

DAVID CLARKE

**THE MENTAL HEALTH (COMPULSORY
ASSESSMENT AND TREATMENT) ACT 1992:
PATIENT RIGHTS**

• LLM RESEARCH PAPER
LAW AND MEDICINE (LAWS 546)
LAW FACULTY
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INTRODUCTION

ABSTRACT

(This paper comprises approximately 15 200 words, excluding its table of contents, footnotes and references.)

The paper examines New Zealand's approach to the compulsory treatment of the mentally ill and focuses on the rights of patients set out in Part VI of the Mental Health (Compulsory Assessment and Treatment) Act 1992. The paper also examines:

- (a) the "*central dilemma*" in mental health legislation: balancing the rights of patients with the need for compulsory treatment;
- (b) the duties which exist in **the 1992 Act** which impose an obligation to provide patients with their rights;
- (c) the mechanisms available to patients to ensure that their rights are respected;
- (d) the need to provide patients with assistance if they are to take advantage of their rights; and
- (e) the barriers which may prevent patient's being granted their rights.

INTRODUCTION

New Zealand's most recent mental health law reform commenced in 1982. In 1982 the Department of Health established a working party tasked to revise the Mental Health Act 1969. This law reform process culminated with the enactment (on 15 June 1992) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 ("**the 1992 Act**").

The long title of **the 1992 Act** provides that this is -

An Act to re-define the circumstances in which and the conditions under which persons may be subjected to compulsory assessment and treatment, *to define the rights of such persons and to provide better protection for those rights*, and generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder.

(Emphasis added). **The 1992 Act** can be seen as an attempt to overhaul mental health law in New Zealand.

In drafting **the 1992 Act** the legislature faced three problems.

1. The difficulty of providing legal safeguards for individual liberty where compulsory power is being exercised on the basis of predictions of future conduct and the prognosis of likely illness. Only
eg defn
just
2. The difficulty of how to deal with the need for compulsory treatment (particularly where such treatment requires the patient to be "*detained*" as an in-patient) while at the same time maintaining the patient's sense of autonomy and freedom which is important to the therapeutic response and the therapeutic alliance.
3. The difficulty of balancing the patient's right to individual liberty with the rights of the community.

This paper focuses on the second and third of these problems. // Why?

The paper also considers:

- (a) the barriers which exist to prevent patients making use of their rights; and

- (b) the need to provide patients, because of the nature of their condition, with assistance to take advantage of their rights.

MENTAL HEALTH AND MENTAL HEALTH ACTS

What is Mental Health?

The 1992 Act does not define the terms "*mental health*" or "*mental illness*".¹

Mason Durie (1984) points out that the term "*mental health*" is hard to define, and it is easy to confuse the terms mental health, mental illness and psychiatry.²

Durie cites Roberts (1969)³ who suggests that abstract conceptual models of mental health are probably less helpful than those models which seek to obtain an appreciation of "*what is mental health*" by focusing on the reality in which we live. In other words our conceptions of "*what is mental health*" is bound by time and culture.

1 A Department of Health discussion paper on the definition of the term mental disorder (anon) points out that the terms "mental health" and "mental illness" are not defined in the Bill which became the 1992 Act. The paper points out that, this omission was deliberate, and has considerable value in terms of flexibility. The paper recognises that omitting definitions to these terms does pose problems. First, from the point of view of civil liberties, where some greater degree of clarity of criteria which will determine non-consensual treatment and detention is desirable; and second, from the point of view of the courts who must make adjudications on this question. The paper points out that the question - What is mental illness? is very much a medical convention and such conventions change from time to time. The paper explains that the definition of general terms such as illness were avoided when drafting the Bill because they tended to be "circular".

2 M Durie "Te Taha Hinegaro: An Integrated Approach to Mental Health" (1984) *Community Mental Health in New Zealand*, Vol 1, No. 1 : 4.

3 C A Roberts "Primary Prevention: to the Present." In C A Roberts edited, *Primary Prevention of Psychiatric Disorders* (University of Toronto Press, Canada, 1969).

Durie emphasises this point when he says that ⁴ -

Obviously, not everyone lives in the same reality and notions of mental health are thus very much bound by culture and by time. A mentally healthy child living in contemporary western society would probably be regarded as disturbed if it lived in the Victorian era.

A number of commentators have attempted a classification of mental health. For example, S Kasl and S Rosenfield⁵ classify mental health into:

- (a) indices based on treatment data;
- (b) psychiatric signs and symptoms;
- (c) indicators of mood and well being;
- (d) indices of functional effectiveness and role performance; and
- (e) indices derived from notions of positive mental health, for example the adequacy of coping mechanisms.

A pragmatic definition of the term "*mental health*" for the purposes of this paper is framed as follows:⁶

A relative state of mind in which a person who is healthy is able to cope with and adjust to the recurrent stresses of everyday living in an acceptable way.

While the 1992 Act does not define the term "*mental health*" it does provide a legal definition of the term mental disorder,⁷ the definition of this

4 M Durie "Te Taha Hinengaro: An Integrated Approach To Mental Health", (1984) Community Mental Health In New Zealand, Vol, No. 1 : 5.

5 Cited in H Freeman (Edited) *Mental Health and the Environment* (Churchill Livingstone, United Kingdom, 1984): 6.

6 *Mosby's Medical Nursing, and Allied Health Dictionary* (Third Edition, C V Mosby and Co., USA, 1990).

7 "**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 health or safety of that person or of others; or
- (b) Seriously diminishes the capacity of that person to take care of him or herself; -

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

term is the legal threshold over which "*potential patients*" must be brought before they become a "*patient*"⁸ in terms of **the 1992 Act**.⁹

The definition of the term "*Mental Disorder*" in **the 1992 Act** has two elements -

- (a) qualitative, that is a description of the mental capacities which have to be disordered; and
- (b) quantitative, that is the degree to which the disorder must be present and its likely consequences.

The definition also has exclusionary elements set out in section 4 of **the 1992 Act**, that is the persons:

- (a) political beliefs;
- (b) religious beliefs;
- (c) cultural beliefs;
- (d) sexual preferences;
- (e) criminal or delinquent behaviour;
- (f) substance abuse; or
- (g) intellectual handicap,

will not alone lead to compulsory treatment and or detention.¹⁰

The definition in **the 1992 Act** is markedly different from the definition of the term "*mentally disordered*" used in the Mental Health Act 1969. The definition in the 1969 Act focused on care and protection¹¹. While the

8 Section 2 of the 1992 Act refers.

9 Legal definitions determine entry into the mental health system created by the 1992 Act. They also exclude those failing to meet the definitional requirements.

10 The exclusionary elements would appear to have been included to prevent abuse of compulsory psychiatric power. See for example, S Bloch, *The Political Misuse of Psychiatry in the Soviet Union*, in S Bloch and P Chodoff (ed) *Psychiatric Ethics*, 1981.

definition in **the 1992 Act** places a greater emphasis on danger to self and others¹².

(It should be noted that the new definition of the term mental disorder is not without some controversy.)¹³

This change is in keeping with the social and political changes which will be identified in this paper.¹⁴ The change represents an "erosion" of the theme of "separatism"¹⁵ in New Zealand mental health legislation in response to civil liberty concerns, to a minimum level designed to protect society's interests in this area. It is also influenced by resource constraints faced by the New Zealand "public" health sector. In the 1990's state funded long term "total care" is no longer a viable option.

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

- (a) Mentally ill-that is, requiring care and treatment:
- (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 the mind.

12 Section 2 of the 1992 Act refers.

13 The Department of Health's User Guide to the 1992 Act suggests that the definition of the term mental disorder is narrower than the definition of that term in the Mental Health 1969. Contrast this with the perspective of Dr Jeremy Anderson, who was one of the presenters of a New Zealand Law Society seminar on the 1992 Act, who suggests that the definition of the term mentally disorder remains broad. He also goes on to identify a number of other criticisms he has of the definitions in the 1992 Act:

"I identify four specific difficulties with the new Act - a difference between the way in which mental disorder is defined in the Act and the diagnostic terminology used by psychiatrists; an ambiguous approach to the duration of mental disorder; the inclusion of "disorders of volition" that may redefine the interface between areas of psychiatric and penal jurisdiction; and the requirement that psychiatrists estimate suicidal risk and dangerousness".

New Zealand Law Society Seminar, The Mental Health (Compulsory Assessment and Treatment) Act 1992 50-58.

14 See pages 15 and 16 of this paper.

15 See page 12 and 13 of this paper.

Mental Health Legislation

The use of the term "*mental health*" in mental health legislation can be misleading in that the use of the term might suggest that such statutes are concerned with the "*active*" promotion of mental health.

Mental health acts are not about the promotion of mental health and **the 1992 Act** is no exception. These statutes provide a basis for the compulsory treatment of the mentally disordered.¹⁶ Stromberg and Stone (1983) suggest that mental health statutes have three social functions¹⁷ -

- (a) the protection of society ("*police power*");¹⁸
- (b) the provision of psychiatric treatment for a patient's "*own good*" (the states "*parens patriae*" role); and
- (c) providing custodial confinement, simply caring for a patients bodily needs.¹⁹

As well as considering the functions of mental health statutes, it is also important to consider the underlying assumptions on which such statutes are based. Namely, that persons suffering from mental disorders -

- (a) frequently fail to recognise their illness and the need for treatment;
- (b) maybe unwilling to accept , or to cooperate, with treatment for their condition; and

16 The Associate Minister of Health, Katherine O'Regan, said during her speech when moving the second reading of the Mental Health (Compulsory Assessment and Treatment) Bill in the House of Representatives-

The Committee (the Social Services Select Committee) agreed that the previous title the - Mental Health Bill - was not truly descriptive of the Bill, as it does not deal with the promotion of mental health but only with the compulsory assessment and treatment of the mentally disordered.

Weekly Hansard 34, 12 March 1992: 6861.

17 C D Stromberg and A Stone "A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 Havard Journal of Legislation: 279 - 280.

18 It is a "*truism*" that mentally disorder persons "*present*" as a large and severe social problem, lying outside the sphere of the criminal law, but seen as a sufficient social and public nuisance to warrant control.

19 The third of these functions is not reflected in **the 1992 Act**. This is because the focus of **the 1992 Act** is on treatment not on the provision of care and protection for patients (the asylum" function).

(c) if left untreated, may pose a threat to themselves or others.²⁰

Based on these assumptions New Zealand provides a mechanism for the "involuntary" assessment and treatment of the "mentally disordered" under the 1992 Act.

THE HISTORY OF NEW ZEALAND'S MENTAL HEALTH LEGISLATION

This paper examines the emphasis placed on patient rights by the 1992 Act. To understand how the 1992 Act came to place this emphasis on patient rights we must first turn to history.

The history of the treatment of the mentally ill has been characterised by abuse and neglect. It has only been in the last century that significant improvements have been made.

Curran and Harding summarise the history of mental health legislation in this way²¹ -

Most of the commitment laws stressing judicial or police involvement were enacted in the middle of the nineteenth century. Emphasis on formal structures and court review continued during the asylum era. The mentally ill and retarded were segregated and generally lost their legal capacity and civil rights. Significant changes in treatment methods and attitudes towards the mentally ill did not tend to have an effect until the middle of the current century. The mental health legislation of many countries was significantly revised after 1950. The last two decades have seen more varied and piecemeal changes in response to the greater complexity of the mental health systems themselves and the lesser concentration upon the long term hospitalisation of the chronically ill.

In this quote, Curran and Harding speak of mental health legislation generally. Many of the themes which they identify can be traced through the development of New Zealand's mental health law.

²⁰ The definition of the term "Mental Disorder" in section 2 of the 1992 Act refers.

²¹ W Curran and T Harding *The Law and Mental Health: Harmonising Objectives* (World Health Organisation, Geneva 1978).

Themes

There have been a number of important themes in mental health legislation in New Zealand.

A. Separatism.

Brunton (1985)²² says that the "skeletal structure" of New Zealand's mental health law has been separatism.

The concept of "separatism" in this context rested on the notion that the mentally disordered were a separate social problem for which special and total care institutions as well as separate laws were needed.²³

Brunton suggests that the differentiation of persons with mental disorder as a separate class was an eighteenth and early nineteenth century phenomena. He identifies three main factors in this development:²⁴

- (1) The common law acceptance that clinical criteria and behavioural deviance, such as a danger to self or others²⁵, were the attributes of a mentally disordered person. This acceptance was translated into statute by way of the United Kingdom Vagrancy Acts of 1714 and 1744 which distinguished "lunatics" from other "social undesirables" such as beggars.
- (2) The second factor was the expansion of the notion of "mens rea" in criminal law and the expansion of concept of mental disorder to cover the criminally insane.
- (3) The last factor is the popular understanding of mental disorder not as illness but as madness "a different form of deviance".

²² *The Future of Mental Health Services in New Zealand: Mental Health Law* Edited by J Dawson and M Abbott, Published by the Mental Health Foundation, September 1985:49.

²³ *The Future of Mental Health Services in New Zealand: Mental Health Law* Edited by J Dawson and M Abbott, Published by the Mental Health Foundation, September 1985: 56.

²⁴ *The Future of Mental Health Services in New Zealand: Mental Health Law* Edited by J Dawson and M Abbott, Published by the Mental Health Foundation, September 1985: 49.

²⁵ Carried over into the 1992 Act with its focus on danger, to self and others, in the definition of the term "mentally disordered" in the 1992 Act.

Because of this tradition of separatism, progress in law reform in this area has been slow (mainly because of prevailing social attitudes and the common belief that "lunatics" were outcasts).

Brunton points out that the traditions of separatism can be quite negative. These traditions ²⁶ -

- (a) impede desirable change in practice of service provision;
- (b) require an undue level of resources to operate;
- (c) impair helpful responses to mental disorder in the community;
- (d) create completely separate mental health services and impede progress towards integration; and
- (e) create or reinforce negative attitudes towards mental disorder.

Though we still have a separate statute dealing with the compulsory treatment of the mentally disordered, the writer suggests that **the 1992 Act** does go some way to reversing the negative influences of separatism in that it:

- (a) "catches up" with new developments in mental health service provision (such as the provision of treatment in the community);
- (b) provides for partial integration of mental health services with other health services. "Voluntary patients" for example, are no longer dealt with under a separate mental health act; and²⁷
- (c) has attempted to erode "negative attitudes" towards patients who are the subject of compulsion, by reinforcing that these patients have rights.²⁸

26 *The Future of Mental Health Services in New Zealand: Mental Health Law* Edited by J Dawson and M Abbott, Published by the Mental Health Foundation, September 1985: 57.

27 Department of Health records on the implementation of the 1992 Act show that the original Departmental drafts of the Mental Health Bill proposed to make amendments to the Area Health Boards Act 1983 rather than provide for a separate "Mental Health Act". This was on the basis of the desirability of integrating service provision. This approach would appear to have been rejected on the grounds that it was seen as desirable to have a separate mental health statute which was "visible" and because of perceived drafting difficulties.

28 Part VI of the 1992 Act refers.

B. Social control.

This theme is a recognition of the interests of the community in compulsory treatment.

Brunton points to links between the recognition of the mentally disordered as a problem group and the steady move towards legislation and institutions being used for the purpose of social control in Eighteenth Century England.

It is interesting to note, that the first law on the subject in New Zealand was intended "*to make provision for the safe custody of and the prevention of offences by persons who were dangerously insane*".²⁹

The writer will demonstrate that this theme continues to be important in the context of **the 1992 Act**.

C. Legal safe-guards.

The mechanics of formal admission to psychiatric hospitals are the product of what Brunton calls the "*save the sane campaign*".

Unlike official intervention for the purpose of public law and order for which public institutions were established, private establishments caring for the mentally disordered operated on basis of private subscription and some medical assessment. Certification was adopted as an early safe-guard against the detention of persons in the infamous "*private*" mad houses of the Nineteenth Century. The United Kingdom Madhouse Act 1828 for example, was formulated to meet public concerns about illegal detention.

Procedural safe-guards continue to play an important part in **the 1992 Act**.

29 The Lunatics Ordinance 1846.

D. *State intervention.*

The gradual emergence of collective responsibility for the mentally ill arose as much from, humanitarian concerns as from the need to protect the sane. Social conscience as much as civil liberty played a part in shaping the Mental Health Act 1969.³⁰ Brunton says that state intervention in health and social services in New Zealand is a long standing tradition and psychiatric services have played an important part in shaping this tradition.³¹

The states influence in this area is reducing. In **the 1992 Act**, there is a greater emphasis on the role of the community in the treatment process. The writer also suggests that the on going reforms in New Zealand's health sector may "*foreshadow*" the considerable erosion of the states influence in this area.

WHAT WAS WRONG WITH THE 1969 ACT?

The most recent development in the history of New Zealand's mental health legislation is the repeal of the Mental Health Act 1969 and the enactment of **the 1992 Act**.

From the enactment of the Mental Health Act 1969 through to the 1980's major sociological and political changes occurred in New Zealand.³² These changes stressed the need to reduce the influence of "*big*" government, and focused on individualism and autonomy.

Mental health law reform in the 1960's was concerned with care and protection. This emphasis must be seen in the social and political context

30 *The Future of Mental Health Services in New Zealand: Mental Health Law* Edited by J Dawson and M Abbott, Published by the Mental Health Foundation, September 1985: 54.

31 *The Future of Mental Health Services in New Zealand: Mental Health Law* Edited by J Dawson and M Abbott, Published by the Mental Health Foundation, September 1985: 54.

32 See for example, S Maharey "Shaping the Future? Labour, Ideology and Socialism" (1987) *Race, Gender and Class* No. 5, B Jesson, *Behind the Mirror Glass, The Growth of Wealth and Power in New Zealand in the Nineteen Eighties* (Penguin Books, New Zealand, 1987) and B Jesson, A Ryan and P Spoonly, *Revival of the Right* (Heinman Read, New Zealand, 1986).

of New Zealand at that time, characterised by economic boom times and "the hay day" of the welfare state and benevolent paternalism.

Mental health law reform in the 1980's and 1990's must be placed in the context of the social and political forces of those decades.³³ Economic restructuring, accountability and the dismantling of the welfare state were amongst the dominant social and political forces. Forces which also shaped our views on how mental health services had been provided in the past and should be provided in the present.

In conjunction with these changes the clinical practices of mental health providers also changed. A far greater emphasis was placed on treatment in the community, made possible with advances in drug and psychotherapy.

At the same time, civil libertarians had turned to champion the cause of the mentally ill. John Dawson made the following criticism of the Mental Health Act 1969 in 1986 - ³⁴

The impotence of families; questionable arrest practices without judicial oversight; illegible and vague medical certificates; compulsory treatment under a standard which specifies the need for detention in a hospital; judicial hearings at which patients are excluded from the evidence; the absence of legal advice; a mono-cultural process - these findings call into question the strength of our commitment to the rule of law and habeas corpus. They indicate the priority given by professionals to committal: the same priority given to psychiatric patients through most of our culture - a culture that provides more protection for property than for the liberty of its most powerless members.

The 1969 Act can also be criticised on civil libertarian grounds because it did not deal with-

- (a) enormous power imbalances characterising the relationships between patients and mental health professionals;
- (b) mental health professionals lack of legal accountability to the public for the exercise of their considerable power;³⁵ and

33 Also at this time mental hospitals were being transferred from central control to hospital boards and later to area health boards.

34 J Dawson, Law Research Foundation Seminar, *Mental Health a Case for Reform*, (1986): 54.

35 C D Stromberg and A Stone "A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 *Harvard Journal of Legislation* 279.

- (c) serious human rights violations which occurred under the old system (such as the circumstances surrounding the death of Michael Watene).³⁶

These criticisms together with the growth of health consumerism³⁷ and the changes in social and political ideology which have taken place in New Zealand over the last ten years have led to the greater recognition of the rights and autonomy of patients under **the 1992 Act**.

THE 1992 ACT

The 1992 Act a Legal or a Medical Model?

The 1992 Act is a hybrid (as was the 1969 Act) of legal and medical models of mental health statutes.

A "*medical model*" conceives of commitment as a process for obtaining treatment for persons who psychiatrists diagnose as being mentally ill. Under this model legal procedures are secondary to therapeutic concerns.

The "*legal model*" on the other hand conceives of commitment as a deprivation of liberty in order to protect society from dangerous persons.³⁸

Shapland and Williams (1983) cite Gostin who suggests that the United Kingdom's law reform in this area is a return to "*legalism*". This reform has three main threads -

The right to effective services (entitlements), the protection against unjustifiable deprivation of civil and legal rights, and the protection against discrimination.³⁹

36 J Dawson, "Mental Health Reform", (1986) NZLJ 323.

37 E Brody "Patient's Rights: Science, Ethics and the Law in International Perspective" (1988) Community Mental Health In New Zealand Vol. 4 No. 1 June :21.

38 C D Stromberg and A Stone "A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 Havard Journal of Legislation 282.

We can see these threads in the fabric of legislation in New Zealand. For example, in the:

- (a) "right to treatment" set out in section 66 of **the 1992 Act**;
- (b) provisions of the New Zealand Bill of Rights Act 1990; and
- (c) protection against discrimination for persons with "psychiatric illnesses", set out in the Human Rights Act 1993.⁴⁰

We can find considerable evidence of the prevalence of the "legal model" used in **the 1992 Act**, for example -

- (a) the emphasis the definition of the term "mental disorder" places on the concept of dangerousness;⁴¹
- (b) the focus on the role of the courts under **the 1992 Act**;⁴²
- (c) the increased focus on the "rights" of patients; and
- (d) the increased emphasis on the role of lawyers, epitomised by the specific right to legal advice set out in **the 1992 Act**.⁴³

And review tribunals

legal representation

The 1992 Act: A Change in the Tutelary Relationship between Doctors and Patients

Fennell (1992)⁴⁴ suggests that important shifts in mental health law are those which involve changes in the nature of the "tutelary relationship".

39 J Shapland and T Williams "Legalism Revived: New Mental Health Legislation in England" (1983) *International Journal of Law and Psychiatry* Vol. 6 : 356-357.

40 See the definition of disability in the prohibited grounds of discrimination in section 21.

41 Section 2 of the 1992 Act.

42 See for example, section 16, 17, 83 and 84 of the 1992 Act.

43 Section 70 of the 1992 Act.

44 P Fennell "Balancing Care and Control: Guardianship, Community Treatment Orders and Patient Safeguards" (1992) *International Journal of Law and Psychiatry* Vol. 15 : 205.

That is, the relationship where patients are under the protection and control of a doctor or some other person.

Fennell identifies three important aspects of the tutelary relationship :

- (1) Care.
- (2) Control.
- (3) Financial support.

Using the above analysis, **the 1992 Act** represents a significant change in New Zealand Mental Health Law evidenced by a number of "firsts" incorporated in the statute including :

- (a) provision for the compulsory review of the medical condition of patients under **the 1992 Act**;
- (b) limited scope to allow patients to consent to treatment and the provision of safe-guards where treatment is given and consent is overridden;
- (c) review tribunals;
- (d) community treatment orders; and
- (d) an express statement of patient rights in Part VI of **the 1992 Act**.

This latter innovation is a clear recognition of New Zealand's intention to honour various international human rights conventions.⁴⁵ Herr(1984)⁴⁶ points out there has been a global upsurge in civil and human rights expectations in the wake of certain United Nations Declarations.

In terms of the recent "*health reforms*" the provisions for the funding of mental health services has also changed. This latter change may prove to be significant. There is now the possibility that private providers may win tenders to provide "*compulsory*" mental health services.

45 For example, the Universal Declaration of Human Rights 1948, and the International Covenant on Civil and Political Rights (ratified by New Zealand in 1978).

46 S Herr, S Arons and R Wallace Jnr, *Legal Rights and Mental Health Care* (DC Health and Co. USA, 1984) :158.

Gostin (1987) has highlighted a number of possible difficulties where we have private providers providing "compulsory" mental health services. He suggests that the private sector produces "an atmosphere of disrespect for human rights"⁴⁷ for three reasons -

- (1) The profit motive. "Private provision" works well where private providers are trying to attract voluntary patients to utilise their services but not where patients are the subject of compulsion.
- (2) "Private hospitals" are independent of the state and difficult to regulate.
- (3) Allowing "private hospitals" to exercise the power of the state by providing compulsory assessment and treatment may involve the abrogation of a power which is the exclusive prerogative of the state.

PATIENT RIGHTS: PART VI OF THE 1992 ACT

Granting Rights

Granting rights to patients suffering from mental disorders is a complex business. This is because of the nature of the patients condition and the nature of the treatment provided.

The granting of such rights presupposes that we know what is or should constitute psychiatric treatment. It also presupposes that we know and can determine what are the influences of psychiatric treatment on the patient.⁴⁸

47 L Gostin "Human Rights in Mental Health: A proposal for Five International Standards based on the Japanese Experience" (1987) *International Journal of Law and Psychiatry* Vol. 10: 353.

48 P Bean and P Mounser, *Discharged from Mental Hospitals* (MacMillan Press, London, 1993) :127.

Definitions

Rights.⁴⁹ A persons entitlements as a member of society, including liberties, such as the right to use the public highway, and "claim rights", such as the right to defence counsel. "To have a right" said Mill "is to have something society ought to protect me in the possession of. The word "ought" is important: the language of rights is inescapably normative (though the question of what rights are recognised in a particular society are straight forwardly factual.

Bloom and Asher identify four different kinds of rights:⁵⁰

- (1) Constitutional rights.
 - (2) Common law or fundamental rights.
 - (3) Entitlements provided by legislation.
 - (4) Rights to be accorded by reason of professional standards.
- } N2 Examples?

The rights set out in Part VI of **the 1992 Act** could be seen as representing a statutory reframing of certain fundamental rights (which have been recognised in psychiatric hospitals for some time).⁵¹ In the context of Part VI of **the 1992 Act**, however, it is more accurate to analyse these rights on the basis that they are "*entitlements*" or "*claim rights*".

The majority of the rights set out in Part VI of **the 1992 Act** are expressed to be "*entitlements*". This means that the rights are not guaranteed though patients have the opportunity to claim them.⁵²

The 1992 Act can be criticised on the basis that it is "*enabling legislation*" rather than a "*guarantee*" of rights. Such a guarantee would of course require the Government to commit resources to allow patients to claim those rights. The writer recognises, that in the context of current

49 *A Dictionary of Philosophy* (Pan Books, United Kingdom, 1984): 306.

50 B Bloom and J Asher Ed. *Psychiatric Patient Rights and Patient Advocacy: Issues and Evidence*, (Human Sciences Press Inc., New York, New York, 1982): 24-25.

51 *Trapski's Family Law - Vol III- Mental Health -Protection of Personal Property Rights Act* (Brooker and Friend, Wellington 1992): A-130.

52 S Bell, "The Mental Health (Compulsory Treatment and Assessment) Act 1992" (1992) *Community Mental Health in New Zealand*, Vol. 6, No. 2: 16.

constraints on health spending such an approach is unlikely to be accepted.

Competency

In analysing the rights set out under Part VI of **the 1992 Act** it should be noted that the enjoyment of virtually all individual rights is subject to the pre-condition, imposed by the law, that an individual must be competent to properly exercise those rights.

In other words, a persons legal competency is used as the measure of their ability to exercise certain basic rights.⁵³

Patients subject to **the 1992 Act** are a group who may be perceived as lacking:

- (a) autonomy and the ability to exercise rights; and
- (b) the ability to exercise rights with responsibility.

How can we, therefore, justify the inclusion of specific patient rights in **the 1992 Act**?

Stromberg and Stone⁵⁴ make it clear that:

- (a) the evaluation of a person as "*mentally disordered*"; or
- (b) the committal of a person for compulsory treatment,

does not justify denying a patient his or her existing rights

Caution must be exercised. Mental disorder does not of itself imply an inability to discharge rights responsibly. Rights should only be restricted on the basis of legal provisions relating to the patients actual competence to perform specific functions⁵⁵.

53 See in this regard the approach taken by Barker J in re S [1992] 1 NZLR 363, 375-75.

54 C D Stromberg and A Stone "A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 Havard Journal of Legislation: 279.

55 C D Stromberg and A Stone "A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 Havard Journal of Legislation 279 at 364.

On the basis of the above analysis a major criticism can be made of **the 1992 Act** in that it has no mechanism for grading "*patients degree of competence*" and therefore the patient's ability to exercise specific rights.

This "*flaw*" could be partially cured by including a "*presumption of competence*" into **the 1992 Act** modelled on section 5 of the Protection of Personal and Property Rights Act 1988 and by having a court make a ruling on a patients ability to make use of their rights at the same time as making a compulsory treatment order.

The Express Rights included in the 1992 Act

The express "*rights*" set out in Part VI of **the 1992 Act** are as follows -

A. *General rights to information.*⁵⁶

This right is the only guaranteed right (guaranteed in that it is expressed to be mandatory) set out in Part VI of **the 1992 Act**.

The right is important as it is the key to "*unlocking*" the other "*entitlements*" set out in **the 1992 Act** and provides that every person must receive a written statement of his or her rights on becoming a patient.

The 1992 Act defines a "*Patient*" as a person who is -

- (a) required to undergo an assessment interview under section 11 or section 13 of **the 1992 Act**; or
- (b) subject to a compulsory treatment order made under Part II of **the 1992 Act**; or
- (c) a special patient.

It follows that in terms of **the 1992 Act** there is no need to furnish a written statement of rights to a person until the certificate of preliminary assessment concerning that person is complete.

56 Section 64 of the 1992 Act.

to it
detention?

Prior to that stage, section 23 of the New Zealand Bill of Rights Act 1990 will apply. It follows that a "potential patient" will have the right to be told at the time of their detention of the reason for it.⁵⁷

Section 64 of the 1992 Act makes it clear that once a person becomes a "patient" they must be kept informed of the legal consequences of the 1992 Act and his or her rights of review in terms of the 1992 Act. The writer suggests, that as far as possible, information should be provided to a patient, pursuant to this right, in a way, at a time and in a setting which is conducive to the patient's understanding of the information.

A clinician should choose the most appropriate time according to the patient's mental state thus informing the patient when he/she is not unduly distressed and most likely to comprehend⁵⁸.

Stromberg and Stone(1983) suggest that: 59 -

Harm could result from administering a long description of legal rights to a agitated, frightened patient who, for the next few hours, needs a different kind of therapeutic interaction. Thus the model law requires telling a patient his rights "as soon after admission as his medical condition permits"...This advice should be viewed as a therapeutic exchange, an effort to explain to the patient what is occurring and why. The dialogue should not degenerate into a routine incantation read from a card, like the "Miranda" warning given to persons taken into criminal custody.

Herr(1984) suggest that rights notifications should be explained by a person well versed in relevant law and social policy to avoid⁶⁰ "high speed mumbled incantations". In North America jurisdictions audio visual aids (which are not used in New Zealand) are available which offer self instructional guides for patients on rights, responsibilities and decision making.⁶¹

57 Section 23(1)(a) of the New Zealand Bill of Rights Act 1990.

58 Department of Health *Review of the Mental Health Act 1969: Discussion Papers*, (1984) Review Working Party, Department of Health NZ.

59 C D Stromberg and A Stone "A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 *Havard Journal of Legislation* 279 at 323.

60 S Herr, S Arons and R Wallace Jnr, *Legal Rights and Mental Health Care* (DC Health and Co. USA, 1984):162.

61 Project Independence, Social Planning Services INC, "Rights Now!: A Learning Programme on Rights and Responsibilities" (National Institute of Mental Retardation, Canada).

The writer has two criticisms of section 64 of **the 1992 Act** -

- (a) the section does not specify on whom the duty will lie to inform a patient of his or her rights as a patient; and
- (b) although the section requires a patient to be given notice of his or her rights it does not clearly impose an obligation on the person supplying the information to ensure that the patient understands the information.

The Privacy Act 1993

The Privacy Act 1993 could prove a useful supplement to section 64 of **the 1992 Act**.

In particular, in terms of the 1993 Act, a patient will have the right -

- (a) to be informed of the fact of collection of health information concerning that patient, the purpose of collection, the intended recipients of the information, the consequences of non supply and his or her rights regarding access and correction;⁶² and
- (b) of access to health information concerning his or her assessment and treatment.⁶³

There are of course a number exceptions to this second right. In this context it is suggested that the most important of these is set out in section 29(1)(c) of the Privacy Act 1993. This subsection would allow the health agency concerned to withhold information from a patient if the release of the information would be likely to prejudice the physical or mental health of the patient.

The writer notes that this sub-section requires the health care provider to consult with the patient's usual medical practitioner in this regard. This requirement could be problematic as in most cases it is considered that the "*patient's*" responsible clinician is the person most able to judge the effect of the release of such information on a patient's physical or mental health.

⁶² Rule 3 of the *Health Information Privacy Code 1993 (Temporary)* refers.

⁶³ Rule 6 of the *Health Information Privacy Code 1993 (Temporary)* refers.

B *Respect for cultural identity*⁶⁴.

This "entitlement" must be considered in conjunction with section 5 of **the 1992 Act**.

The "entitlement" was included in the Mental Health Bill by the Social Services Select Committee in response to criticisms of the mono-cultural nature of the Bill⁶⁵. Criticism of the mono-cultural nature of New Zealand mental health acts is not new. Criticism of the mono-cultural nature of the Mental Health Act 1969 Act was levelled by the "Gallen" Inquiry⁶⁶; and John Dawson.⁶⁷ Such criticisms have also led to the recognition of this "entitlement" in **the 1992 Act**.

The "entitlement" is an important one. It has been suggested that section 5 of **the 1992 Act** will either -⁶⁸

- (a) be an important relevant consideration in the decision making process concerning a patient; or
- (b) have the equivalent status of section 9 of the State Owned Enterprises Act 1986, controlling the exercise of all other compulsory powers and capable of grounding an injunction when there is a direct conflict between a mode of treatment and deeply held cultural beliefs.

A court is unlikely to favour the second option. This is because a court is likely to have regard to Parliament's intention in this regard evidenced by the general nature of **the 1992 Act** (imposing as it does compulsory treatment).

64 Section 65 of the 1992 Act.

65 The submissions from the Mental Health Foundation, the Maori Woman's Welfare League and Pacifica refer.

66 *Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters* (1984).

67 Legal Research Foundation Inc Seminar, *Mental Health: A Case For Reform* (University of Auckland 1986).

68 J Dawson "Mental Health Reform in the Midst of Health Reorganisation", (1992) Council Brief, November: 6.

This "*entitlement*" is more likely to be an important consideration when considering how the patient is to be treated and how that treatment is to be carried out.

The "*entitlement*" cannot be regarded as a "*panacea*" however as it is suggested that cultural barriers, no matter how skilful the expert, will continue to impede the attainment of "*health*".⁶⁹

C. *Right to treatment.*⁷⁰

Section 66 of **the 1992 Act** recognises that a patient is entitled to receive health care which is appropriate to his or her condition.

This section does not guarantee the best conceivable treatment, though it is suggested that the patient should receive "*prompt, competent and appropriate treatment*".⁷¹

The section may be used as to exclude those persons from **the 1992 Act** who are incapable of treatment.

Arguably, this section incorporate a "treatability" criteria into the Act. It would, therefore, follow that patients who may not benefit from treatment but who may fall within the definition of "mental disorder" because of the inclusion of "disorders of volition" should not be made subject to the Act. See Psychiatric Report 1988 (Mason Report) at 224, '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".⁷²

The "*entitlement*" in section 66 of **the 1992 Act** is derived from an idea well developed in American jurisdictions.

69 F Varghese "The Racially Different Psychiatrist: Implications for Psychotherapy" Australian and New Zealand Journal of Psychiatry (1983), 17:329.

70 Section 66 of the 1992 Act.

71 *Trapski's Family Law - Vol III- Mental Health -Protection of Personal Property Rights Act* (Brooker and Friend, Wellington 1992): A138.

72 *Trapski's Family Law - Vol III- Mental Health -Protection of Personal Property Rights Act* (Brooker and Friend, Wellington 1992): A138.

In *Wyatt v Stickney*⁷³, Chief Judge Frank Johnston Junior held patients had a remedy for the states "*unfulfilled paternalistic responsibility*"⁻⁷⁴

To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then to fail to provide adequate treatment violates the very fundamentals of due process.

The origin of this principle in the United States comes from a Federal Government model statute.⁷⁵ and from an articulation of psychiatric patients "*rights to treatment*" in 1960 by Dr Morton Birnbaum.⁷⁶

In a wider context this "*entitlement*" is connected with our society's respect for the individual, articulated in section 23(5) of the New Zealand Bill of Rights Act 1990. This is because at the core of the "*right to treatment*" is the idea that treatment must be geared to needs of the individual.

Herr⁷⁷ suggest that a "*right to treatment*" raises four "*thorny*" questions⁻⁷⁸

1. Will voluntary patients share in the right to treatment?⁷⁹
2. Are there any settings in which a right to treatment is either infeasible or counter productive?
3. Resources. How do we best achieve the right in the community setting.
4. How do you gauge the adequacy of treatment when the patient objects.

73 325 F Supp 781 (1971) M D Ala); 344 F Supp 373 (1972) (M D Ala).

74 *Wyatt v Stickney* 325 F Supp 781, 785 (1971) M D Ala).

75 Federal Security Agency, "A Draft Act Governing Hospitalisation of the Mentally Ill" (Public Health Service Publication No. 51, 1952).

76 M Birnbaum "The Right to Treatment" (1960) 46 ABAJ 499.

77 S Herr, S Arons and R Wallace Jnr, *Legal Rights and Mental Health Care* (DC Health and Co. USA, 1984).

78 This paper does not attempt to answer these questions. It is suggested that further research could usefully be carried out in this area.

79 The rights set out in Part VI of the 1992 apply only to "patients" as defined in the 1992 Act and not to "voluntary patients". In New Zealand however, it is arguable all patient have a right to treatment.

Quite apart from section 66 of the 1992 Act a "right to treatment" is available to patients (and arguably to all classes of patients not just those who are subject to compulsion under the 1992 Act) from other sources.

For example, section 151 of the Crimes Act 1961 provides:

(1) Every one who has charge of another person unable, by reason of detention, age, sickness, insanity, or any other cause, to withdraw himself from such charge, and unable to provide himself with the necessaries of life, is (whether such charge is undertaken by him under any contract or is imposed upon him by law or by reason of his unlawful act or otherwise howsoever) under a legal duty to supply that person with the necessaries of life, and is criminally responsible for omitting without lawful excuse to perform such duty if the death of that person is caused, or if his life is endangered or his health permanently injured, by such omission.

(2) Every one is liable to imprisonment for a term not exceeding 7 years who, without lawful excuse, neglects the duties specified in this section so that the life of the person under his charge is endangered or his health permanently injured by such neglect.

The provision of medical care and hospital treatment is included within the "necessaries of life"⁸⁰.

The writer also notes that medical practitioners have

An ethical responsibility to render medical services to any person regardless of colour, religion, political belief, and regardless of the nature of the illness so long as it lies within their limits of expertise as a practitioner.⁸¹

D. *Right to be informed about treatment*⁸².

Successful treatment depends upon a therapeutic alliance between the patient and the treating professional. It has been suggested that with active participation in the therapeutic process all will benefit.⁸³

80 See R v Burney [1958] NZLR 893 and D Collins, *Medical Law in New Zealand* (Brooker and Friend Ltd, Wellington, 1992) :192- 194.

81 Article 6 of the New Zealand Medical Associations Code of Ethics.

82 Section 67 of the 1992 Act.

83 Department of Health *Review of the Mental Health Act 1969: Discussion Papers*, (1984) Review Working Party, Department of Health NZ.

Though the patient may have no say in whether or not to accept treatment, it is extremely important to preserve the patient's "entitlement" to be involved in the therapeutic process. It is the quality of this involvement that is important.

The "entitlement" to be informed about treatment may help to remind service providers that patients are human beings. This is line with the suggestion that the possession of rights enhances the dignity of the person who holds the rights and exemplifies our idea of respect for people.⁸⁴

There is also clinical and empirical evidence to suggest that -⁸⁵

- (a) a failure to involve patients in treatment decisions can be detrimental to their health; and
- (b) a lack of patient involvement increases potential sources of error as well as providing an impediment to speedy recuperation and beneficial outcomes in the long term.

It is noted that arguably doctors as a matter of "good medical practice" owe this "entitlement" to all classes of patient not just to those subject to **the 1992 Act**. Recognition of this "entitlement" can be found in doctors ethical obligations to -

Accept the right of all patients to know the nature of any illness from which they are known to suffer, its probable cause, and the available treatments together with their likely benefits and risks.⁸⁶

84 Campbell, *Justice* (MacMillan, London 1988).

85 Morris (et al) , *The Benefits of Providing Information to Patients*, Cited by H Teff in the *Journal of Contemporary Health Law and Policy* (1993) Volume 9 at 212.

86 Article 7 of the New Zealand Medical Associations Code of Ethics.

E. *Further rights in respect of visual or audio recording*⁸⁷.

Section 68 of **the 1992 Act** provides that where it is intended to make a visual or audio recording of any part of a patient's treatment, the patient is entitled to be informed of the fact. No visual or audio recording may be made without the consent of the patient or his or her personal representative (as defined in section 68(3) of **the 1992 Act**).

The genesis of this "*entitlement*" can be found in criticisms such as those levelled by "*Gallen inquiry*" when commenting upon the manner in which photos were taken of Michael Watene while he was being bathed. The inquiry suggested to take photos in this way was an affront to human dignity.⁸⁸

The Privacy Act 1993 will also have application in conjunction with section 68 of **the 1992 Act**. In this context

"Privacy as a whole or in part, represents the control of transactions between person(s) and other(s), the ultimate aim of which is to enhance autonomy and/or to minimise vulnerability."⁸⁹

In particular the following privacy "*rules*" will apply in respect of the collection of health information from patients subject to **the 1992 Act**:⁹⁰

- (a) The collection of health information from a patient must be for a lawful purpose connected with the functions or activities of the health agency concerned;⁹¹
- (b) the health agency concerned (subject to a number of specified exceptions) must collect information directly from the patient. This rule emphasises the need for the patient's consent to the collection of health information⁹².

87 Section 68 of the 1992 Act.

88 *Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters* (1984).

89 Margulkis cited in B Bloom and J Asher Ed, *Psychiatric Patient Rights and Patient Advocacy: Issues and Evidence*, (Human Sciences Press Inc., New York, New York, 1982):175.

90 It is recognised that these rights are not unique to patients who are the subject of the 1992 Act and apply to all classes of patients.

91 Rule 1 of the *Health Information Privacy Code 1993 (Temporary)* refers.

92 Rule 2 of the *Health Information Privacy Code 1993 (Temporary)* refers.

In terms of a patient subject to **the 1992 Act** a number of exceptions to this rule are relevant. These exemptions are set out in Rule 2 (2)(b), (c)(i), d(iii), and (e) of the *Health Information Privacy Code 1993 (Temporary)*. For example, some patients may be incapable of consenting to the collection of health information, in which case a substitute authorisation is permitted. It is suggested that the onus of proof of patient incapacity in this regard will lie with the health agency concerned;

- (c) The patient concerned must be informed of the fact of collection, the intended recipients of the information, the consequences of not supplying the information and the patient's rights of access to and correction of information;⁹³

It is noted that the health agency concerned only needs to take such steps as are reasonable in the circumstances to inform the patient of the above and that the mental capacity of the patient in this regard will be relevant. The onus will be on the health agency concerned to show that informing the patient of the above mentioned requirements is not reasonably practicable. Because the health agency concerned must tell the patient of the collection of the information at the time of collection, or "*as soon as practicable there after*", the health agency concerned will still have a duty to inform the patient as soon as his or her mental state is such that the patient is best able to comprehend this disclosure;⁹⁴ and

- (d) Lastly, health information must be collected from the patient in a manner which is lawful, fair and with the minimum intrusion possible into the personal affairs of the patient.⁹⁵ This rule is particularly apposite to section 68 of **the 1992 Act**. This is because the taking of a video or audio recording without a patient's consent would be regarded as the unfair collection of health information.

⁹³ Rule 3 of the *Health Information Privacy Code 1993 (Temporary)* refers.

⁹⁴ See in this regard the comments made on page 24 of this paper concerning the timing of disclosures under section 64 of **the 1992 Act**.

⁹⁵ Rule 4 of the *Health Information Privacy Code 1993 (Temporary)* refers.

F. *The right to independent psychiatric advice*⁹⁶.

Section 69 of **the 1992 Act** allows the patient to seek consultation from an independent psychiatrist and if that psychiatrist agrees to the consultation, for access to the patient by that psychiatrist at the patient's request.

This "*entitlement*" would only seem to be available to those patients with sufficient financial resources to afford to avail themselves of it. There is no funding for those who cannot. For this reason it is a "*paper*" "*entitlement*" only.

Contrast this position with Stromberg and Stone's model law where a patient (if he/she is unable to pay) shall have an "*entitlement*" to a state funded examination, by an independent psychiatrist, for the purposes of a "*committal*" hearing.⁹⁷

G. *Right to seek legal advice*.⁹⁸

Section 70 of **the 1992 Act** permits a patient to request a lawyer to advise on his or her rights and status as a patient. Where a lawyer agrees to act for a patient the lawyer is entitled to access to the patient on request.

Under the Mental Health Act 1969 there were no restrictions on a patient's "*entitlement*" to have access to legal advice. Patients though were seldom legally represented. John Dawson reported that in terms of hearings under the 1969 Act 2% of patients were legally represented.⁹⁹

It is suggested that this "*entitlement*" may have been included in **the 1992 Act** as a reminder to staff, patients and patient's families of the availability of legal advice for patients.

Access to a lawyer could be critical to the ability of patients to understand and enforce their rights under **the 1992 Act**. Though cost again is a

96 Section 69 of the 1992 Act.

97 C D Stromberg and A Stone "A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 *Harvard Journal of Legislation* 279 at 338.

98 Section 70 of the 1992 Act.

99 Legal Research Foundation Inc Seminar, *Mental Health: A Case For Reform* (University of Auckland 1986).

consideration. Legal aid will provide only limited help, it would cover the costs to the patient of providing counsel during a compulsory treatment order hearing but not on any other matters.¹⁰⁰

As with the "entitlement" to independent psychiatric advice, the "entitlement" to legal advice may be illusory in the absence of proper funding for those who cannot afford representation.¹⁰¹ Because of the nature of the patient's condition it is possible that some patients may make large numbers of capricious requests for advice which could make state funded legal advice problematic. The writer considers however that such problems could be overcome with suitable controls.

Some clinicians agree that there is a definite need for access to legal services to help to resolve certain socio-economic problems. Access may relieve certain anxieties beyond the reach of therapy which may be impeding the effectiveness of treatment.¹⁰²

*H Right to company and seclusion.*¹⁰³

Section 71 of the **1992 Act** provides that a patient is entitled to the company of other persons. A patient can only be placed in seclusion or isolation where it is necessary for the care and treatment of that patient or the protection of other patients. Seclusion may only be used with the concurrence of the responsible clinician.

A major criticism of this section is that it does not set guide-lines on the use of seclusion. **The 1992 Act** leaves clinical matters such as the use of seclusion up to the medical professionals concerned.

There are other statutory provisions which would control the inappropriate use of seclusion. (The use of seclusion for punishment or behaviour modification for instance would be inappropriate). To use seclusion in an

100 Section 19 of the Legal Services Act 1991 refers.

101 Some lawyers are prepared to provide advice on a voluntary basis. The Wellington Community Law Centre for example, provides a duty roster for lawyers who are willing to provide patients with legal assistance.

102 S Herr, S Arons and R Wallace Jnr, *Legal Rights and Mental Health Care* (DC Health and Co. USA, 1984):79.

103 Section 71 of the 1992 Act.

inappropriate manner could arguably be in breach of sections 9 and 23 (5) of the New Zealand Bill of Rights Act 1990.

*I. Right to receive visitors and make telephone calls.*¹⁰⁴

Every patient is entitled, at reasonable times and intervals to receive visitors and make telephone calls. This "entitlement" is only limited to the extent the responsible clinician considers that such visitors would be detrimental to the patient's interests or to his or her treatment. The onus is of course on this clinician to demonstrate such detriment.

The section specifically provides that the power of the responsible clinician in this regard is not to abrogate from the "entitlement" of access to a lawyer or independent psychiatrist.¹⁰⁵

It is also suggested that this section places an onus on institutions to provide adequate facilities to observe this "entitlement".¹⁰⁶

*J. Right to receive letters and postal articles.*¹⁰⁷

A patient is entitled to receive, unopened, any mail addressed to the patient.

There is an exception to this entitlement set out in section 123 of **the 1992 Act**. Where there are reasonable grounds for believing that the receipt of the letter or article may be detrimental to the patient or his or her treatment the responsible clinician may direct that the letter or article be opened and if necessary withheld from the patient.¹⁰⁸

104 Section 72 of the 1992 Act.

105 Sections 69 and 70 of the 1992 Act.

106 *Trapski's Family Law - Vol III- Mental Health -Protection of Personal Property Rights Act* (Brooker and Friend, Wellington 1992): A144.

107 Section 73 of the 1992 Act.

108 If however, the letter or article has been sent by one of categories of persons listed in section 123 (3) of the 1992 Act, then that letter or article may not be withheld.

Where a letter or article is withheld the responsible clinician has to return it to its sender.¹⁰⁹ If this is not possible, it must be presented to the District Inspector or Official Visitor.¹¹⁰ The patient should be told that the letter or article has been withheld unless it would be detrimental to his or her interests or treatment to do so.¹¹¹

K. Right to send letters and postal items.¹¹²

Section 74 of **the 1992 Act** provides that a patient is entitled to have his or her out going mail dispatched promptly and unopened.

In considering this entitlement regard must be had to section 124 of **the 1992 Act**. This section provides that any letter sent by a patient may be held if -

- (a) sending the letter would be detrimental to the patient's interests (but the item may not be held if addressed to one of the categories of person set out in section 123(3) of **the 1992 Act**); or
- (b) if the addressee (including the categories of person set out in section 123(3) of **the 1992 Act**) has notified the hospital that he or she does not want to receive mail from the patient.

Any mail which is withheld must be produced for the District Inspector or Official Visitor¹¹³ and the patient must be told that the mail has been held unless it is detrimental to the patient's interests or treatment to do so.¹¹⁴

Are the Rights Set Out in Part VI of the 1992 Act "Unique" to "Patients"

The rights in Part VI of **the 1992 Act** are not unique to "*patients*" as defined in **the 1992 Act**. The rights set out in sections 65, 66, 67, 68, 69

109 Section 125(1)(a) of the 1992 Act.

110 Section 125(1)(b) of the 1992 Act.

111 Section 123(1) of the 1992 Act refers.

112 Section 74 of the 1992 Act.

113 Section 125(2) of the 1992 Act.

114 Section 125(3) of the 1992 Act refers.

and 70 of **the 1992 Act** are arguably available to all categories of patient. The rights set out in sections 64, 71, 72, 73 and 74 of **the 1992 Act** are more relevant to "*patients*" under **the 1992 Act** as a class, though are not "*peculiar*" to that class.

As we have seen the rights set out in Part VI of **the 1992 Act** are not new or unique. These rights represent a statutory re-framing of certain fundamental rights.¹¹⁵ The question must be asked therefore, "*why did the legislature incorporate a re-statement of these rights in Part VI of the 1992 Act?*"

11 p. 21
is not so
clear

We can identify a number of reasons for the inclusion of these rights-

- (a) to honour various human rights conventions to which New Zealand is a signatory;¹¹⁶
- (b) to "*break down*" the negative influences of "*separatism*" and the idea that the mentally disordered are "*outcasts*".¹¹⁷ The "*re-statement*" of the rights set out in Part VI of **the 1992 Act** can be seen as an attempt to erode negative attitudes towards patients by setting out statutory expressions of the value of patients as "*people*" with rights;
- (c) to help combat the problem, in terms of therapy of how to deal with the need for compulsory treatment (particularly where such treatment requires the patient to be "*detained*" as an in-patient) while at the same time maintaining the patients sense of autonomy and freedom which is important to the therapeutic response and the therapeutic alliance; and
- (d) As a statutory "*reminder*" that patients have rights. This "*reminder*" is required because research has shown that violations of rights are judged less unfair where the victim is judged "*abnormal*".¹¹⁸

is this
answered?

115 See page 21 of this paper.

116 See page 19 of this paper.

117 See pages 12 and 13 of this paper.

118 P White "Judgments of Abnormality and their Consequences for Judgments of Infractions of Human and Civil Rights" (1989) *Community Mental Health in New Zealand* Vol.4, No.2:72. Also see the comments on pages 59 and 60 of this paper.

CIVIL LIBERTY V COMPULSORY TREATMENT

When considering the civil rights of patients in terms of **the 1992 Act** we must not lose sight of the objects of the social task at hand. In this respect **the 1992 Act** represents a "*trade off*" of civil liberty for social protection.

Compulsory Treatment

In **the 1992 Act** a judgment has been made as to the circumstances when compulsory treatment will be imposed on a person.¹¹⁹ In those circumstances it has been decided that it is justifiable to override a number of the patient's civil liberties and impose compulsory treatment on the patient. During the second reading of the Mental Health (Compulsory Assessment and Treatment) Bill, Helen Clark put it this way¹²⁰ -

The Bill will not please everyone because it draws a line. It draws a line between the rights of people with serious mental disorder and the rights of the community that might be disturbed by them. The explanatory note of the original Bill set out the "central dilemma" the law has to deal with in this area. It expresses it this way: "...in what circumstances should a civilised 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?" In a nut shell this is the problem.

The underlying assumption behind this judgement is that -

Mental illness creates a variety of problems for the community as well as for families of the mentally ill. Mentally ill persons may be a nuisance in the community and may disrupt normal social activities; they may be dangerous or frightening. They may be so depressed, disorientated, or deluded that their presence in the community poses serious risks to their own health and welfare. A person with a psychotic depression may be a serious suicide risk, and persons suffering from extreme states of agitation and confusion may undertake actions which seriously harm their own and their families welfare. Public policies have developed from removing mentally ill persons considered dangerous from the community and providing them with treatment or custody.¹²¹

119 This judgment places just as much emphasis on the rights of patient's families and the community as upon the benefits treatment may bring to a patient.

120 Weekly Hansard 34, 12 March 1992: 6864.

121 D Mechanic, *Mental Health and Social Policy* (3 ed Prentice Hall Inc, New Jersey 1989).

We can find a number of examples of the recognition of the rights of the community and of patient's families or whanau in **the 1992 Act**, these include -

- (a) the emphasis the definition of the term "*Mental disorder*" used in **the 1992 Act** places upon "*serious danger to the health or safety...of others*"¹²² It follows that **the 1992 Act** is likely to be invoked where a person's abnormal state of mind impacts on some one close to them for example a close family member;
- (b) the right of any person to make an application for assessment of another under section 8 of **the 1992 Act**;
- (c) the right of the patient's principle care-giver to be sent a copy of the-
 - (i) certificate of preliminary assessment under section 10(4)(a) of **the 1992 Act**;
 - (ii) certificate of further assessment under section 10(5) of **the 1992 Act**; and
 - (iii) certificate of final assessment under section 14(4)(b) of **the 1992 Act**,

(The patient's principle care-giver also has the right to be present through out a compulsory treatment order hearing¹²³ and has the right to be heard at that hearing, whether in person or through legal counsel¹²⁴);

- (d) the assistance available to care-givers from Duly Authorised Officers under **the 1992 Act**¹²⁵; and

122 Section 2 of the 1992 Act refers.

123 Section 19(6) of the 1992 Act.

124 Section 20(3) of the 1992 Act refers.

125 See in this regard sections 37, 38, 39, and 40 of the 1992 Act. The position of "Duly Authorised Officer" was added to the Mental Health Bill by the Social Services Select Committee after received submissions from the Schizophrenia Fellowship and the National Council of Women on the question.

- (e) the manner in which people are "*committed*". John Dawson found that under the 1969 Act: 53% of "*committal*" applications came from family applications; 14% from police and social agencies (probably at bequest of families); and 26% from the staff in general or psychiatric hospitals.¹²⁶

How do you Balance the "Competing Rights" of Patients and of the Community: The Principle of the Least Restrictive Alternative

One mechanism for achieving the balance between the civil rights of patients and the wider interests of the community is the "*least restrictive alternative principle*".

This principle is not a right of itself. It is a safeguard on the exercise of rights, and only the most basic rights: those which fall under the rubric of fundamental rights. Such rights can only be restricted to the extent necessary to carry out a valid purpose.¹²⁷

The principle is often used as a test for accommodating potentially conflicting civil liberties and therapeutic interests and as such is pertinent in terms of the scope of **the 1992 Act**.

The principle has found statutory expression in section 8 of the Protection of Personal and Property Rights Act 1988. It could be argued that such statutory expression could usefully be repeated in **the 1992 Act** as a guide to balancing the rights set out in Part VI of **the 1992 Act** with wider interests.

The writer would argue however, that there is an implied "*least restrictive alternative principle*" set out in common law.¹²⁸

126 Legal Research Foundation Inc Seminar, *Mental Health: A Case For Reform* (University of Auckland 1986) : 19.

127 S Herr, S Arons and R Wallace Jnr, *Legal Rights and Mental Health Care* (DC Health and Co. USA, 1984):79-87.

128 Though it would seem that the "*balance*" in terms of the application of the principle in this regard is tipped in favour of the individual patient.

For example in *Mitchell v Allen*¹²⁹ Woodhouse J said of the Mental Health Act 1969:

On the other hand it should not be forgotten that the protection is merely one facet of a powerful statute and that the statute itself contains the clearest evidence of an intention that there will be no peremptory or indiscriminate interference with personal freedom. Obviously, it is of fundamental importance that whenever the Mental Health Act is invoked to detain a man against his will, a high degree of care must be exercised to see that the facts of the case are within the strict boundaries which the Act defines.

While society's interests in terms of **the 1992 Act** are important they are not absolute. **The 1992 Act** does not authorise the "*preventive detention*" of patients. To illustrate this point, commentators have pointed out that the coercive and highly intrusive measures set out in **the 1992 Act** represent -¹³⁰

An exceptional concession to the normal powers of the state. In the context of this legislation such measures should not be employed unless the prospect of therapeutic success is significantly greater than the detriment to the patient conceived in terms of loss of liberty and the right to self determination.

Clause 18 (f) of the Health and Disability Services Commissioner Bill may provide a statutory mechanisms to further "*tip*" the right to "*the least restrictive alternative*" in the patient's favour.

Clause 18(f) provides for the inclusion in the Code of Health and Disability Services Consumer Rights to be promulgated under the Bill of:

The duties of health care providers and disability service providers to provide services in a manner that respects the dignity and **independence** of the individual.

(Emphasis added.)

129 [1969] NZLR 110, 113.

130 *Trapski's Family Law - Vol III- Mental Health -Protection of Personal Property Rights Act* (Brooker and Friend, Wellington 1992): A-11.

DUTIES

Logically the presence of express patient rights in **the 1992 Act** implies the existence of correlative duties.

To ascertain with whom such duties may lie it is necessary to look at the roles of the various main "*players*" in terms of **the 1992 Act**.

The Responsible Clinician

Responsible clinicians are responsible for the overall management of a patient's condition in terms of **the 1992 Act**.

Though **the 1992 Act** does not specify "*on whom*" the duty to provide access to the various rights set out in Part VI of **the 1992 Act** lies, it is reasonable to assume (given the correlation between the nature of these rights and the patient's treatment) that the responsible clinician will have a prominent role.¹³¹

District Inspectors and Official Visitors

District Inspectors and Official Visitors are responsible for investigating breaches of patient rights under **the 1992 Act**.

Section 75(1) of **the 1992 Act** provides that where a complaint is made by, or, on behalf of a patient about a breach of a right the matter shall be referred to a District Inspector or Official Visitor for investigation.

Section 75(2) requires the District Inspector or Official Visitor to talk to the patient and/or complainant and everyone else involved in the case and to generally investigate the matter.

Where the District Inspector/Official Visitor considers that the complaint has substance he or she must report the matter to the relevant Director of

131

It is also suggested that the service provider concerned whether it be a (Crown Health Enterprises or otherwise) should be regarded as having a duty to provide patient access to the rights set out in Part VI of the 1992 Act.

Area Mental Health Services together with such recommendations as he or she thinks fit.

In terms of section 75(3) of the Act, they must also report their findings to the patient.

Directors of Area Mental Health Services

After receipt of a report from a District Inspector or Official Visitor in respect of an alleged breach of a patient's right(s) under Part VI of the **1992 Act**, the Director of Area Mental Health Services is required to "*take such steps which are necessary to rectify the matter*".¹³²

While the Act leaves the decision of "*what steps are necessary*" up to the discretion of a Director, the writer suggests that the manner in which this discretion is exercised can be the subject of judicial oversight (on an application for judicial review of the Director's decision in this regard).

Review Tribunals

Review Tribunals have an important role in terms of "*patient rights*". This is because they have a role in investigating whether the rights of patients have been denied or breached, where the patient (or the complainant where this is not the patient) consider that they are not satisfied with the outcome of their complaint.¹³³

Role of Lawyers and Clinicians

Lawyers

The expression of patient rights in Part VI of the **1992 Act** relies heavily on legal interpretations of rights being devised by lawyers with legal definitions in mind.

132 Section 75(2) of the 1992 Act refers.

133 Section 75(4) of the 1992 Act refers.

It relies upon patients and others defining their rights according to the law and seeking professional legal assistance when those rights are violated.

It also relies upon the active involvement of lawyers willing to take up the patients cause. For this reasons lawyers have a crucial role in terms of the attainment of the rights set out in **the 1992 Act**.¹³⁴

The importance of the role of lawyers in terms of **the 1992 Act**, may be further emphasised because of the strength of criticisms levelled at psychiatry. Psychiatry attracts more criticism than any other branch of the medical profession. One reason for this is that psychiatrists often treat their patients without their patient's consent¹³⁵. Psychiatry is especially vulnerable to charges of infringement of patient's rights because its ability to predict the outcomes of (compulsory) therapy is less than other branches of medicine.¹³⁶

Lawyers v Clinicians?

Some commentators argue that clinicians and lawyers have diametrically opposed "roles" in terms of the "*civil liberty v compulsory therapy*" conflict.

Bean (1988) points out that law and psychiatry stem from different epistemological traditions¹³⁷.

One emphasises the rational self determination of the individual, the other the deterministic nature and effect of the disease condition. One starts from the assumption that legal rules protect patients from arbitrary decisions, the other that rules inhibit and restrict treatments.

Analogous changes to **the 1992 Act** have been criticised in other jurisdictions by psychiatrists who contend that the new standards are detrimental to their therapeutic role.¹³⁸

134 P Bean, *Mental Disorder and Social Control* (2ed University Press, Cambridge, 1988):188.

135 J K Mason and R A McCall-Smith, *Law and Medical Ethics* (Butterworths, London, 1988).

136 E Brody "Patient's Rights: Science, Ethics and the Law in International Perspective" (1988) *Community Mental Health In New Zealand* Vol. 4 No. 1 June :21.

137: P Bean, *Mental Disorder and Social Control* (2ed University Press, Cambridge, 1988):167.

138 The Mental Health (Compulsory Treatment and Assessment) Act , *Community Mental Health in New Zealand* Vol. 6, No. 2 August 1992 , 16.

This criticism is on the basis that :

- (a) the process of assessment and treatment of patients is a clinicians expertise;
- (b) the diagnosis of mental disorder is a clinical decision;
- (c) the adversarial approach within the judicial process is incompatible with the clinical process; and
- (d) that the continued participation of the legal system within the clinical process continues to undermine the validity of the clinicians expertise.

The writer does not agree that we can necessarily assume that lawyers and clinicians will always be on "*opposite sides*" in debates on patient rights. The writer suggests that the clinicians role in protecting the "*rights*" of the patient cannot be understated. Because the clinicians primary allegiance is to the patient, the clinician has a need to respect the rights of the patient as a "*sign-post*" to the carrying out of their professional and ethical responsibilities.

The Role of the Judiciary: Section 84 of the 1992 Act

Greig J has said that the purpose of the High Courts jurisdiction in terms of the Mental Health Act: ⁻¹³⁹

...is to provide additional protection and an additional safeguard to those who may be detained or kept in a mental hospital. It is an important supervisory function of the Court and is a statutory expression of the inherent jurisdiction of the High Court to maintain a protective and supervisory function over those who are under a disability. It partakes to some extent of the application of the jurisdiction in habeas corpus... .

The effectiveness of the Court in this regard will depend very much on the expertise of the Judge concerned.

139 Re M unreported. 21 April 1986 H C Wellington M716/85:15.

John Dawson reported ¹⁴⁰ that under the Mental Health Act 1969, few judges had the forensic skills to expose medical evidence to close scrutiny and in practice medical witnesses were likely to be the main decision makers.

There are mechanisms available to Judges exercising this jurisdiction under **the 1992 Act** to ensure that the evidence of clinicians, responsible for the patient's care, is the subject of close scrutiny. The Court has the power to summon medical and other witnesses to testify in respect of the matter and has the option of requesting that a Review Tribunal provide a report.¹⁴¹

To conclude, in terms of **the 1992 Act** the "*responsible clinician*" and the service provider¹⁴² are the persons with whom the duty will lie to provide patients with their rights under Part VI of **the 1992 Act**. The review tribunal and the High Court have a "*supervisory role*" in this regard and lawyers have an all important role as advocates of patient rights.

HOW CAN PATIENTS CLAIM THEIR RIGHTS

If a right is to be a positivist right we could contend that there is no right unless there is the power to secure the performance of that right. There are many different facets of this idea, though power may only come from coercive sanction to enforce a correlative duty in **the 1992 Act**.

There are a number of different "*coercive sanctions*" which may be available to ensure patients rights under **the 1992 Act** are respected.

A. *Internal Mechanisms*

Section 75 of **the 1992 Act** provides "*an internal mechanism*" for handling complaints in respect of breaches of patient rights. The section has one important limitation in that it only applies to those rights set out in Part VI

140 Legal Research Foundation Inc Seminar, *Mental Health: A Case For Reform* (University of Auckland 1986) :41.

141 Section 84(7) of the 1992 Act refers.

142 Whether Crown Health Enterprise or otherwise.

of the **1992 Act** and so is of no assistance in respect of complaints of breaches of any rights which may be contained in other parts of the **1992 Act**.

The mechanism can be criticised because it may "*lack teeth*". It is not clear from the provisions of the **1992 Act**, what coercive power a Director of Area Mental Health Services may have to "*rectify (a) matter*" where there has been a breach of a patient's rights.¹⁴³

While in most cases it is anticipated that service providers will comply with a recommendation to rectify a breach of a patient's rights, made by a Director of Area Mental Health Services, in more serious cases, an ability to impose punitive sanction may help to ensure compliance.

A suggested sanction which could usefully be incorporated into the **1992 Act** is as follows:¹⁴⁴

...2. Any person who takes into custody, admits for evaluation, detains for a further period of time, discharges, or administers medication or treatment to a patient, or takes other actions affecting the substantial rights of a patient, doing so knowingly and willingly in substantial violation of this Act, shall be subject to a civil fine, and shall be liable for injunctive relief and money damages, in addition to any other liability under the law. This paragraph shall not be invoked in cases of minor, merely technical, or otherwise justifiable breaches of the provisions of this Act.

The option of recommending the imposition of this sanction could be made by a Director of Area Mental Health Services to a Court which would make the final determination as to whether to impose a sanction.

B. The Parens Patriae Jurisdiction of the High Court

An obvious avenue of complaint for a patient complaining of a breach of his or her rights under the **1992 Act** would be to make an application to the High Court to ask that the Court exercise its "*Parens Patriae*" powers to rectify the situation.

143 Section 75(2) of the 1992 Act refers.

144 C D Stromberg and A Stone "A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 *Harvard Journal of Legislation* 279 at: 394.

The Parens Patriae jurisdiction of the High Court is set out in section 17 of the Judicature Act which provides -

The Court shall also have within New Zealand all the jurisdiction and control over the persons and estates of...idiots, [mentally disordered persons], and persons of unsound mind, and over the...[managers] of such persons and estates respectively, as the Lord Chancellor of England, or any Judge or Judges of [Her Majesty's] Court of Appeal, so far as the same may be applicable to the circumstances of New Zealand, has or have in England under the Sign-Manual of [Her Majesty] or otherwise.

The Parens Patriae jurisdiction is the expression of the Crown's duty to protect the sovereign's subjects and in particular those subjects who cannot look after themselves.

Lord Eldon in *Wellesley v Duke of Beaufort* (1827) 2 Russ 1 at p 20 said -

This jurisdiction is founded on the obvious necessity that the law should place somewhere the care of individuals who cannot take care of themselves, particularly in cases where it is feared that some care should be thrown around them.¹⁴⁵

Doubt has however been cast on the continued existence of this jurisdiction in the case of *Re H*.¹⁴⁶ In *Re H*, Inglis J discusses the exercise of the parens patriae jurisdiction of the Courts.¹⁴⁷ Inglis J points out that it was thought that even though the jurisdiction was lost in the United Kingdom, when it was revoked contemporaneously with the passing of comprehensive mental health legislation, there was evidence that the jurisdiction survived in New Zealand.¹⁴⁸

Inglis J suggests that this latter view has been overtaken by the decision of *Re F (Mental Patient: Sterilisation)*¹⁴⁹ where it was held (apparently for the first time in the United Kingdom) that the Warrant was revoked and

145 Cited in D Collins, *Medical Law in New Zealand* (Brooker and Friend Ltd, Wellington, 1992): 104.

146 [1993] NZFLR 225, 228-29.

147 In the United Kingdom the jurisdiction was assigned by Warrant under the Sign Manual to the Lord Chancellor and the Chancery Judges. In New Zealand it was assigned to Judges of the High Court under section 17 of the Judicature Act 1908.

148 For example in *Re P (A Mental Patient)* [1961] NZLR 1028 and *Re R (A protected Patient)* [1974] 1 NZLR 339 (CA) and is also evidenced by the fact that in the Mental Health Bill there was provision for the repeal of section 17 of the Judicature act 1908 though it was decided to "retain" the jurisdiction and not repeal the section in the 1992 Act.

149 2 AC 1.

that its resurrection depended upon the legislature not the courts. Inglis J suggests that the wording of the Judicature Act 1908 in the present tense does not seem apt to assign a jurisdiction deliberately withdrawn 30 years ago to Judges appointed in New Zealand since 1960.

To put the continued existence of the *parens patriae* jurisdiction beyond doubt it is suggested that the High Court should address the question, or alternatively, that the legislature expressly resurrect the jurisdiction by way of an appropriate statutory amendment.¹⁵⁰

C. *Offences*

The offence provisions in **the 1992 Act** could provide a safeguard to ensure that patient's rights are respected.

Section 114 of **the 1992 Act** provides that the intentional neglect or ill-treatment of mentally disordered persons by any person concerned with their oversight, care or control is an offence. This section, could for example, operate to ensure "*the right to treatment*" set out in section 66 of **the 1992 Act** is respected.¹⁵¹

D. *Public Law Remedies*

The 1992 Act lies within the wider field of public law. The New Zealand Bill of Rights Act 1990 may be especially relevant to considerations of the application of **the 1992 Act** to patient rights (as those acting under **the 1992 Act** exercise wide statutory powers with important consequences for the liberty of patients).

The courts have provided some guidance on how the New Zealand Bill of Rights Act 1990 will be applied to **the 1992 Act**.

150 Such an amendment could be modelled on section 9(3) of the Guardianship Act 1968.

151 Section 151 of the Crimes Act 1961 will also be relevant.

Gallen J in *Re M* said¹⁵² -

The provisions of the Mental Health Act (1969) continue to apply regardless of the passing of the New Zealand Bill of Rights Act, but they are to be interpreted as far as possible in the light of [it] and it may well be that earlier interpretations may no longer be appropriate".

Patients interests in liberty and fair procedure (and in the interpretation of their rights) may now be given a higher priority than previously in the committal process.¹⁵³ It is suggested that where **the 1992 Act** confers a wide discretionary power, which may infringe a right under the New Zealand Bill of Rights Act 1990, such powers should be interpreted as if they were subject to the implied limit "*but not so as to infringe the rights in the New Zealand Bill of Rights Act 1992*".¹⁵⁴

Application can also be made by patients for judicial review of the exercise of statutory powers affecting their rights. The remedies available to a successful patient would of course be public law ones. A writ of mandamus could be used for example to ensure that a Director of Area Mental Health Services takes all necessary steps to rectify any breach of a patient right set out in Part VI of **the 1992 Act**.¹⁵⁵

Some commentators also suggest,¹⁵⁶ that because of the way the way rights and entitlements are specifically set out in **the 1992 Act**, they may be enforceable in the Courts in the same way that the right to obtain official information has been held to be enforceable in the Courts.¹⁵⁷

152 [1992] 1 NZLR 29, 40.

153 J Dawson, J Anderson and S McCarthy, New Zealand Law Society Seminar "The Mental Health (Compulsory Assessment and Treatment) Act 1992, (1993) February-March.

154 McClean, Rishworth and Taggart, Law Research Foundation Seminar *The Impact of the New Zealand Bill of Rights on Administrative Law* (1992): 73.

155 Section 75(2) of the 1992 Act refers.

156 J Dawson, J Anderson and S McCarthy, New Zealand Law Society Seminar "The Mental Health (Compulsory Assessment and Treatment) Act 1992, (1993) February-March.

157 *Commissioner of Police v Ombudsman* [1988] 1 NZLR 385.

E. *Disciplinary Proceedings*

Another possible source of sanction for a breach of a patient's rights would be disciplinary proceedings against any medical professionals involved.¹⁵⁸

F. *The Privacy Act 1993*

A complaint may be made under the Privacy Act 1993 where a patient alleges that any action is or appears to be an "*interference with the privacy of an individual*"¹⁵⁹. Section 66 of the 1993 Act sets out, for the purpose of the complaints mechanism created by the 1993 Act, the circumstances under which an action will amount to "*an interference with the privacy of an individual*".

Of most relevance to a patient in terms of **the 1992 Act**, is the fact that a complaint may be based on the violation of one of the information privacy rules set out in the Health Information Privacy Code 1993 (Temporary). As is discussed elsewhere in this paper, there is considerable scope for a patient under **the 1992 Act** to use the code in addition to his or her rights under Part VI of **the 1992 Act**.¹⁶⁰

Once a patient establishes that an information privacy rule had been breached, before the matter will be regarded as an "*interference with the privacy of an individual*" the Privacy Commissioner or the Complaints Tribunal constituted under the 1993 Act must be of the opinion that the breach has -

- (a) caused or may cause loss, detriment, or damage to the individual concerned; or
- (b) adversely affected or may adversely affect the rights, benefits and privileges of that individual; or
- (c) resulted in or may result in significant humiliation, significant loss of dignity, or significant injuries to the feeling of that individual.¹⁶¹

¹⁵⁸ The Health and Disability Commissioner Bill will also be relevant in this regard if it is enacted.

¹⁵⁹ It must be noted that a number of the complaints procedures in respect of the 1993 Act do not come into force until 1 July 1996, see section 79 of the 1993 Act.

¹⁶⁰ See pages 25, 31 and 32 of this paper.

¹⁶¹ Section 66(1)(b) of the Privacy Act 1993 refers.

In terms of the requirements set out above, the patient who wishes to establish that the conduct complained of amounts to "*interference with the privacy of an individual*" (for the purposes of section 66 of the 1993 Act) has a high threshold to overcome.

Any person may bring a complaint alleging that an action or decision is or appears to be, an "*interference with the privacy of an individual*". It follows that a patient's lawyer, a family member, a district inspector or some other person could bring a complaint.¹⁶²

A complaint would not necessarily need to be made before the Privacy Commissioner will become involved. There is provision in the 1993 Act to enable the Privacy Commissioner to avoid being completely complaints driven. If complaints of a certain type continue to arise or concerns were raised in respect of practices in the mental health area, the Commissioner may choose to exercise his or her power to investigate the matter of his or her own volition.¹⁶³ The Commissioner's ability to investigate complaints "*pro-actively*" is particularly important if you consider the nature of the conditions suffered by the mentally ill.

The Privacy Commissioner has two particular functions in relation to complaints ¹⁶⁴⁻

1. To investigate.
2. To act as a mediator to attempt to reach a settlement.

In respect of this second function the Privacy Commissioner has the power to call compulsory conferences.¹⁶⁵ The purpose of such a conference is to identify the matters in dispute and to try to reach a

¹⁶² Section 67 of the 1993 Act refers.

¹⁶³ Section 13(1)(m) of the 1993 Act refers.

¹⁶⁴ Section 71 of the 1993 Act provides that the Privacy Commissioner has a discretion whether to act on an complaint. The Commissioner may decide to take no action where there is an adequate remedy or right of appeal available to the person in respect of whom the privacy violation has occurred. In the case of a patient under the 1992 Act there is a complaints mechanism set out in section 75 available in respect of violations of the rights set out in Part VI of the 1992 Act.

¹⁶⁵ Section 76 of the 1993 Act refers.

resolution of the dispute¹⁶⁶. If a dispute cannot be resolved, there is the possibility that the Privacy Commissioner may refer the matter to the Proceedings Commissioner for action before the Complaints Review Tribunal.¹⁶⁷

The Proceedings Commissioner can bring "*class actions*".¹⁶⁸ This power may prove to be important in respect of patients in terms of **the 1992 Act**. The Commissioner may take an action for instance on behalf of all the patients in a particular institution or region, or in respect of a number of institutions or regions, where mental health service providers are acting in a way that constituted an "*interference with the privacy of individuals*" in their care.

The Complaints Review Tribunal set up by the 1993 Act is empowered to grant a number of remedies in respect of proven instances of "*interference with the privacy of an individual*". The remedies which may be awarded are set out in section 85 of the 1993 Act. One of the remedies available is provision for damages. Section 88 of the 1993 Act goes on to set out the circumstances where damages are available under the 1993 Act and the maximum quantum of those damages.

To conclude, as we have seen, there are arguably a number of "*coercive sanctions*" available to patients to ensure that their "*rights*" in terms of the Part VI of **the 1992 Act** are delivered. The existence of the "*coercive sanctions*" outlined above does not, however, "*guarantee*" that these sanctions will be used.

166 The compulsory conference power is based on the pre-hearing conferences in the Protection of Personal and Property Rights Act 1988.

167 Section 83 of the 1993 provides that aggrieved individuals can bring an action to the Complaints Review Tribunal themselves where the Privacy or Proceedings Commissioners have declined to act.

168 Section 82(4) of the 1993 Act refers.

HELPING PATIENTS CLAIM THEIR RIGHTS

Rights are not self-executing.

Mental health patients because of the nature of their condition, may in particular be:

- (a) unaware of their rights; or
- (b) unable to assert their rights.

The statement of rights in Part VI of **the 1992 Act** does not include guarantees that these rights will automatically be implemented and enforced. The mechanism for implementation and enforcement is advocacy.

Advocacy can be defined as a means of defending, promoting or pleading a cause on behalf of another. It can also be defined as¹⁶⁹ -

A device for increasing pressure against the social structure to achieve social equity and justice.

The two definitions, set out above, illustrate the fact that there are two types of advocacy -

- (1.) Service advocacy which looks after patients interests on a case by case basis.
- (2.) Policy advocacy which provides advocacy for patients generally as a class.

In terms of **the 1992 Act**, District Inspectors and Official Visitors fulfil a limited "*advocacy role*". Though the role of these officials in this regard can be seen as more analogous to an ombudsman than to an advocate.¹⁷⁰

¹⁶⁹ N V Lourie cited in B Bloom and J Asher Ed. *Psychiatric Patient Rights and Patient Advocacy: Issues and Evidence*, (Human Sciences Press Inc., New York, New York, 1982): 25

¹⁷⁰ In terms of section 75 of **the 1992 Act**, District Inspectors and Official Visitors are responsible for investigating complaints regarding the alleged breach of patient rights set out in Part VI of **the 1992 Act**. In this role District Inspectors and Official Visitors are not responsible for the "*implementation or enforcement*" of patient's rights. Their role is to investigate, and to report on the results of their investigations (together with such recommendations as they think fit) to the relevant Director of Area Mental Health Services.

At the time of the enactment of **the 1992 Act** there was pressure to include specific provision to provide patients with access to patient advocates other than legal practitioners.¹⁷¹ This pressure seems to have been resisted because of the possibility of the enactment of the Health Commissioner Bill.¹⁷²

While the role of lawyers, as advocates for patients under **the 1992 Act** cannot be understated,¹⁷³ it cannot be assumed that lawyers will make the best advocates for patients in all circumstances.

It is important to recognise that many problems faced by patients are not of a legal nature and that short lengths of stay in hospital may constrain traditional legal strategies. In some cases a mediating fact finding and counselling posture is often preferable to litigation in resolving patient's problems.¹⁷⁴ There is also some evidence to suggest that:

- (a) lawyers lack experience in dealing with patient clinical issues; and¹⁷⁵
- (b) an over emphasis on formal and legal procedures by lawyers can prove to be a barrier to the effectiveness of patient advocacy.¹⁷⁶

Research has shown that advocacy has proven most successful in areas covering such matters as reviewing patient medication and behaviour management¹⁷⁷, a role for which lawyers may not be well qualified.

171 See the Report Back of the Mental Health Bill to the House of Representatives by the Social Services Select Committee, Hansard (1989): 13602-13605.

172 In recent months there have been indications that this Bill may soon be enacted. A Supplementary Order Paper has recently been referred to the Select Committee considering the Bill. This Supplementary Order Paper proposes major changes to the Bill.

173 See the comments on page 43 and 44 of this paper.

174 C D Stromberg and A Stone "A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 *Havard Journal of Legislation* 279 at: 387.

175 For example clinical issues involving the right to treatment in section 66 of the 1992 Act.

176 G Bridgman "Does Advocacy Work?" (1992) *Community Mental Health in New Zealand* Vol 6. No. 2: 16.

177 G Bridgman "Does Advocacy Work?" (1992) *Community Mental Health in New Zealand* Vol 6. No. 2: 16.

The Health and Disability Commissioner Bill (incorporating proposed amendments from a Supplementary Order Paper of Tuesday 3 August 1993).

The Health and Disability Commissioner Bill could provide patients under **the 1992 Act** with access to advocacy services in a limited range of circumstances.

The Bill provides for the appointment of a Health and Disability Commissioner who will investigate complaints against person or bodies that provide health and/or Disability Services.

The Commissioner will also have general functions in respect of the protection of the rights of health and disability services consumers as set out in the Bill.

The Bill also sets up a Health and Disability Consumer Advocacy service and provides for the promulgation of a Code of Health and Disability Consumer's Rights.

This Code of Rights is central to the Bill.¹⁷⁸ The functions of the Health and Disability Services Commissioner and the Health and Disability Services Consumer Advocates established by the Bill are closely related to the terms of the Code. For instance the functions of the Commissioner and advocates in regard to complaints relate to complaints in respect of breaches of the Code.

If patients under **the 1992 Act** wish to avail themselves of the Bill's advocacy mechanisms in respect of their "*rights*" (in terms of Part VI of **the 1992 Act**) such services may only be available where the "*right*" which is claimed corresponds to a "*right*" protected by the provisions of the Code.

The Code of Rights as such will not be promulgated until the enactment of the Health and Disability Commissioner Bill. It is possible to gauge the scope of the provisions which may be included in the Code by considering Clause 18 of the Bill which sets out matters which must be included in the Code.

¹⁷⁸ The Code is to be drafted by the Health and Disability Services Commissioner and then forwarded to the Minister of Health. There is a mechanism in clause 64 of the Bill to give the code "legal force" by promulgating the code as regulations.

There is some overlap between the provisions of clause 18 of the Bill and the rights of patients set out in Part VI of **the 1992 Act**. For example, Clause 18(c) of the Bill overlaps with sections 5 and 65 of **the 1992 Act**. The sub-clause provides that the Code shall include provisions relating to rights of health and disability services consumers and the duties of providers of those services as they relate to -

- (iv) The provision of services that take into account the needs, values, and beliefs of different cultural, religious, social and ethnic groups...

Solving Problems "In- House"

As well as external advocacy mechanisms, some commentators suggest that there is a need for internal procedures for the resolution of grievances at treatment facilities. For example, Stromberg and Stone's model law provides¹⁷⁹ -

Every treatment facility shall establish a fundamentally fair procedure for the assertion, resolution, and redress of patient's grievances, and shall have a patient's representative or similar person who shall hear patient's grievances, attempt to solve problems, and protect the patient's interests.¹⁸⁰

There is arguably scope in Clause 18(e) of the Health and Disability Services Commissioner Bill to require health and disability services providers (including providers of mental health services) to establish internal complaints mechanisms.

Clause 18 (e) of the Bill provides for:

The establishment and maintenance, by health care providers and disability service providers, of procedures for dealing with complaints against them by health consumers

179 C D Stromberg and A Stone "A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 *Havard Journal of Legislation* 279 at: 385-386.

180 Stromberg and Stone point out that the proponents of an external advocacy model stress the importance;

- (a) of advocate independence;
- (b) an adversarial system; and
- (c) legally enforceable remedies.

While proponents of an internal system of dispute resolution argue that more can be achieved through conciliation and administrative reform.

or disability services consumers, or both, and access by health consumers and disability services consumers to such procedures.

There is empirical evidence to demonstrate the effectiveness and advantages of an such a system. Krajewski and Bell (1992),¹⁸¹ report that such a system run by the Maryland Department of Health and Mental Hygiene (to serve patients hospitalised in 12 state institutions) resolved the vast majority of patient complaints through mediation between patients and clinical staff.

The system in question uses two "tiers". The first tier is a four level appeal program which attempts to resolve grievances through mediation between patients and staff. At all stages during this first tier the patient's interests are represented by a "patient's rights adviser" (most of whom are social workers or former nurses).

At the first level of the resident grievance system, the rights adviser investigates the allegation and tries to resolve the grievance through mediation that usually involves the patient's treating physician. If the grievance cannot be satisfactorily resolved, it proceeds to the second level of the system, in which mediation typically involves the clinicians supervisor or the medical director of the facility. At stage three, the grievance is heard by the facilities rights committee, which includes patients, family members, staff and representatives of patient advocacy groups in the community. This committee makes recommendations for resolution of the complaint to the chief executive officer of the hospital, who can elect to implement the recommendations or take alternative action to resolve the grievance. The fourth and final stage of the resident grievance system is a hearing before the central review committee of the Department of Health and Mental Hygiene. ... Any grievance that is not resolved by the resident grievance committee moves to the second tier of the advocacy system, referral to a legal service provider under contract to the state of Maryland. The legal service provider represents the patient's interests in presenting the grievance to the state court.¹⁸²

Clinicians in the facilities in question supported the system because they perceived that most complaints in the system are resolved in a therapeutic and non-adversarial way.¹⁸³

181 T Krajewski and C Bell "A System for Patient's Rights Advocacy in State Psychiatric In-Patient Facilities in Maryland" (1992) Hospital and Community Psychiatry, Vol. 43, No. 2 :127.

182 T Krajewski and C Bell "A System for Patient's Rights Advocacy in State Psychiatric In-Patient Facilities in Maryland" (1992) Hospital and Community Psychiatry, Vol. 43, No. 2 :128.

183 T Krajewski and C Bell "A System for Patient's Rights Advocacy in State Psychiatric In-Patient Facilities in Maryland" (1992) Hospital and Community Psychiatry, Vol. 43, No. 2 :129.

This system could not be used in New Zealand because of the provisions of section 75 (1) of **the 1992 Act**.¹⁸⁴ The writer suggests that appropriate statutory amendments should be made to allow for mediation of patient rights complaints in appropriate cases under **the 1992 Act**. Such a system could prove to be simple cost effective and provide a "*transparent mechanism*" for the resolution of patient's complaints in respect of breaches of their rights under Part VI of **the 1992 Act**.¹⁸⁵

BARRIERS TO PATIENTS CLAIMING THEIR RIGHTS

The provision of advocacy services for patients under **the 1992 Act** is doubly important because of the fact that there are a number of barriers which may hinder a patient in claiming his or her rights under **the 1992 Act**.

To effectively "*deliver*" patient rights we must be aware of these barriers and overcome them.

A. *Labels*

Person suffering from mental disorder are more than most in need of special protection to protect their civil rights. Their disabilities frequently of themselves prevent them from looking after their own interests, and because of the nature of the illness from which they suffer, their complaints are likely to be either not taken seriously or substantially discounted.¹⁸⁶

White (1989) suggests that because the mentally ill are not regraded as "*normal*" infringements of "*their rights*" are often not regarded as a breach of rights. People make a categorical distinction in their beliefs between normality (or mental health) and abnormality (or mental disorder). When an individual or group is regarded as normal, part of what that means is

184 The 1992 Act requires that all complaints made in respect of breaches of patient's rights must be referred to a district inspector or official visitor.

185 Or, in deed in respect of any other grievance a patient may have.

186 *Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters* (1984)

that they are implicitly endowed with a set of rights, privileges responsibilities and duties.¹⁸⁷

Persons judged as abnormal on the other hand, will not as a result be endowed with that same set of rights, privileges and duties. The result is that if such a person is a victim of, what in other circumstance would be, a violation of rights that violation might not be seen as unfair by those who judge it. It might even not be considered a rights violation at all because the victim may be seen as having no rights in the first place.

This situation occurs because of the relationship between characteristics and rights.¹⁸⁸ A normal adult because of the characteristics of normality, is judged as able to exercise rights and privileges in a responsible way.¹⁸⁹ The justification for withholding rights and privileges is that the group from which they are withheld would not or could not use them responsibly because they have those characteristics which lead them to be judged abnormal.

Evidence of this attitude can be found in the reasoning of Barker J in *Re S*.¹⁹⁰ In that case the Judge suggested that the right to refuse treatment in the New Zealand Bill of Rights Act 1990 did not apply to "*committed*" patients. This was because, the phrase "*everyone*" in section 11 of the New Zealand Bill of Rights Act 1990 only applies to those persons who were competent to consent.

This decision has been the subject of criticism.¹⁹¹

As we have seen ¹⁹² caution must be exercised in this area. To repeat a point made earlier, mental disorder does not of itself imply an inability to discharge rights responsibly. Rights should only be restricted on the

187 P White "Judgments of Abnormality and their Consequences for Judgments of Infractions of Human and Civil Rights" (1989) *Community Mental Health in New Zealand* Vol. 4, No. 2: 72.

188 P White "Judgments of Abnormality and their Consequences for Judgments of Infractions of Human and Civil Rights" (1989) *Community Mental Health in New Zealand* Vol. 4, No. 2: 72.

189 Responsibilities go with rights and they are accorded to those who are judged able to use them reasonably.

190 [1992] 1 NZLR 363, 374-75.

191 G Austin "Righting a Child's Right to Refuse Medical Treatment: Section 11 of the New Zealand Bill of Rights Act and the Gillick Competent Child (1992) 7 *Otago LR* 578, 582.

192 Page 22 and 23 of this paper.

basis of legal provisions relating to the patients actual competence to perform specific functions.¹⁹³

B. *The Balance of Power*

A major barrier to patients claiming their "rights" is that the "balance of power" in the physician patient relationship is very much in favour of the physician. Physicians are seen as knowledgeable, responsible and rational while of course the patient is not. The onus very much lies on the patient to show that he or she is rational or aware until proven otherwise. One manifestation of this "balance of power" is that patients are very much on the back foot when it comes to taking legal action against psychiatrists. Klien and Glover¹⁹⁴ point out that psychiatrists are trained to deal with their patients hostility and this helps them to forestall threatened law suits.

C. *Resource Barriers*

Resource barriers may hinder patients in claiming their rights under **the 1992 Act.**

It is important to recognise that the underprivileged, including the mentally ill, may have difficulty in gaining access to justice. Obstruction to such access will include the cost of litigation, and hiring a lawyer.¹⁹⁵

D. *Lack of Knowledge*

Hoyer (1986) quotes a Danish Study which concluded that patient's lack of knowledge about their rights was substantial.¹⁹⁶

193 C D Stromberg and A Stone "A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 Havard Journal of Legislation 279 at 364.

194 Klien and Glover 1983 "Psychiatric Malpractice" International Journal of Law Psychiatry Vol 6 No. 2 131-57.

195 See the comments on page 33 and 34 of this paper.

196 The study also showed that patients in general hospitals had more knowledge about their rights than patients with mental disorders.

Hoyer suggests that the main reason for mental health patients inability to use their existing rights is a lack of information about their rights and a lack of knowledge of the complaints procedure to be followed.

On a general level he points out the following paradox -

- (a) compulsory detained patients are regarded as disturbed so that it is justified to deprive them of their personal freedom;
- (b) on the other hand legal rights are established for patients to make use of.

The procedures to make use of rights are complicated and to make use of them a certain amount of knowledge is presupposed. It is questionable then, to what extent such patients can take part in this complex process.

Hoyer also points out that there are other barriers which need to be overcome by patients in order to make contact with officially appointed bodies who will uphold their rights, the clients behaviour and the manner of communication are important in this context.¹⁹⁷

E. The Nature of the Patient's Condition.

A Patient's condition may be a major barrier to his or her articulating complaints in respect of alleged breaches of rights.

It has been suggested that they may prove to be difficult clients for those who would seek to advocate their rights because:¹⁹⁸

- (a) they may be mute, voluntarily or otherwise;
- (b) they may be suffering from physical incapacity caused by medication;
- (c) they may be ambivalent to attempts to provide assistance;

197 G Hoyer " Compulsory Admitted Patients Ability to Make Use of their Legal Rights" (1986) *International Journal of Law and Psychiatry*: 413.

198 J Dawson, J Anderson and S McCarthy, *New Zealand Law Society Seminar "The Mental Health (Compulsory Assessment and Treatment) Act 1992, (1993) February-March*: 39.

- (d) they may be openly threatening;
- (e) they may be suicidal; and
- (f) they may be paranoid.

Overcoming barriers

The most important factor in overcoming the barriers set out above, is clearly the availability to patients of appropriately trained advocates.¹⁹⁹

Because of patients ignorance or ambivalence towards their rights and because their complaints may be difficult to check, it is also suggested that further measures may be needed.

For instance, a mandatory reporting regime, to apply in respect of the violation of patient rights, could be incorporated into **the 1992 Act**. The advantages of this scheme would be that where a patient was unwilling or unable to complain of a breach of his or her rights another person would be required to make a complaint on his or her behalf. Such a scheme has precedents. In an number of US states there is a legal duty to report cruel, maltreatment and abuse of the mentally ill.²⁰⁰

WHAT CAN THE RIGHTS APPROACH ACHIEVE?

There are no specific assessment structures either:

- (a) built into **the 1992 Act**; or
- (b) designed to accompany **the 1992 Act**,

for the purpose of assessing the effectiveness of the rights approach, manifested in Part VI of **the 1992 Act**. It is only possible therefore, to

¹⁹⁹ See pages 54 to 59 of this paper for a discussion on advocacy.

²⁰⁰ S Herr, S Arons and R Wallace Jnr, *Legal Rights and Mental Health Care* (DC Health and Co. USA, 1984).

make general comments on the usefulness of the rights set out in Part VI of the 1992 Act.

It can be suggested that the rights in the 1992 Act may help to restore something which patients lose when they enter the "mental health system", that is some degree of independence:

Independence is associated with full adult status and is highly valued. The definition of those peripheral groups as dependant, therefore, also labels them as people of low status, and must inevitably undermine their self-esteem, and teach them implicitly, that they have never achieved, or have fallen from full adult status, and all the rights, privileges and respect that status attracts.²⁰¹

It has also been suggested that the possession of rights enhances the dignity of the person who holds the rights and exemplifies our idea of respect for people.²⁰²

Incorporating legally enforceable rights into legislation and advising treatment staff, patients and the public that those rights must be respected also helps ensure that civil commitment will actually advance therapeutic and protective goals.²⁰³

The writer suggests that other advantages of a rights based approach are:²⁰⁴

- (a) to promote a belief that patients are more than an aggregate of their symptoms;
- (b) to create the impression that patients are neither wholly insane or wholly sane but in the midst of their insanity can be presumed to be capable of making decisions; and
- (c) to protect the "patients" self and essential humanity.

201 J Rowland and R McKinley "Caring, Curing and Controlling: An Outsiders Look at Life and Work in New Zealand Psychiatric Hospitals" (1985), Department of Health.

202 Campbell, *Justice* (MacMillan, London 1988).

203 C D Stromberg and A Stone "A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 *Havard Journal of Legislation* 279 at: 283.

204 See the comments made on page 37 of this paper.

From a different perspective, Bean (1993) suggests that as a method of prompting change rights may have a limited use. On one hand rights can improve the patients perception of him or herself and prevent intrusion, though he points out that they rarely promote new, more humane, or more effective methods of treatment.²⁰⁵

Bean suggests the reason for this is that patients rights and patients care stem from different sources. One source takes the view that man should be protected from those who care for him because they may be prone to abuse him. The other source, the view that patient care deals with the whole person and requires direct intervention in all aspects of his or her life.²⁰⁶

AREAS FOR FURTHER EXPLORATION

The writer recognises that a number of issues dealt with in this paper require further detailed examination, these include:

- (a) a detailed discussion of the "fate" of the High Court's "*parens patriae*" jurisdiction;
- (b) an examination of the relationship between **the 1992 Act** and the Health and Disability Commissioner Act in its final form;
- (c) an examination of how in practice the complaints procedures in the Privacy Act 1993 will apply to patients under **the 1992 Act**;
- (d) the practical need for and desirability of, an internal "*transparent*" dispute resolution mechanism in mental health services;

²⁰⁵ The "*rights based approach*" does not go beyond the legal level and consider other important issues such as -

- (a) issues connected with the quality, care and proper funding of mental health services;
- (b) provision of properly trained and motivated staff;
- (c) questions of the day to day management of the patient and any problems these may bring.

²⁰⁶ The first view can be traced to a Kantian view that paternalism is the greater evil, or to Mill where the sovereignty of the individual is paramount. The second view can be traced to the idea that mental disorder is debilitating and that to cure the patient is an ethnically justifiable task.

- (e) the practical need for mandatory reporting of rights violations; and
- (f) thorough research into and assessment of the effectiveness of the rights set out in Part VI of **the 1992 Act** as they pertain to individual cases.
- (g) the position of "*special*" and "*restricted*" patients under **the 1992 Act**, and the application of patient rights to "*in*" and "*out*" patients.²⁰⁷

CONCLUSION

In this paper the writer has undertaken a critical analysis of the rights set out in Part VI of **the 1992 Act**. This analysis has been placed in social and political context of New Zealand in the 1980's and 1990's.

The paper has considered the origins of the rights set out in Part VI of **the 1992 Act** and has examined why the rights in question were included in **the 1992 Act**. In this context the paper has:

- (a) examined the fact that the rights set out in Part VI of **the 1992 Act** are not unique to patients in terms of that Act;
- (b) concluded, that those rights set out in Part VI were available to patients before **the 1992 Act** came into force; and
- (c) offers explanations why **the 1992 Act** included a "*restatement*" of existing rights.

The social task of **the 1992 Act** has been considered by examining the "*central dilemma*" of any mental health statute, the civil liberty v compulsory treatment conflict. From this examination, the writer has concluded that any mental health statute must involve a "*trade off*" of patient's rights for the rights of others, such as the community.

The duties to provide the rights set out in Part VI of **the 1992 Act** have been reviewed and conclusions drawn as to where such duties lie.

²⁰⁷

It is recognised that the rights set out in Part VI of the 1992 Act have most application to "in-patients".

The sanctions available to ensure that patient's rights are respected have been examined and suggestions made concerning the need to provide "teeth" to the procedures set out in section 75 of **the 1992 Act**.

The paper has examined the barriers which exist to patient's attaining their rights and the means of overcoming these barriers. Finally, the paper has conducted a general evaluation of the "rights" approach in the 1992 Act. The writer has drawn conclusions as to what, in practical terms, the inclusion of the patient rights in Part VI of **the 1992 Act** can achieve for patients.

To conclude, it must be remembered that at the heart of the legal reform movement promoting patients rights is the fundamental vision that patients under **the 1992 Act** should be able to satisfy their basic need for treatment without sacrificing their basic rights. It must also be stressed, that if patients are to have access to their basic rights they must also have access to the means of attaining those rights.

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ACKNOWLEDGMENTS

The writer wishes to acknowledge the assistance of his wife Maree Foley
and Catherine Coates of the Ministry of Health in the writing of this paper.

The writer is an employee of the Ministry of Health. The views expressed
in this paper are the writers and do not represent the views of the Ministry.

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