not consistent with the right to refuse treatment.

(b) Compulsory treatment order – natural meaning and consistency

The provision under which a community treatment order is made is section 27 which provides:

"27 Court to consider patient's condition

(1) On an application for a compulsory treatment order, the court shall determine whether or not the patient is mentally disordered.

(2) If the Court considers that the patient is not mentally disordered, it shall order that the patient be released from compulsory treatment forthwith.

(3) If the Court considers that the patient is mentally disordered, it shall determine whether or not, having regard to all the circumstances of the case, it is necessary to make a compulsory treatment order."

Prior to the hearing, the judge is required, as was the case for a section 16 review, to visit the patient and discuss the patient's views on the proposed course of treatment. At this point in the process the Court has the opportunity and the informational basis to take into account the patient's decisional capacity with regard to treatment. It would

seem that on a natural meaning, even though a patient is "mentally disordered", if he or she has decisional capacity and is prepared to consent to treatment, it is not, in all the circumstances, necessary to make a CTO.

However, if the patient has decisional capacity, comes within the definition of "mentally disordered" and refuses treatment, the discretion would not, on a natural meaning, extend to not making a CTO because this would mean the patient would not be treated.

The conclusion is that on its natural meaning, the making of a CTO is inconsistent with the section 11 right, and so the next step will be whether the limitation on the right is a justified one.

(c) Compulsory treatment for the first month under a CTO – natural meaning and consistency

Section 59(1) is as follows:

"59 Treatment while subject to compulsory treatment order

(1)Every patient who is subject to a compulsory treatment order shall, during the first month of the currency of the order, be required to accept such treatment for mental disorder as the responsible clinician shall direct".

An aspect to notice about a CTO is that the statutory preference is that the order is for treatment as an outpatient under a community treatment order. The Court is to make an inpatient order only if the patient cannot be adequately treated in the community.[90]

Section 59(1) does not appear on a natural interpretation, open to meaning that a responsible clinician has a discretion not to direct treatment if the patient refuses. The word *shall* is used both in relation to the patient accepting treatment and the responsible clinician directing. If there was no acceptable treatment for the patient's mental

[90] Section 28(2) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

condition, that would be a circumstance in which the clinician could not prescribe, but apart from such circumstances, the requirement is to treat and to accept.

The conclusion is that the natural meaning is that there is no basis on which a competent patient could exercise the section 11 of the BoRA right to refuse treatment for the first month of a CTO.

(d) Compulsory Treatment Order of indefinite duration – natural meaning and consistency

On the third extension of a CTO, that is, after 18 months, the CTO becomes indefinite in duration. The wording of section 34(4) is:

"(4) If. … the Court then further extends the order, the patient shall remain subject to the order unless and until he or she is released from compulsory status."

Treatment is not compulsory after the first month and further compulsory treatment must be authorised under section 59(2) or section 60.

Release from compulsory status, whether by decision of the responsible clinician under section 35, the Review Tribunal under section 79 or the District Court is on the basis that the patient is "fit to be released from compulsory status".

The conclusion is that the natural meaning of indefinite CTOs with release effectively only on the basis that the person is no longer "mentally disordered", means on-going compulsory detention of patients who are decisionally capable, and is not consistent with the right to refuse treatment.

(e) Compulsory treatment under section 59(2), and treatment under sections 60 and 61 – natural meaning and consistency

Section 59(2) and (4) provide:

"(2) Except during the period of 1 month referred to in subsection (1) of this section, no patient shall be required to accept any treatment unless—
(a)The patient, having had the treatment explained to him or her in accordance with section 67 of this Act, consents in writing to the treatment; or
(b)The treatment is considered to be in the interests of the patient by a psychiatrist (not being the responsible clinician) who has been appointed for the purposes of this section by the Review Tribunal…
…
(4)The responsible clinician shall, wherever practicable, seek to obtain the consent of the patient to any treatment even though that treatment may be authorised by or under this Act without the patient's consent".

After the first month subject to a CTO there are a number of possibilities. One is that the patient remains subject to a CTO, but is not required to undergo further treatment.[91] A second possibility is that the person is considered "fit to be released from compulsory status" and is released.[92]

Another possibility is further treatment under section 59(2). This provision appears to align with the right to refuse treatment because of the opportunity given by section 59(2)(a) for the patient to give informed consent to treatment, and subsection (4) which requires the responsible clinician to seek consent to treatment, even though treatment can be imposed without consent.

However, take a case where the patient initially gives consent under section 59(2)(a), but then withdraws it under section 63. On the wording of section 59(2) the health care providers are not constrained by the withdrawal of consent, but can proceed with treatment considered in the interest of the patient by the psychiatrist appointed by the Review Tribunal. The patient's refusal can be overridden: it was merely an opportunity for the patient to participate in decision-making, but legally a refusal is of no consequence at all.

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[91] Section 59(2) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
[92] Section 35(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

In his paper Denys Court has pointed out that the words "wherever practicable" are a weakness in subsection (4).[93] "Wherever practicable" is undefined so is open to excuse any exigency for not seeking the patient's consent, even administrative inconvenience. The only real justification for not seeking the patient's consent is that the patient lacked decisional capacity. Court makes the point that section 59 does not include an obligation to assess the patient's decisional capacity, and contends that a finding of decisional capacity must be required in order to validate a consent under section 59(2)(a).[94]

The Ministry of Health's Guidelines to the Mental Heath (Compulsory assessment and Treatment) Act 1992 state that "care should be taken to scrutinize whether the patient is competent to give informed consent to the proposed intervention."[95] The Guidelines recognize the possibility of and need for decisional capacity for a consent under section 59(2)(a). If there are reasonable grounds for believing that the patient is not competent to consent under s 59(2)(a), the Ministry's advice is for the responsible clinician to have the treatment authorised under section 59(2)(b).[96] Refusal by a patient who has the capacity to consent is not envisaged by either the Act or the Guidelines.

In contrast to section 59(2), section 60 has no equivalent to section 59(4) requiring that the responsible clinician seek the patient's consent to treatment. Section 60 allows electro-convulsive therapy if either the patient gives informed consent under (a), or, under (b), a psychiatrist appointed by the Review Tribunal considers the treatment to be in the interests of the patient. Decisional capacity is obviously relevant under (a). Section 63 allows a patient to withdraw consent given under (a), but like section 59(2), section 60 does not recognize a right to refuse treatment.

Section 61 sets out the pre-conditions for brain surgery to be performed on a patient and is consistent with the right to refuse treatment because surgery to the brain

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[93] Denys Court "Mental Disorder and Human Rights: The Importance of a Presumption of Competence", above n 58, 11.
[94] Court, ibid.
[95] Ministry of Health "Guidelines to the Mental Heath (Compulsory Assessment and Treatment) Act 1992", (Wellington, 1 April 2000) 2.1.
[96] Ministry of Health, above n 102.

cannot be performed without the free and informed consent of the patient.

An aspect of sections 59(2)(b) and 60(b) which is inconsistent with the BoRA is that the psychiatrist appointed by the Review Tribunal may impose treatment which he or she considers is in the patient's interest. Neither the MH (CAT) Act nor the Ministry give any guidance as to how or what matters the patient is to take into account in deciding whether and what treatment is in the interests of the patient.

The standard under sections 59(2)(b) and 60(b) is only the interests of the patient, rather than the common law standard of the patient's best interest.[97] However, there is nothing of consequence in the difference in wording as the standard is still directed at the patient's not the care provider's interest.

The terms of sections 59(2) and 60(b) are that the patient is required to accept such treatment as the psychiatrist considers is in the interest of the patient. Considering that the objectives of the MH (CAT) Act are directed at treatment of the patient as an outpatient, and ultimately getting the patient to a state where he or she is "fit to be released from compulsory status", these factors suggest a bias in favour of treatment. As a natural meaning it is inconsistent that the patient's refusal would be part of the patient's interest.

(f) Review under section 79 and Appeal under section 83 – natural meaning and consistency

Regular 6 monthly reviews of the patient's condition must be carried out under section 76 by the responsible clinician as long as the patient remains subject to a CTO. There is a right to have the responsible clinician's assessment reviewed under section 79 by the Review Tribunal.

The Tribunal is an administrative body and the hearing it is not a judicial one. The Tribunal's procedure is set out in the First Schedule to the MH Act.

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[97] *F v West Berkshire Health Authority and another (Mental Health ct Commission intervening)*above n 41.

It has been suggested that the Review Tribunal lacks the statutory capacity to address Bill of Rights issues, such as a patient's right to refuse treatment.[98] The wording and context of the Tribunal's jurisdiction under section 79 on a natural meaning supports that assessment.

Section 79(1) provides that:
"(a) the Review Tribunal may at any time …review the condition of any patient who is subject to a compulsory treatment order:"

Under subsection (6) the Tribunal may refuse the application for review if the Tribunal has recently carried out a review and has no reason to believe the patient's condition has changed since then, and under subsection (7), the certificate of the Tribunal's finding is as to whether the patient is "fit to be released from compulsory status". Clause 4 of the First Schedule further indicates the focus of the review:

"4 (1) A Review Tribunal may, if it is satisfied that it is necessary for the proper review of a patient's condition, request … a medical, psychiatric, psychological, or other report of the patient."

The terms and context of review are directed at the mental health of the patient, and are not, on a natural meaning, consistent with recognising a patient's refusal to undergo treatment.

From the Review Tribunal there is a right of appeal to the District Court under section 83 of the MH (CAT) Act. The District Court's jurisdiction on appeal is set out under section 83(2):

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

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[98] Brookersonline I*ntroduction to the Mental Health (Compulsory Treatment and Assessment) Act 1992* MH Intro .03(3).

Although the Judge must meet with the patient and discuss his or her views on treatment, the review is directed to the question whether the patient is "fit to be released from compulsory status". Giving effect to a patient's wish to refuse treatment imposed by the psychiatrist appointed by the Review Tribunal is, on the natural meaning, outside the District Court's jurisdiction.

The conclusion is that the natural meaning of the review and appeal provisions is not consistent with the right to refuse treatment.

F JUSTIFICATION OF INCONSISTENCY

Having identified the natural meaning of the relevant parts of the MH (CAT) Act, and concluded that they are not consistent with a right to refuse treatment, the third inquiry is whether the limitations imposed by the MH (CAT) Act on the right to refuse psychiatric treatment can be justified in terms of section 5 of the BoRA . This is the approach taken by the effective majority of McGrath J and Tipping J in the Supreme Court in *R v Hansen*.[99] Tipping J set out the test as follows:[100]

"(a) does the limiting measure serve a purpose sufficiently important to justify curtailment of the right or freedom?

(b) (i) is the limiting measure rationally connected with its purpose?

(ii) does the limiting measure impair the right or freedom no more than is reasonably necessary for sufficient achievement of its purpose?

(iii) is the limit in due proportion to the importance of the objective?"

1 A sufficiently important objective

The Bill which became the MH (CAT) Act 1992 Act was introduced into the House on 8 December 1987, before the BoRA, but its passage was a long one and overlaps the

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[99] *R v Hansen,* above n 3, [192].
[100] *R v Hansen,* above n 3, [104].

BoRA. In fact the MH Act came into force on 1 November 1992, after the BoRA.[101] In the first Reading the Hon. David Caygill stated that the major rethinking behind the Bill was to bring New Zealand's mental health legislation into line with overseas legislation, notably the United Kingdom, by reflecting current themes in psychiatry:

- that psychiatric patients should be treated as much like other patients as possible;
- that treatment should be in the least restrictive environment possible;
- that patients' rights should be protected; and
- that a multidisciplinary approach to treatment decision-making should apply.

Through the Reading speeches there is reference to striking the balance between the rights of patients, those who manage them, and the wider society. In the Second Reading the Associate Minister of Health noted that important constraints had been placed on non-consensual treatment but considered there were appropriate protections in place for patients.

From a consideration of the background to the Bill, the objectives to be served by the measures imposing compulsory treatment appear to be, firstly to ensure that those who are "mentally disordered" have the experience of the benefit of treatment. A second objective is to treat the majority of "mentally disordered" people in the least restrictive environment. For most patients this means as outpatients under community treatment orders.[102]

The bipartisan support for the Bill in its stages through the House is a good indicator of the widespread perception of the importance attached to achieving the objectives of the legislation.

The first objective has been expressed as limited in time, ceasing to be relevant for ongoing treatment. However, the second objective of enabling the patient to live in the community becomes relevant for on-going treatment.

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[101] The New Zealand Bill of Rights A ct 1990 came into force on 25 September 1990.
[102] *Waitemata Health, above, n 3, [93] and [94].*

2 A rational connection

Mental disorder impairs the ability of a person to exercise rights, including the right to refuse to undergo medical treatment.[103] The benefit from treatment is that it enables the person to recover and reach a state where they are again have the capacity to exercise rights.

Requiring people who are suffering from a mental disorder to undergo treatment in most cases directly ensures they experience treatment. In cases where the patient opposes treatment the first objective will not always be achieved, and indeed if the person physically resists treatment there must be questions around whether there will be any therapeutic benefit. An example is *Wilkinson's case,*[104] where the patient physically fought the administration of anti-psychotic drugs to an extent to raise concerns that he would suffer a heart attack.

However the second objective may be relevant. Treatment may keep the patient in a stable condition, and enables them to live in the community. In the absence of a compulsory order some patients would not accept medication.

Re S is an example of such a case.[105] S lived in his own home and was regularly visited by hospital personnel who administered medication to him. After awhile he indicated that he wanted to discontinue treatment. The evidence was that S lacked insight into his illness and did not appreciate the necessity to continue with medication in order

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[103] This point was articulated by the advisers in the Ministry of Justice in the 5 October 1998 Briefing by Ministry of Justice to the Attorney-General: Compliance with the Bill of Rights Act 1990: Mental Health (Compulsory Assessment and Treatment) Amendment Bill

[104] *Regina (Wilkinson) v Broadmoor Special Hospital Authority and others*, above n 23.

[105] *Re S, above n 50.*

to control his paranoia which would otherwise bring him into conflict with his neighbours.

(a) Compulsory treatment during the assessment phase and for the first month of a CTO

Imposing compulsory treatment is likely to be particularly necessary in the early stages of mental health treatment because patients are often in a state such that they deny they are ill and need treatment.

The result of imposing treatment is that the person suffering from mental disorder experiences the benefits of medication and has the opportunity to reflect on the contribution treatment makes to their quality of life. There is therefore a clear connection between the limit on the right to refuse and the stated objective. The treatment received during the assessment phase and for the first month under the CTO enables the patient in every other way to experience a normal life.

There is a rational connection between the grounds for release from compulsory treatment during this time, which are that effectively the patient is not "mentally disordered", and the objectives.

(b)` Compulsory treatment order under section 27(3)

There is a rational connection between an order requiring a patient to submit to compulsory treatment, and ensuring that patients experience the benefits of treatment. Placing patients under a regime in which they must undergo regular treatment requires them to experience the difference on a sustained basis. A CTO can be either on an inpatient basis, which can be a temporary situation, until the patient is able to cope as an outpatient and the CTO then becomes placed under a Community Treatment Order, which is directly related to the second objective of living in the community.

The rational connection between the grounds for release is as for the assessment and first month of treatment.

(c) A CTO of indefinite duration

Indefinite compulsory status does not always have a rational connection with the first objective. The case of *Re K [mental health]*[106] illustrates that patients who have an experience of treatment do not always favour continuing treatment. Mrs K had been subject to a community treatment order for more than a year. Her responsible clinician sought an extension of the order but Mrs K opposed this.

The judge's finding was that the mental disorder Mrs K was suffering from had affected her mental processes and she was unable to fully appreciate the contribution the treatment made to her wellbeing. Mrs K had experienced the benefits but argued that the CTO affected her right to self-determination.

An order imposing continuing treatment was made in order to maintain Mrs K's stable condition and enable her to continue to be a well-respected and productive member of the community. There was a connection between the limitation on Mrs K's right to refuse, including continuing mental disorder and the second objective of enabling her to continue in the community.

(d) On-going Treatment and sections 59(2) and 60(b)

There is a rational connection between the limitation of compulsory on-going treatment and the second objective of enabling the patient to live in the community. Without the appropriate treatment the patient's abnormal state of mind poses the problematic consequences described in the second limb of the definition of "mentally disordered".

(e) Review under section 79 and appeal under section 83

Limiting the right to refuse by not making it enforceable through the review and

[106] *Re K [mental health]*, above n 44.

appeal procedure has a rational connection with the first objective in that the patient must undergo treatment through to the end of the first month of a CTO, unless not mentally disordered or fit to be released. There is no rational connection between limiting the right and enabling life in the community.

3 Minimal impairment

This formulation of the test as one of limiting the right no more than reasonably necessary to achieve the objectives was favoured by the effective majority of the members of the Supreme Court. Tipping and McGrath and Blanchard recognised that this formulation gives appropriate latitude to Parliament.[107]

The intention expressed by members of Parliament at the time the MH (CAT) Act was passed was that its application would be limited, through the gatekeeper definition, to those whom it is necessary to treat compulsorily and because their condition is serious.[108] Similarly in the *Waitemata Health case* the Chief Justice noted that the MH (CAT) Act applies only to those who it is necessary to assess or treat compulsorily and then only if their condition reaches a sufficient state of seriousness.[109]

The hope was also expressed by the members of Parliament that for the majority of patients, compulsory status would be short term.[110] The limitation was therefore intended to apply to small numbers of people, of whom few would be competent to refuse treatment.[111]

It was also intended to apply in the least intrusive way by allowing for treatment to be administered to the patient in their own home in the community.

The Mental Health Commission and the Director of Mental Health agree that data

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[107] *Hansen v R*, above n 3, [126]. The standard has at time been expressed in terms that the limit must impair the right as little as possible.
[108] Hon Katherine O'Regan (12 March 1992) NZPD 6860.
[109] *Waitemata Health v Attorney-General, above n 4*, [67].
[110] Hon D Caygill (8 December 1987) 485 NZPD 1381.
[111] *Re S,* above n 50, at 374; Barker J's comment that "Being mentally disordered and competent are not mutually exclusive, the presence of both factors simultaneously is no doubt uncommon."

on the number of people subject to compulsory treatment is of poor quality.[112] The Commission has referred to one overseas study which found that the restriction impairs the right to refuse treatment for a larger group and for longer than it possibly needs. The study found that both the number of people subject to CTOs in New Zealand, and the length of time spent subject to CTOs was high by comparison with other comparable countries such as the United Kingdom.[113]

An estimate is that at any one time as many as 60 persons per 100,000 New Zealanders are subject to a CTO.[114]

(a) Compulsory treatment during the assessment phase and for the first month of a CTO

This phase enables health professionals to commence treatment and make an assessment of the patient's current mental health.

Safeguards against impairing the right more than is reasonably necessary during the assessment phase include short duration; the assessment and treatment phase can be a maximum of 78 days, and the right to apply for review of the patient's condition by the District Court under sections 11(7) and 12(12). The 78 day maximum period of compulsory treatment is reasonably necessary to achieve the objective of enabling the patient to experience the benefits of treatment.

The conclusion is that the limit is no more than a minimal impairment.

(b)` Compulsory treatment order under section 27(3)

The making of a CTO appears to be a minimal impairment of the patient's right to refuse medical treatment because after the first month the status of the patient as subject to a CTO does not mean the patient must receive medication. The CTO can act as a

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[112] Mental Health Commission "No-Force Advocacy by Users and Survivors of Psychiatry" Tina Minkowitz and Others", Wellington, 2005, 21.

[113] Lawton-Smith, above n 5.

[114] Office of the Director of Mental Health "Annual Report 2005", Wellington 2005, 23.

safety measure so that if treatment is needed to be administered involuntarily this can be done under the section 59(2) powers.

There are protections for the patient in the CTO process in the high threshold of "...whether or not, having regard to all the circumstances of the case, it is necessary to make a compulsory treatment order", but as noted earlier, this would not allow not making a CTO where a person refused treatment.

The patient's responsible clinician may direct the release of a patient from compulsory status at any time where he or she considers the patient is "fit to be released".[115] District inspectors have the power to refer the case of a patient to the Review Tribunal for a review of the patient's condition. [116]

In conclusion, a CTO of six months' duration is a minimal impairment of the right.

(c) A CTO of indefinite duration

The CTO becomes one of indefinite duration if the Court decides to extend compulsory status at the third judicial hearing at 18 months. This is a more than minimal impairment of the right to refuse treatment in that it ends regular judicial oversight of the treatment of the patient. The patient's consent can be obtained to treatment without a judicial assessment of his or her decisional capacity. A psychiatrist appointed by the Review Tribunal can make their own assessment of the patient's interest without judicial oversight.

Under the natural meaning, a CTO could be made in respect of a patient who is only intermittently mentally abnormal and who in the past has committed a single serious assault. This seems a more than minimal impairment.

(d) On-going Treatment and sections 59(2) and 60(b)

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[115] S 35(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
[116] See section 76(9)(b) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

The rationale that was adopted in both *Re S* and *Re K [mental health]* was that mental illness continued to limit these patients' insight into the benefits of medication and the effects of the illness.[117] The first objective of providing the patient with an opportunity to experience the benefits of compulsory treatment had been expended and had not been achieved because, after more than a year on medication, the patient refused treatment.

In relation to the objective of enabling the patient to continue to live in the community, provided the patient is able to enjoy quality of life in their own home, the impairment of the right to refuse is arguably no more than is reasonably necessary.[118]

However, in *Re S* and *Re K [mental health],*[119] both patients considered the intrusion of treatment by hospital staff was more than they were prepared to tolerate. S was prepared to accept medication at a lower dosage which may mean he would be less stable and have more difficulties with neighbours. In Mrs K's case, she expressed a preference to rely on the power of faith; a preference that was consistent with her values and beliefs. There would possibly be periods when she would need to be hospitalized. The test applied by the court as to competency appeared to be based on acceptable outcomes, and did not allow for individual preference to rely, wholly or partly, on other sources of support.

The limitation on the right to refuse appears more than is reasonably necessary to achieve the objective of enabling patient's to live in the community.

(e) Review under section 79 and appeal under section 83

The constraint on the Review Tribunal's power on review, and of the Court's powers on appeal, of denying jurisdiction to give effect to a patient's refusal are further constraints on the right.

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[117] *Re S,* above n 50; *Re K [mental health],* above n 44.
[118] *Re S* and *Re K [mental health],* ibid.
[119] *Re S* and *Re K [mental health],* ibid.

The limitation is more than is reasonably necessary to achieve the objective of enabling the patient to live and receive treatment in the community.

4 Is the limit in due proportion to the importance of the objectives?

(a) Compulsory treatment during the assessment phase and for the first month of a CTO

This period is of limited duration and allows the responsible clinician to find the medication best suited to the patient, and to ensure the patient experiences the benefits of the medication. The hope is that from a limited period of compulsory treatment, the outcome is that the patient comes to appreciate the benefits, and will be cured, or accept treatment on a voluntary basis, or be able to live in the community under a Community Treatment Order.

With this in mind this initial period of compulsory treatment is proportionate to the importance of the objectives.

(b)` Compulsory treatment order under section 27(3)

An order is a proportionate limitation on the right to refuse, considering that the duration is 6 months, the patient is not necessarily subject to treatment for the entire time, the process for making a CTO involves the Judge meeting with the patient, and there is the high threshold for making the order in that it must in all the circumstances, be necessary. The objectives are in comparison much more substantial than the limits.

A patient subject to an indefinite CTO is not necessarily required to take medication; they could be taking the medication willingly, so it could be suggested that the compulsory status is of small moment in terms of the right to refuse. However, it is disproportionately burdensome to leave a person subject to compulsory status as a back-up measure. A psychiatrist appointed by the Review Tribunal can at any time make use of the power under section 59(2) on the grounds of the patient's interest. There is no direct judicial oversight of the patient once the CTO becomes indefinite.

The conclusion is that on a natural meaning the making of a CTO of indefinite duration is a disproportionate limitation on the right to refuse treatment.

(d) On-going Treatment and sections 59(2) and 60(b)

It is in this area of the Act's processes that there is the greatest cause for criticism in relation to the right to refuse treatment. This is because, as noted earlier, there is no prior finding of the patient's decisional capability by a judicial authority, and certain unsatisfactory aspects of the provision for review.

In *F v West Berkshire Health Authority and another (Mental Health act Commission intervening)* the House of Lords ruled that there should be judicial oversight as to whether treatment was in the patient's best interest.[120] Although at common law a doctor could operate on a patient provided the operation was in the best interests of the patient, in practice the question as to whether a treatment was in the patient's best interest should be established by judicial process. The same criticism could be made of the minimal process provided by sections 59(2) and 60(b).

The Review Tribunal's appointed psychiatrist can override an express refusal by a patient. Considering that the right has the purpose of protecting the patient's most important interests, their human dignity, autonomy and self-determination, the right should not be overridden without judicial determination that the patient lacks the necessary capacity to exercise it.

The power given under sections 59(2)(b) and 60(b) is a more than disproportionate limit on the right to refuse.

(e) Review under section 79 and appeal under section 83

On a natural interpretation of these appeal rights, the review Tribunal and the District

[120] *F v West Berkshire Health Authority and another (Mental Health act Commission intervening)*, above n 41.

Court are limited to considering the patient's clinical condition. This constraint affects the patient's right to refuse treatment. Up to the end of the first month of a CTO the limitation is not disproportionate so that the objectives can be achieved.

On an on-going basis it is disproportionate to deny the right to have the Tribunal or Court enforce the right, considering the fundamental and constitutional nature of the right. It may be that the patient lacks the decisional capacity to exercise the right but before overriding it, there needs to be a judicial determination that the patient lacks the necessary capacity.

5 Conclusions as to justification of limits on the right to refuse

It should be remembered that the limit is to the patient's right to refuse psychiatric treatment. The purpose of the right is to uphold the patient's autonomy and dignity as a person. The scope of the right is every person to the full extent of their decisional capacity with respect to treatment. The objectives of the compulsory powers have been identified as being to ensure the patient experiences the contribution that treatment can make to their wellbeing, and to enable patients to live and receive treatment in the community.

The areas where the limitations on the right were found to be unjustified are indefinite CTOs, compulsory treatment under sections 59(2)(b) 60(b), and the jurisdiction of Review Tribunals and the District Court in relation to the right to refuse treatment.

C A Bill of Rights Consistent Interpretation

The next step is to consider whether a BoRA rights consistent interpretation of those aspects of the MH (CAT) Act regime which have been identified as being unjustified, is possible.

1 Indefinite compulsory status

Nigel Dunlop argues that a section 11 of the BoRA-consistent interpretation is possible within the definition of "mental disorder", supported by justification under section 5.[121] He considers that the Court of Appeal in *Waitemata Health* does not prevent the release from compulsory status of patients who are able to consent and accept treatment in the community on a voluntary basis, and neither does it prevent the release of patients who refuse treatment.[122] The Chief Justice's statement was that release of patients who remain "mentally disordered" to a voluntary regime was not permitted by the Act.[123] This part of the decision needs to be read in the context of legislation that applies to patients who need to be treated compulsorily and whose condition is of a sufficient state of seriousness.[124]

Nigel Dunlop argues that the effect of the decision in *Waitemata Health* has correctly focused attention on the definition of "mental disorder".[125] His view is that a satisfactory basis for decisions to release from compulsory status, can be found in the two consequential limbs of the definition of "mentally disordered".[126] A person who does not present a serious danger to themselves or others, and is capable of taking the prescribed medication voluntarily should be considered outside the "mentally disordered" definition.

Likewise, the section 11 right of a patient who is found to have decisional capacity and chooses to refuse treatment, will be recognized provided the person is not "mentally disordered". A person will not be "mentally disordered" if the decision-maker, for example, the responsible clinician's, assessment is that the patient will exercise his or her decisional capacity so as to be outside the consequential limbs of the "mentally disordered" definition. In other words, the outcomes of the person's decisions are not going to cause serious danger to the health and safety of others, or to his or her capacity for self-care.

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[121] Nigel Dunlop, above n 77, 232.
[122] Nigel Dunlop, ibid.
[123] *Waitemata Health v Attorney General,* above n 4, [93].
[124] *Waitemata Health v Attorney General,* above n *4,* [67].
[125] Nigel Dunlop, above n 77, 225
[126] Nigel Dunlop, above n 77, 232.

There is an argument that the matter cannot be entirely resolved on the section 6 basis of the definition because the definition of "mental disorder" is not a completely satisfactory test for decisional capacity. It is still possible that a person will have decisional capacity or be competent in terms of the *Re MB* test; a ,[127] but in terms of the "mental disorder" definition, their abnormal state of mind is assessed as likely to mean the patient would be a serious danger to other people's safety.

It sounds unlikely that a patient could be assessed in terms of the *Re MB* test of understanding, weighing and using information in the process of coming to a decision,[128] as having decision capacity and come within the definition of "mental disorder" because of the assessed outcome from the use of her or her decisional capacity. In other words, the patient would lack decisional capacity because of being "mentally disordered."

The definitional limit in refusal can resolve the apparent conflict and there is no breach of the BoRA by virtue of a section 6 consistent interpretation.

2 Treatment in the patient's interest under sections 59(2) or 60(b)

"Interests of the patient" in sections 59(2) and 60(b) is not defined but a BoRA consistent interpretation is that the patient's interest includes an interest in a right which has as its purpose protecting his or her human dignity, autonomy and self-determination.

A psychiatrist considering imposing treatment must take account of the patient's right to refuse treatment to the full extent possible. If there has been a finding that the patient lacks competence to decide the course of his or her treatment, the psychiatrist, must, in the patient's interest, treat the patient with the objective of restoring the patient's decisional capability. While it is possible for the psychiatrist to do this under the MH (CAT) Act, the requirement is not explicit, and needs to be.

In *F v West Berkshire Health Authority and another (Mental Health ct Commission intervening)* the House of Lords stated that treatment will be in the patient's

[127] *Re MB (Medical Treatment),* above n 65.
[128] Ibid.

best interests only if it is carried out in order either to save their lives or to ensure improvement or prevent deterioration in their physical or mental health.[129] This interpretation should argued if a similar case arose in New Zealand.

3 Review under section 79 and appeal under section 83

The Review Tribunal's jurisdiction under section 79 is to review the condition of a patient who is subject to a CTO and decide whether he or she is "fit for release from compulsory status". The term patient's condition is not defined, but surely includes the medication or treatment they are receiving or that is proposed. Furthermore, the patient's condition in the wider sense includes the exercise of his or her BoRA rights. Earlier it was noted that the indications in section 79 and the First Schedule procedural provisions supported a natural meaning of patient's condition as being limited to the patient's medical condition, but a wider Bill of Rights consistent interpretation is possible.

On appeal to the District Court, the Court is required to review the patient's condition. Again this is in regard to the patient's fitness for release, which relates to mental disorder. The additional basis for suggesting that the patient's condition includes the patient's rights is that section 83(2) requires the Judge to carry out the section 16 steps of having a discussion with the patient on matters including treatment, so that a patient's wanting to refuse treatment is relevant.

The conclusion is that a BoRA interpretation is possible to bring the patient's decisional capacity and attitude to treatment within the subject matter of the patient's condition. If the evidence is that the patient has decisional capacity and refuses treatment that would be a matter for the Review Tribunal or the Court to take into account. However, if the person's abnormal mental state is that they pose a danger to the health or safety of others, they are still within the definition of "mental disorder" and cannot be released from compulsory treatment.

The conclusion is that a BoRA rights-consistent interpretation is possible to bring the

[129] *F v West Berkshire Health Authority and another (Mental Health ct Commission intervening),* above n 41, 548.

patient's right to refuse treatment within the jurisdiction of Review Tribunals and the Court. It would be preferable if it were more explicit.

III CONCLUSIONS

(i) The purpose of the right to refuse medical treatment in section 11 of the BoRA is to safeguard human dignity, autonomy and self-determination, including that of people within the description "mentally disordered" under the MH (CAT) Act. The right is the basis for genuine consent and applies to everyone to the extent that they have decisional capacity to refuse treatment.

(ii) Provided compulsory treatment is justified in terms of s 5 of the Bill of Rights there is no breach of the BoRA. Justification is largely provided by the MH (CAT) Act which imposes treatment for reasons of emergency, or on those who are within the definition of "mentally disordered". Compulsory treatment is justified for the initial period of assessment and treatment, and for the first month of a CTO.

(iii) There is a sufficient degree of alignment between the definition of "mentally disordered" and the test for decisional capacity in Re MB for a consistent interpretation between the MH (CAT) Act and section 11 of the BoRA.[130]

(iii) A specific judicial determination should be required prior to treatment under sections 59(2)(a) or (b) and 60 of the MH (CAT) Act as to the patient's decisional capacity in relation to treatment.

(iv) The patient's interest includes the exercise of his or her BoRA rights. A BoRA consistent interpretation of the MH (CAT) Act is that review of the patient's condition by either the Review Tribunal or the Court implicates BoRA rights.

The curtain call is for section 6 which provided a consistent interpretation where

[130] *Re MB*, above n 65.

the limitation on the right could not be justified in section 5 terms.

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