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CIVIL COMMITTAL UNDER THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992 - HAS THE RIGHT BALANCE BEEN ACHIEVED?

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INTRODUCTION-

"[The Mental Health Compulsory Assessment and Treatment Bill] is a Bill that reflects the best about the community, in that it does responsibly draw a line between the interests of the community and the interests of the person who is seriously mentally disordered[1]

Until relatively recently in New Zealand and other Commonwealth jurisdictions the balance between these competing rights has weighed heavily in favour of society's right to confine mentally disordered persons; exposing the mentally ill to potential violation of their civil rights at the expense of the perceived need to confine and treat them. Public consciousness of the problem has been raised in recent years by intense media interest in the plight of the mentally ill, and the depiction of nightmare scenarios such as that in the controversial film "One Flew Over the Cuckoo's Nest", in which a patient was given a frontal lobotomy without his consent, and the book "Faces in the Water". In the legal context, the combination of paternalism and derision with which mentally ill people were regarded was reflected in the titles of various mental health statutes prior to 1969, such as the Lunatics Act 1894 and the Mental Defectives Act 1911, and in the descriptions given to mentally ill people in colloquial parlance, such as "loonies" (touched by the moon) and "nutcases". Campbell, Gillett and Jones describe the problem thus:

".. psychiatric patients are often stigmatised as being somehow tainted in the essence of their identity as persons, and not just as affected by an incidental condition."[2]

Small wonder then that the late 1970s and early 80s witnessed a wave of reform in mental health legislation around the Common Law world, designed to accord ordinary civil rights to mentally ill persons and more closely regulate the circumstances in which they could be compulsorily detained and treated by the State. In the United Kingdom a new Mental Health Act was passed in 1983, and reforming legislation was passed in many of the Australian jurisdictions in the late 1980s. New Zealand's

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[1] The Rt Hon Helen Clark, Third Reading of the Bill, New Zealand Parliamentary Debates, 2 June 1992, p 8457

[2] Practical Medical Ethics, p 131

turn came in 1982, when a scandal involving the compulsory adminstration of Electro-Convulsive Therapy to a patient in a secure ward at Oakley Psychiatric Hospital provoked a public outcry about the treatment of psychiatric patients, and led to the formation of a Committee of Inquiry into procedures at Oakley. The Committee published a comprehensive report in 1983, which made a number of important recommendations relating to mental health care in general. This in turn led to the formation of a Taskforce on mental health law reform, which began the comprehensive task of overhauling the Mental Health Act 1969. Nine years later in 1992 the reform has finally reached fruition with the enactment of the Mental Health (Compulsory Assessment and Treatment) Act 1992 in June 1992.

Unlike its predecessor, the Act deals solely with compulsory treatment - reflecting perhaps the overriding concem about the ease with which people were committed under the Mental Health Act 1969, and the erosion of their ordinary civil rights while subject to detention under the Act.[3]

Whether one is as sanguine as the member for Mt Albert about the merits of the new mental health regime, it must at least be recognised that the Act is a step forward in both the jurisprudence and the practice of mental health care, in that it defines more stringently the criteria for committal of mentally disordered persons, and explicitly provides for

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3 Hon Katherine O'Regan, NZ Parliamentary Debates, 12 March 1992, p 6860. 'Towards Mental Health Law Reform', chs 15,16 and 17. The Taskforce on Mental Health Law Reform set up in 1982 recommended that a comprehensive code of patient rights, covering both voluntary and involuntary patients, be included in the new legislation.

Statistics in 1984 indicated that only about 21% of admissions to psychiatric institutions were pursuant to a committal order under the Mental Health Act 1969, although the statistics for admissions pursuant to the Criminal Justice Act and the Alcoholism and Drug Addiction Act would undoubtedly be higher. Furthermore, there is evidence of abuse of voluntary patients. According to Dawson they are sometimes administered psychotropic (mind altering) drugs without their consent. There is no statutory authority for this - any authority must be derived from Common Law powers to treat people in emergencies - see 'The Process of Committal', p 37. In 1977 there was a case where a 13 year old Niuiean Boy being held in solitary confinement at Lake Alice Hospital as a voluntary patient was subjected to ECT (Electro Convulsive Therapy) without his consent. Neither his parents nor the Social Welfare Department who was responsible for him were notified. See'Mental Health Law Reform', John Dawson, p 324

patient rights for the first time in the history of mental health law in New Zealand.[4]

The new Act deals with a broad range of issues relating to mental health care, including the treatment of 'special patients' who are referred by the criminal justice system and the treatment of children. The focus of this paper however is upon civil committal [5] under the Act, in terms of the criteria for compulsory treatment and the procedures by which mentally disordered persons can be subjected to compulsory treatment. Attempts will be made to assess whether the committal regime addresses the concerns associated with previous legislation, whether it will operate sucessfully in practical terms, and whether it strikes the appropriate balance between patient and community rights. The discussion will focus particularly upon the new definition of 'mental disorder' in the Act, and jurisprudential issues associated with committal of the mentally ill.

I. JUSTIFICATION FOR COMMITTAL - THE DEFINITION OF MENTAL DISORDER

Under the new Act a person can be subjected to compulsory treatment only if they are "mentally disordered" within the meaning of s 2 of the Act..

Section 2 defines 'Mental Disorder' as:

> an abnormal state of mind (whether of a continuous or intermittant nature), characterised by delusions , or by disorders of mood or perception or volition or cognition of such a degree that it -
>
> (a) poses a serious danger to the health or safety of that person or of others; or

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[4] See comments of Katherine O'Regan during the 2nd reading of the Bill, 12 March 1992, NZ Parliamentary Debates at p 6861: "Several key themes run through the reforms: an increased emphasis on the need to protect patients' rights, appropriate appeal and review procedures, provision of treatment in the least restrictive environment, treatment of psychiatric patients like any other patient wherever possible, integration of mental health services with general services, and multi disciplinary participation in decision on the care and treatment of patients.

[5] The term 'committal' is no longer strictly appropriate in view of the de emphasis on detention under the new Act and the ability of the Family Court to order community treatment. However, where the term is used in the paper it refers to any kind of compulsory treatment order in respect of a mentally disordered patient

(b) seriously diminishes the capacity of that person to take care of him or herself.

In addition to these criteria the court must determine whether in all the circumstances of the case
it is necessary to make a compulsory treatment order.[6] No person can be subjected to assessment under the Act by reason only of that person's:

(a) political, religious or cultutral beliefs
(b) sexual preferences
(c) criminal or delinquent behaviour
(d) substance abuse
(e) intellectual handicap[7]

The decision to commit a person to a mental institution has always involved considerations broader than simply that the patient is mentally disordered - it is a fundamental premise of liberal societies that no person shall be deprived of their liberty without compelling reasons,[8] so while the fact that someone is mentally ill makes it desirable that they receive treatment, it does not in itself justify compulsory detention and treatment by the State. This entails that committal decisions are not based purely on medical factors,[9] but require delicate legal judgments about the social implications of permitting a mentally disorded person to remain at large in the community.
To this end, the involvement of the judiciary is pivotal in committal decisions.[10]
Given that a mentally disordered person's right to freedom rests ultimately in curial hands, an adequate legal definition of mental disorder becomes crucial. The requirements of a statutory definition were described by the Taskforce in the following terms:

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6 Section 27(3) of the Act
7 Section 4 of the Act
8 This principle is grounded in the ancient writ of *habeus corpus* - no one has the right to detain another person without specific legal authority. See 'The Process of Committal' at p 1and J.S Mill 'On Liberty': "The only purpose for which power can be rightfully exercised over any member of a civilised community against his will is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant"
9 See 'The Process of Committal', Dawson, p 5: "To a considerable extent committal is a medico-legal process"
10 The Mental Health Act 1969, s 21, Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 27 & 28

" We believe the statutory language must give sufficient meaning to committal standards to prevent their arbitrary and discriminatory enforcement, to provide adequate guidance to those who enforce the standards and warning to those liable to be detained under them, and to permit meaningful review of decisions made. Committal criteria must accurately delineate the type, extent and immediacy of those harms which the statute is designed to prevent as well as those kinds of evidence which must be considered in making the committal decision"[11]

From that definition of the requirements, it is submitted that two factors are important in any definition of 'mental disorder' -

1. Conceptual Clarity

The purpose of the conceptual clarity requirement is principally to ensure that Judges making committal decisions under the Act can exercise independent judgment, and are not forced to defer to the opinion of doctors and psychiatrists in making committal decisions. It is acknowledged that uncertainty and disagreement as to what constitutes mental disorder is inherent in the mental health system.[12] The problem is alleviated to some extent by the development of international diagnostic guidelines, which set out specifically the range of symptoms

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11 'Towards Mental Health Law Reform', p 55

12 The comments of the Hon Helen Clark in NZ Parliamentary Debates, 12 March 1992 at p 6860 are particularly pertinent in this regard: "to some extent how the definition is applied will reflect the clinical judgments, practices and standards of the day. That is something that cannot be clearly defined in a statute". See also 'Towards Mental Health Law Reform', p 36, 'The Process of Committal' Dawson at p 149 and 'The Reality of Mental Illness' (1986) M Roth and J Kroll, p 79. The conditions which most often pose problems for psychiatrists are psychopathia and neurotic disorders.

associated with each illness,[13] but the interface between mental illnesses and personality disorders is still unsettled.[14] As Gostin points out:

"It is when psychiatry enters the grey area of personality disorder or neurosis, or when it claims an ability to identify an illness which is not apparent to the rest of us, that it is most vulnerable as a profession"[15]

For this very reason however legislation is the place to address such conflicts,[16] if not by explicitly detailing mental disorders covered by the Act, by at least excluding conditions which are clearly not intended to be covered by the Act, such as neuroses or personality disorders.[17] The list of exclusions in s 4 of the Act goes contributes in some measure toward a clarification of the types of conditions intended to be covered; according to Mellsop, the terms used in the definition (such as "disorder of mood") have an accepted meaning in psychiatry, and thus would be

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13 The first serious attempt to reduce diagnostic unreliability was the promulgation by the American Psychiatric Association of DSM-III in 1980 - the 'Diagnostic and Statistical Manual'. For each disorder there are general descriptions followed by more specific diagnostic criteria. For a more extensive discussion of the system see 'Psychiatric Trends: Developments in Diagnosis in Psychiatry', GW Mellsop, [1983] NZ Medical Journal 1010.
Mellsop claims that the ICD-10 system has an accuracy rate of 80%. See also the International Classification of Diseases, 10th Edition (1992). The new diagnostic system is discussed in 'Reliability of the Draft Diagnostic Criteria for Research of ICD-10 in Comparison with ICD-10 and DSM-III-R', GW Mellsop et al, (1991) Acta Psychitr Scand 332-335.

14 The U.K Mental Health Act includes psychopathia as a mental disorder but the New Zealand Act does not.

15 'The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry' in 'Mental Illness: Changes and Trends', Bean (ed), pp 27; 38

16 See 'Towards Mental Health Law Reform' at p 36 - "[t]he idea that defining the boundaries of mental disorder should be left within the realm of medical expertise is further attacked on the ground that psychiatric diagnoses are far from reliable... while diagnostic reliability may be increasing, it is far from clear that psychiatrists are able to diagnose mental disorder with an accuracy sufficient to satisfy the requirement that persons should not be deprived of their liberty except on the basis of thoroughly reliable evidence"

17 Although some psychiatrists would like to see such disorders covered by mental health legislation, there seems little point in doing so, as many are not susceptible to psychiatric treatment. "The distinction between a mental illness and a personality disorder would appear to be that personality disorders are not 'organic', in the sense of being a discase that overlays the person's normal personality" - M Roth, 'Psychopathic (Sociopatliic) Personality' in Bluglass and Bowden (eds) 'Principles and Practices of Forensic Psychiatry'. The Auckland District Law Society in its submission to Select Committee on the Bill recommended that personality disorders be excluded from the definition.

interpreted consistently by psychiatrists perfroming assessments under the Act.[18]

However, it it is submitted that in view of the fact that the committal process has been opened up to involve mental health professions outside orthodox psychiatry the need for a clearer statutory definition is more pressing.[19] For example, the definition of mental disorder could require those interpreting it to have regard to the International Classification of Diseases.

The U.K Mental Health Act draws a distinction between the criteria for admission for assessment, and those for admission for treatment. While 'mental disorder" (the criterion for assessment) is defined widely to potentially include personality disorders, admission for treatment requires "mental disorder, severe mental impairment, psychopathic disorder or mental impairment"[20] It is submitted that the approach in the new Act has simply been to sidestep the issue. The definition of mental disorder does not enable those applying the Act to clearly determine what constitutes mental disorder or to attempt a diagnosis of the condition; it simply outlines a range of symptoms which may or may not constitute mental disorder.[21] The consequence of this lack of clarity will be that the ultimate decisionmaker under the Act (the Family Court Judge) will defer inordinately to medical opinion - faced with a definition that is unusably wide.[22] It is submitted that in all cases where compulsory treatment is being proposed a diagnosis of the condition

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[18] Graham Mellsop is the Professor of Psychiatry at Wellington Clinical School of Medicine. The author had discussions with him on 11 September 1992.

[19] Section 7(b) of the Act provides that the Director may appoint any registered health professional to the position of responsible clinician if in the opinion of the Director he has the relevant training and competence in treating the mentally ill.

[20] Mental Health Act 1983, s 1. The Butler Committee in the U.K defined 'Mental Illness' as: "a disorder which has not always existed in the patient but has developed as a condition overlying the sufferer's normal personality" - Report of the Committee on Mentally Abnormal Offenders.

[21] See 'The Process of Committal', Dawson in 'Mental Health: A Case for Reform', Legal Research Foundation Seminar at p 49 - 'In practice the key to committal is diagnosis, through which behaviour is constituted as mental disorder liable to control by the Mental Health Act...[t]he doubtful cases are those in which no clear diagnosis is expressed".

[22] This was one of the major problems with the 1969 Act. See the comments of the Taskforce, 'Towards Mental Health Law Reform' at p 55: "the committal decision is left largely to the medical profession by default". See also 'The Process of Committal', Dawson, in 'Mental Health: A Case for Reform', Legal Research Foundation at p 42, in which Dawson points out that committal hearings are characterised by an overabundance of medical evidence, and medical certificates which are formally correct are never rejected by judges.

should be mandatory. In Victoria the Mental Health Review Board has laid down guidelines for the decision as to whether a person is 'mentally disordered'. These include consideration of expert evidence and reference to diagnostic manuals.[23]

The approach adopted in the New Zealand act fails adequately to maintain the distinction between the "mad" and the "bad".[24] While it is not legitimate to commit people simply on the basis of mental illness, neither is it legitimate to commit people who are not mentally ill and have committed no crime. As Mason McCall and Smith point out:

".. [i]t is.. axiomatic that a person who is dangerous but has not yet committed a crime is entitled to his liberty whatever his potential for future harm may be. We are left then with a paradox - why would so few people argue against the prophylactic detention of a dangerous person who is suffering from a mental illness? The answer must be that the illness itself may provide a basis for asserting that certain forms of violent or irrational conduct may be reasonably anticipated."[25]

They further state that:

" .. the boundaries of mental illness should not be drawn so widely as to embrace forms of behaviour which are no more than non-conformist. Compulsory admission should be limited to conditions which amount to an *illness* that can be said to compromise the mental health of the sufferer"[26]

2. Should Personality Disorders be Included in the Definition of 'Mental Disorder'?

Thus far the discussion has proceeded on the basis that personality disorders are not a form of mental illness, cannot be treated adequately in mental institutions and should therefore be excluded from any definition of 'mental disorder'.[27] The ICD-10 diagnostic system, which

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[23] See 'The Process of Civil Commitment under the Mental Health Act 1986', Neil Rees, p 255.

[24] See comments of Katherine O'Regan in the Second Reading of the Bill at p 6860: "the line between the mad and the bad is extremely fine".

[25] 'Law and Medical Ethics', p 391.

[26] Ibid, p 399.

[27] The World Health Organisation ICD defines 'personality disorder' as: "Deeply ingrained maladaptive patterns of behaviour... [t]he personality is abnormal either in the balance of its components, their quality or expression, or in its total aspect. Because of this deviance or psychopathy the patient suffers or others have to suffer,

has been adopted by the Psychiatric Association in New Zealand, includes personality disorders. Similarly, the view that personality disorders should not be included has been challenged recently by the Law Reform Commission of Victoria, which has argued that amendments to the 1986 Victorian Mental Health Act are needed to ensure that persons with 'anti social personality disorders' are caught by the definition.[28] Section 8 of the Victorian Act authorises a hospital to detain a person only if they "appear to be mentally ill". Thus, the definition does not appear to enable those with personality disorders to be detained. According to the Commission, there is considerable debate as to whether personality disorders are mental disorders.[29] The Commission was particularly concerned to ensure that persons with psychopathia were subject to the Act.

A recent decision of the Mental Health Review Board - The Appeal of KMC, indicates that in the absence of specific words to that effect, parliament will be presumed not to have intended personality disorders to be excluded. The Board stated:

" People with personality disorders have been patients in the State's psychiatric hospitals for many years and we believe that if Parliament had intended that people with personality disorders were not to be regarded as having a mental illness for the purposes of this Act it would have said so explicitly"

Although this decision apparantly related only to 'borderline personality disorders' (such as psychopathia), its implications for the New Zealand legislation are significant. It would effectively require any ambiguity in the definition of 'mental disorder' (which in the writer's view is created primarily by the use of the broad term 'disorder') to be construed in favour of including personality disorders. This view is reinforced by the Victorian Commission which stated that in its view the South Australian legislation, which defines mental illness as 'any illness or *disorder* of the mind, would include persons suffering from personality disorders.

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and there is an adverse effect on the individual or society..". Mellsop described the distinction to the writer as follows - personality disorders are a quantitative deviation from normal, in that the person concerned is normally like that, whereas diseases have a clear onset and are a qualitative deviation from normal.

28 'The Concept of Mental Illness in the Mental Health Act 1986', Report No 3 of the Commission, April 1990.

29 See for example 'Diagnostic and Statistical Manual of Mental Disorders' (DSM III), 1987, American Psychiatric Association; 'Oxford Textbook of Psychiatry' (1985), R Gregory, pp 104-130, for a summary of the debate.

If this view were correct it would signal a breakdown in the distinction between 'mad' and 'bad', and change the nature of mental institutions to become more paternalistic and less treatment oriented (at least in cases where the institution was not equipped to treat that kind of personality disorder).

There are personality disorders other than psychopathia about which there is much less agreement that they should be included in the definition. These conditions were described by the Commission as 'antisocial personality disorders', and are at present excluded under s 8(2)(1) of the Victorian Act. For instance, the Royal Australian and New Zealand College of Psychiatrists is against such inclusion:

" There are some persons with very severely disordered behaviour which is so bizarre and dangerous that the community tends to perceive them as 'mad'. Most psychiatrists however would not consider these persons to be suffering from a mental illness. Some psychiatric techniques including counselling and occasionally pharmacotherapies may have a limited influence on such people..[but] [t]here is certainly no place for the long term hospitalisation of such people which may sometimes amount to preventive detention under the guise of treatment. Within a hospital these persons divert attention from patients in greater need of care and often disrupt the treatment of other patients...[s]taff are ill equipped to cope with violence that does not respond to standard psychiatric interventions. Scarce resources are consumed unprofitably while the morale of the institution declines as the treatment team come to see themselves as warders rather than therapists"[30]

Other commentators have expressed contrary opinions. For example, Kaplan and Sadock state:

" Patients with personality disorders continually demonstrate to mental health professionals the limits of their expertise...[p]sychiatry nevertheless cannot ignore personality disorders. Although psychiatrists until recently were reluctant to acknowledge it, those with perosnality disorders are functionally more disabled than the neurotics psychiatrists prefer to treat. Obviously, psychiatry must learn to understand the personality disorders better than it has done in the past"[31]

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[30] Submission to the Social Development Committee.
[31] 'Comprehensive Textbook of Psychiatry' (4th ed), 1989, p 1352.

In the writer's view the two quotations encapsulate radically different views about the role of psychiatry in the treatment of disordered persons. The argument in favour of including personality disorders advocates a change in the very nature of psychiatry, such that psychiatrists must learn to become counsellors in addition to ministers of medicine. The argument against inclusion embodies a more realistic conception of the role and scope of psychiatry, and recognises that there are limits to the kinds of disorders which will respond to conventional psychiatric expertise and the nature of mental institutions at present. Unless a complete overhaul of psychiatric practice in New Zealand is envisaged by the new Act, it would seem more realistic to specifically exclude personality disorders from the definition and enable them to be dealt with by those with the appropriate expertise - psychologists and counsellors. The desirability of persons with personality disorders receiving treatment appropriate to their condition is not an argument in favour of using a compulsory treatment process designed for the mentally ill to compel them to receive inappropriate treatment in inappropriate institutions.

In the Commission's view the fact that many personality disorders cannot be treated by conventional psychiatric medicine is not an argument against committing persons with these disorders for care in a mental institution as opposed to treatment.[32] However it is submitted that incarceration in a mental institution may discourage such persons from seeking counselling or behavioural therapy on a voluntary basis, and may traumatise them unnecessarily. The absence of adequate information and resources for treating personality disorders highlights the need for government health authorities to put resources into that area, rather than extending the ambit of mental health legislation to cover such persons.

The exposure of the committal process to mental health professionals other than psychiatrists will exacerbate the confusion as to which disorders are covered by the Act. The Health Department in Victoria expressed the view that mental health legislation should not attempt to define the concept of mental illness; a task best left to psychiatrists. However, unless there is a set of guidelines universally agreed upon by persons exercising powers under the Act it is submitted that the definition needs to be as specific as possible. If the legislature is intent

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[32] Supra n 27, p 8.

on including personality disorders in the definition a solution may be found in the explicit adoption of ICD-10; the International Classification of Diseases, which sets out the personality disorders which are regarded as mental disorders and the diagnostic criteria for these.[33]

The Commission was of the view that including personality disorders in the definition of 'mental illness' would not unduly extend the power to commit and detain under the Act becuse there were sufficient safeguards relating to the need for the person to be a danger to themselves or others. This, with respect, misses the point. The power to commit and detain is unduly extended where it covers a class of people who will not respond to psychiatric treatment, cause disruption and trama in psychiatric institutions and are best dealt with elsewhere.In view of the controversy in Victoria over this issue it is submitted that the New Zealand definition should be clarified so as to expressly exclude personality disorders from the compulsory treatment process.

Concerns about committal of persons who were merely 'eccentric' led to the establishment of an 'anti psychiatry' movement in the United States in the late 1970s, whose proponents held that there was no such thing as mental illness - that what purports to be mental illness is just socially deviant behaviour, and psychiatry is an instrument of control imposed by the ruling classes to control deviants whose 'radical voices' threaten the existing social order.[34] While the voice of the anti psychiatry movement has now become somewhat subdued, it must be borne in mind that there is a fine line between legitimate coercion and mind control.

In summary, the mental health system, which is geared towards medical treatment of mental conditions is not the appropriate way of dealing with people who are simply violent or difficult.[35] The focus of the definition on symptoms rather than conditions allows for the possibility that these kinds of people may become subject to the Act,[36] and opens up an

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[33] See discussion in supra n 29.

[34] See for example 'The Myth of Mental Illness', T Szatz, New York 1961; 'Schizophrenia and the Theories of Thomas Szatz' (1976) British Journal of Psychiatry 129.

[35] This view is endorsed by Prof. Graham Mellsop, who says that the mental health system is not equipped to deal with the kinds of therapy required for personality disorders.

[36] For a recent example of just such a case see Bravenboer v Finlayson & Anor, High Court Auckland Registry, M 1216/ 85, 9 April 1987. Ms Bravenboer , a law student at Auckland University, has been causing difficulties in the Law Faculty and with her family over exam time. At the behest of an administrative assistant in the Faculty she went to see a doctor at Student Health who, after a consultation with her,

enormous grey area in respect of conditions such as Alzheimer's Disease,[37] Anorexia Nervosa and various kinds of obsessive behaviour.

3. Should Intellectual Handicap be Excluded from the Definition of Mental Disorder?

A similar issue raised recently by Dawson is whether the exclusion of intellectual handicap as a sole justification for committal can be justified.[38] Dawson noted that the definition purports to include 'disorders of cognition' - the paradigm of which are intellectual handicaps, and yet excludes them in s 4 of the Act. It seems beyond contention that the exclusion of intellectual handicaps stems primarily from s 1(3) of the U.K Mental Health Act 1983, and from intense lobbying by groups such as the IHC Association. The issue is whether such exclusion is desirable, given the frequent inability of intellectually handicapped persons properly to look after themselves and conduct independent lives in the community, and the problems and injustices inherent in dealing with such persons through the prison system.

Despite these undoubtedly valid reservations, it is submitted that the same considerations which militate against personality disorders being included also militate against the inclusion of intellectual handicap. Without a radical revision of the concept of mental illness and an overhaul of the institutional structures attending this concept, it is difficult to envisage how an intellectual handicap, which usually stems from birth and forms the basis of a person's normal personality, can be termed a 'mental disorder', and treated within the conventional mental health structures with conventional medical responses. Situations such as the locking of the "shame ward" at Kingseat Hospital in 1987 are testament to the inability of the mental health system to cope with

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filed an application in the District Court to have her committed, largely on the basis of hearsay from Faculty members. Neither of the doctors certifying the plaintiff, nor the psychiatrist or the judge at the hearing thought that the plaintiff was mentally disordered. In a recent (as yet unpublished) article by Sylvia Bell of the Mental Health Foundation on the new Act the author acknowleges that the definition of mental disorder may not be as narrow and "water tight" as the Foundation had thought.

[37] For instance in a recent case in Queensland - Re Warby and the Mental Health Services Act 1974-1989, Supreme Court of Queensland, 9 May 1991 No 4/91 it was held that a woman suffering from Alzheimers Disease was not 'mentally ill' within the meaning of the Act.

[38] Comments of John Dawson at a seminar on the new Act held at Buddle Findlay on 29 September 1992.

intellectual handicap.[39] Many such handicaps cannot be cured by psychiatry - what is required is intensive special learning programmes and the more modern concept of mainstreaming to encourage the handicapped to realise their fullest potential. In the writer's view such realisation could not occur within the mental health system as it exists at present without a massive infusion of funding and a decisive move away from the medical/ psychiatric model of mental health towards an all encompassing notion which includes intellectual handicaps and psychological problems. While the Act may be seen to be encouraging this type of shift, the practical responsibility for mental health care will remain in the hands of those most qualified to administer it - doctors and psychiatrists.

4. Explicit Statement of Social Goals

The Act outlines for the first time in the history of mental health law the rationale for committal - that a person is dangerous to themselves or others or is incapable of looking after themselves. These criteria will become particularly important in the committal process, because the logical consequence of the focus in the definition on symptoms and behaviour rather than diagnosable conditions is that committal decisions will focus on whether a person is dangerous to themselves or others, not simply whether they have a diagnosable mental illness. The dangerousness requirement is a major step forward from the 1969 Act, which simply stated that a person could be committed if:

> the District Court Judge is satisfied that the person is mentally disordered and requires detention in a hospital either for his own good or in the public interest[40]

There were no guidelines as to when it would be in the public interest to detain and treat a person, and therefore committing Judges were given almost unlimited discretion to decide upon the criteria for committal.[41]

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[39] The reference is to the practices and procedures adopted at Villa 16 at Kingseat - a special ward for intellectually handicapped adults which achieved notoriety in 1987 when inhumane practices such as open toilets, sharing clothes and patients sitting on cold concrete floors came to light.

[40] Mental Health Act s 24(1)

[41] As John Dawson points out in his paper 'The Civil Committal Process' in 'Mental Health: A Case for Reform', Legal Research Foundation, judges in committal hearings seldom pay more than scant regard to the statutory definition of

Under the new Act consideration will need to be given at two stages of the process - the assessment by the Responsible Clinician and the hearing before a Family Court Judge, to whether the person is dangerous, and evidence of this will need to be adduced.

5. Dangerousness

The image of the mentally ill as crazed and dangerous pervades the public consciousness both here and overseas; two well publicised incidents being the attempt on President Reagan's life by the paranoid John Hinckley, and the escape of John Lennon's killer from a hospital in Hawaii, from which he fled to New York and gunned down the famous Beatle.

Dangerousness as the criterion for compulsory treatment originated in the strict climate of civil libertarianism prevailing in the United States in the 1970s. Many jurisdictions moved from a *parens patriae* approach to civil committal, in which all that was required was a need for treatment and a refusal to get treatment, to a much more resticted approach whereby a patient had to be dangerous to themselves or other before they could be committed.[42] It is submitted that dangerousness as a criterion is a vast improvement on the 1969 Act in which there was no requirement that a patient be dangerous - it is vital that mentally ill people should be left at liberty unless they are harming themselves or others. However, the inclusion of a dangerousness criterion creates a number of problems; the most significant being the difficulty in predicting whether a person is likely to be dangerous. As Dershowitz points out:

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mental disorder. This lack of rigour is perhaps a consequence of the inefficacy of the definition they are forced to work with. He points out that varying rationales are put forward for committal. Some judges favour a "treatability standard"; being prepared to bend the definition to encompass such conditions as substance abuse and personality disorders if they consider that the person requires treatment, and others preferring to restrict committal to persons who are dangerous to themselves or others (see pp 47-51). In about half of the committal hearings he observed during 1984 Dawson noted that patients were committed with no refernce being given to to whether they were dangerous.

[42] See 'Civil Commitment: An Overview', Mark Mills, March 1986 ANNALS, 28; 'A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered', Morse, Calif Law Rev 70:54-106 (1982).

"..psychiatrists are rather inaccurate predictors.. it seems that psychiatrists are particularly prone to one type of error - over prediction. In other words, they tend to predict antisocial conduct in many instances where it would not in fact occur."[43]

Smith and Meyer argue:

"Civil commitment ultimately must depend on the ability accurately to predict who is dangerous. Otherwise, it is little more than a lottery"

Studies have shown that psychiatrists overpredict dangerous conduct by a ratio of at least five to one.[44] There are a number of reasons for the inaccuracy of predictions, including the absence of literature on prediction methodology, and the failure of psychiatrists to follow up patients and get feedback on their decisions.[45] Another significant reason for over prediction in the United States has been psychiatrists' fear of being held liable for harm to the public resulting from a wrong prediction that a patient was not dangerous. This 'duty of care' to the public was imposed in the landmark decision of Tarasoff v Regents of the University of California[46], in which it was held that a psychotherapist owed a duty of care to an identifiable person to warn him of imminent harm as a result of a patient's actions. It is unclear whether the *ratio* of the case extends to a duty to the general public not to make a wrong prediction of dangerousness, but assuming that were so the implications for a responsible clinician making decisions under the new Act would be considerable. Every time he made a decision not to commit a person or to release a patient he would be exposing himself to potentially enormous liability. The temptation in light of these obstacles is to dispense with the dangerousness criterion and adopt some other, more 'rational' basis for committal. However, in the writer's view the preservation of civil liberties depends upon the adoption of the dangerousness criterion. The solution to the practical difficulties is to remove the responsibility of predicting dangerousness from individual psychiatrists and place it upon a multi disciplinary body such as the Mental Health Review Tribunal or by at least two

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[43] 'Psychiatry in the Legal Process: A Knife that Cuts Both Ways', Dershowitz, 51 Judictature 370 (1968)
[44] 'The Prediction of Dangerousness in Mentally Ill Criminals', Rubin, 27 Arch. Gen. Psychiatry 397 (1972).
[45] Ibid.
[46] 529 P 2d 553

psychiatrists working in tandem. Although psychiatrists may be able to indicate whether a certain illness predisposes a patient to violence, this information must be considered in conjunction with numerous other factors which psychiatrists may not be equipped to decide on. The American Psychiatric Association has stated:

".. 'dangerousness' is neither a psychiatric nor a medical diagnosis, but involves issues of legal judgment and definition as well as issues of social policy. Psychiatric expertise in the prediction of 'dangerousness' is not established and clinicians should avoid 'conclusory' judgments in this regard."[47]

It is submitted that the response outlined above would enhance the accuracy of the prediction and spread responsibility for errors in a more equitable fashion. An argument against the reasonableness of a tribunal's decision on dangerousness would meet with much less success than an argument that an individual psychiatrist has breached a duty of care owed to the public.

From the public's point of view the dangerousness criterion fails to provide an adequate safeguard against the violence of mentally ill persons - the backlash against civil libertarian standards resulted not only from a perception that many mentally ill people were gravely incapacitated and would not seek help voluntarily, but from a realisation that the mentally ill people who did not meet the committal threshold were committing crimes and being dealt with by the criminal justice system.[48] In the writer's view although the adoption of the dangerousness criterion is a big step forward, it must not be so restrictive that a mentally ill person has to threaten murder or suicide before they can be committed. There is a danger that the "seriousness' requirement for dangerousness goes too far in this direction; New Zealand should take heed of the U.S experience and temper civil libertarianism with a measure of caution. It is submitted that if the illness criterion is satisfied, a belief that the person is likely to be dangerous shouldbe sufficient for committal.

A second problem with the dangerousness criterion in the definition is that it lacks specificity as to the type of dangerousness that will warrant

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[47] 'Clinical Aspects of the Violent Individual', Task Force Report (1974) 33.

[48] See 'The Social and Medical Consequences of Recent Legal Reforms of Mental Health Law in the USA: the Criminalisation of Mental Disorder', Alan Stone in Psychiatry, Human Rights and the Law, Roth and Blugrass (eds), 9.

committal. It is clear from the definition that only serious danger will be considered sufficient for committal, but judgments as to what constitutes "serious" are likely to vary considerably amongst individual decisionmakers. Given the difficulties associated with prediction, it is arguable that the definition should contain more detailed guidelines as to the factors which are relevant in predicting dangerousness (such as family history or past record of violence). The Taskforce recommended that the statute require evidence of past violence in order for a person to be committed.[49] In the writer's view this standard is unnecessarily high, and would entail that a mentally ill person would have to demonstrate dangerous behaviour before they could be committed. There are good policy reasons against allowing such freedom, such as the need to protect society against dangerous persons. However it is clear that the definition must be interpreted with care, and there must be a genuine "likelihood" of dangerousness before a person can be committed. It is to be hoped that the courts will develop a coherent jurisprudence of committal that will precribe guidelines for the interpretation of concepts such as "serious" and "danger".

6. "Seriously Diminishes the Capacity of [the Patient] to Take Care of Him or Herself"

The wave of civil libertarianism and the strict new criteria for committal in the United States in the 1970s resulted in many patients in need of treatment being deprived of that treatment because they were not actively dangerous or suicidal. This in turn placed enormous pressures on families, who often had to look after severely incapacitated relatives, and the criminal justice system, which was forced to accommodate mental patients who were not considered dangerous enough to meet the committal threshold, but went on to commit crimes.[50]

These problems led to the enactment in many states of provisions enabling persons who were gravely incapacitated to be committed in the interests of their own welfare and that of their families.[51] The definition

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[49] 'Towards Mental Health Law Reform', p 67.

[50] See 'Care and Treatment of the Mentally Ill in the United States: Historical Developments and Reforms', Morrissey and Goldman, March 1986 ANNALS 12; 24-25.

[51] Washington State was at the forefront of these reforms - it had enacted a very restrictive committal statute in 1973 during the wave of civil libertarianism. After a number of murders an advocacy group - 'Washington Advocates for the Mentally Ill'

of 'mental disorder' in the New Zealand Act enables persons whose ability to take care of themselves is seriously diminished to be committed. This is a welcome move away from the strict libertarianism of the United States, but once again the lack of clarity in the Act as to what constitutes "ability to take care of" and "seriously diminished" is a concern.

For instance, it is not clear whether "ability to take care of" related solely to physical aspects of a person's life such as eating and performing ablutions, or whether it extends to the person's financial situation and social abilities. Similarly, it is not clear whether the person's family and other support networks can and should be taken into account in determining whether they can take care of themselves. If such support could be take into account then the burden of caring for mentally ill persons would be placed on families and caregivers; depriving the mentally disordered person of the treatment he needed. The definition should not be interpreted so narrowly as to preclude large numbers of mentally ill people from being treated. The barriers to mentally ill people seeking treatment voluntarily - lack of money and motivation, are considerable, and thus the committal threshold should not be inordinately high.

7. Treatability?

The definition also seems to incorporate an implied criterion that the illness must be able to be treated as the *sine qua non* of committal. Treatability of the illness as a criterion for committal has been adopted in a number of overseas jurisdictions; most notably the United States. In the 1975 Supreme Court decision of O'Connor v Donaldson[52] Stewart J stated that:

"A finding of mental illness alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement"

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was set up to push for changes to the law. See 'Legal Intervention in Civil Commitment: the Impact of Broadened Criteria', Durham and Pierce, (1986) ANNALS, 42. See also 'The Mentally Disabled and the Law', Brakel and Rock, Chicago 1971; 'Developments in the Law: Civil Commitment of the Mentally Ill', Harv Law Rev 87:1190-1406 (1974).

52 422 US 563

This view has been affirmed in New Zealand as recently as 1988 in the Mason Report on Psychiatric Services in which it was stated:

"An offer of effective treatment must be the quid pro quo for society's right to confine mentally disordered persons.."[53]

The definition itself does not require that adequate treatment be provided, but s 66 provides that
every patient has the right to receive treatment appropriate to his condition. Similarly s 29, dealing with Community Treatment Order provides (inter alia):

A community treatment order shall require the patient to attend at the patient's place of residence....for treatment by employees of the specified institution, and to accept that treatment (emphasis added)

It may be doubted whether s 29 authorises anything other than treatment. Section 30, dealing with Inpatient Orders provides (inter alia):

(1) Every inpatient order shall require the continued detention of the patient in the hospital specified in the order.... for the purposes of treatment, and shall require the patient to accept that treatment.

It is submitted that this implied requirement of treatability fails to accommodate the need for 'asylum'. Some mentally ill patients who are dangerous to themselves or others must simply be institutionalised to avoid harm, notwithstanding that their condition may not be susceptible to treatment. In such cases the rationale for committal is that the person is dangerous to themselves or others and must be removed from society. The criminal justice system is not the appropriate way of dealing with such people, and cannot provide them with the care they need. The U.K Mental Health Act 1983 also fails to accommodate the need for asylum; providing that an application for admission may only be made if the mental disorder is of a nature or degree which makes it appropriate that the person receives treatment in a hospital.[54] The Victorian Mental

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53 At p 223
54 Mental Health Act 1983, s 3(2)(a)

Health Act 1986 contains what are (in the writer's view), more appropriate criteria for committal. Section 8(1) provides:

"A person may be admitted to and detained in a psychiatric inpatient service as an involuntary patient...only if -

(a) the person appears to be mentally ill; and

(b) the person's mental illness requires immediate treatment or care and that treatment or care can be obtained by admission to and detention in a psychiatric inpatient service; and

(c) the person should be admitted and detained.. for that person's health or safety or for the protection of members of the public; and

(d) the person is unable to consent to the necessary treatment or care for the mental illness; and

(e) the person cannot receive adequate treatment or care for the mental illness in a manner less restrictive of [their] freedom..."

It is submitted that the inclusion of the two alternatives - treatment or care is a recognition that in some cases a mentally ill person may have an untreatable condition, but may nonetheless need to be institutionalised. The definition in the New Zealand Act should be amended accordingly.

8. The Victorian Definition - An Improvement on the New Zealand Act?

The Victorian definition has other advantages over the New Zealand definition:

First, its focus is upon mental illness rather than symptoms of mental disorder, and thus it requires certifying doctors to attempt a diagnosis of the condition. The Mental Health Review Board, which performs the vital function of reviewing initial decisions by doctors to commit patients (there is no court hearing), has developed its own guidelines for interpreting s 8. These include ensuring that the symptoms being exhibited by the patient conform to a recognised pattern associated with a mental illness. It is not enough simply to identify disordered symptoms[55] In this regard it is submitted that the U.K Mental Health

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[55] See 'The Process of Civil Commitment under the Mental Health Act 1986', Neil Rees, for a fuller discussion of the Victorian mental health system and the functions of the Mental Health Review Tribunal.

Act also places a more appropriate emphasis on diagnosing the condition rather than simply identifying symptoms. Section 1(2) provides that 'mental disorder' means, inter alia, mental illness. Furthermore, the four conditions justifying compulsory treatment - mental disorder, severe mental impairment, mental impairment and psychopathic disorder are described with a much greater degree of particularity than the definition in the New Zealand Act.

Secondly, the Victorian definition requires certifying doctors to consider whether adequate treatment can be provided on an inpatient basis. Section 28 of the New Zealand Act, which sets out the general considerations to be taken into account in making a compulsory treatment order, makes no reference to the need for adequate resources and treatment in relation to inpatient orders, although it does require that the court satisfy itself in making a community treatment order that adequate and appropriate treatment can be provided.

Thirdly, the Victorian criteria expressly require the decisionmaker to consider whether the person has refused or is unable to consent to the necessary treatment. The New Zealand Act contains no such requirement. It is important that consent to detention or treatment be sought wherever possible, and that an unwilling patient should be actively persuaded to accept treatment on a voluntary basis. The New Zealand Act should require an applicant for a Compulsory Treatment Order to state that he or she has sought the consent of the patient to treatment on a voluntary basis, and there should be a continuing duty on the Responsible Clinician at all three stages of assessment to seek the consent of the patient to voluntary treatment.

II. COMMITTAL UNDER THE MENTAL HEALTH ACT 1969

Under the Mental Health Act 1969 there were four ways in which a person could enter a mental institution: as a voluntary patient under s 16, by way of ordinary admission under s 19, pursuant to a Reception Order by the District Court under s 21, or by the exercise of police powers under s 35.

(1) Voluntary Patients (s 16) - Under s 16 the superintendant of the hospital to which a person had been admitted informally could apply for

a reception order under s 21 either while the person was in hospital or up to 72 hours after their discharge, and could detain the person in hospital until the hearing or apprehend and detain them if they had left hospital.[56]

(2) Ordinary Admissions (s 19) - Where it was in the public interest or in the interests of the welfare of the person, any person could apply to the superintendant of a hospital to have the person admitted. the application had to be accompanied by two medical certificates. Emergency admissions could be carried on one certificate.[57] The superintendant was required to notify the nearest District Court of the patient's admission within 21 days, but until the hearing, was authorised to detain and treat the patient in the hospital. Applications of this kind were normally made by family and friends.[58]

(3) Reception Orders - (s 21) - Anyone could apply directly to the District Court to have a person committed pursuant to an examination by the Judge and two registered medical practitioners and a committal hearing. The application had to be accompanied by at least one medical certificate.[59]

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56 See 'The Process of Committal' at pp 95-99 for a more complete discussion of this procedure. The main reason for committal of voluntary patients under this section was to give hospitals more control over patients who were refusing treatment or behaving aggressively, and to "legalise" the administration of this treatment. For this reason the procedure was used frequently at Canington Hospital after the Oakley Inquiry in 1983 into the death of a patient after ECT treatment.

57 S 19(4) Mental Health Act 1969. Thc criteria for emergency reception under this section were that the Superintendant of the hospital had to be satisfied that to refuse admission would cause hardship to the patient or any other person ind that it was impracticable to obtain a second certificate. In any case a second certificate had to be obtained within 72 hours after admission. There is evidence that this procedure was widely abused; parficularly at Carrington Hospital. See 'The Process of Committal' pp 83-85. Dawson states that the s 19(4) procedure was used in nearly half of all s 19 admissions to Carrington Hospital in 1984, and in 80% of cases where the patient was examined by a police surgeon. The superintendant was required to notify the nearest District Court of the patient's admission within 21 days, but until the hearing, was authorised to give the patient care, treatment, training or occupation in the hospital. Applications of this kind were normally made by family members or friends.

58 'The Process of Committal', p 22

59 S 21(4) of the Mental Health Act. Applications of this kind were usually made by Superintendants, the police and neighbours, and were used more often for male patients than for females. Under s 22 the District Court judge and two medical practitioners had to examine the patient in person.

Judges had the power to summon any witnesses to give evidence as to the mental condition of the person subject to the application, but this was seldom done in practice.[60]

(4) Application by the Police or the Medical Officer of Health (s 35) - this was not in reality a separate committal procedure, but an authorisation for the police or the MOH to apprehend a person found wandering at large, whom he or she reasonably suspected to be mentally disordered, and to apply for their committal under s 21, or if detention or treatment was urgently needed, to take that person to 2 medical practitioners to be certified and admitted to a hospital under s 19.[61]

Any person committed to a hospital could be compulsorily treated under s 22. This included the administration of psychotropic drugs, ECT (Electro Convulsive Therapy) and placing patients in solitary confinement for long periods of time.[62] The reception order continued in force indefinitely until the person was discharged by the superintendant of the hospital.[63] Discharge could only occur in one of three ways:

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[60] Mental Health Act 1969 s 22(3). See 'The Process of Committal' p139. Dawson points out that judges in committal hearings are inordinately deferential to medical opinion, and seldom call for further evidence or cross examination on any of the medical opinions given.

[61] See'Towards Mental Health Law Reform' at pp 49-50. Tbe Taskforce was very critical of the broad police powers under the Mental Health Act, on the basis that police officers are not sufficiently knowledgeable about mental disorder to be arresting people on a "reasonable suspicion" of mental disorder. Tbey stated that the police should only have the power to apprehend people suspected of having committed, or being about to, commit a crime. Section 35 has been re enacted in s 109 of the Mental Health (Compulsory Assessment and Treatment) Act, despite the reservations of the Taskforce.

[62] For concerns about the use of compulsory treatment under the 1969 Act see' Mental Health Law Reform', Dawson at pp 323 & 324; The Process of Committal' Dawson, p 2 and the Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters', pp 96-98; Towards Mental Health Law Reform', ch 15.
In practice some hospitals; notably Kingseat, Carrington, Porirua and Wellington, did seek consent
before administering some types of treatment; particularly ECT.

[63] Mental Health Act 1969, s 28

(1) If the superintendant was satisfied that the person was fit to be discharged[64]

(2) By the patient applying to a District Court Judge for a review of their need for detention[65]

(3) By the patient applying to the High Court for a judicial inquiry into their need for detention [66]

There was no automatic review of the patient's condition,[67] and no legal provision for the patient to be detained anywhere other than a hospital [68] although in recent years Judges have been moulding the provisions of the Act to order community treatment in cases where this has been deemed more appropriate.[69] Reformers of the legislation identified a myriad of problems with the 1969 Act; many of which ire too compendious to be detailed here. In short, the following emerged as the overriding concerns about the current regime; in pressing need of reform:

(1) The power of hospital staff to administer treatment to committed patients without their consent. This was objected to from both a jurisprudential and a practical viewpoint. In ethical terms it was felt that mental patients should not be distinguished from anyone else in terms of their right to refuse consent to treatment - there should not be a presumption that mentally ill people were incompetent to make

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64 Ibid, s 73

65 Ibid, s 73(3)

66 As Dawson points out in 'The Process of Committal' at p 25, judicial review of the patient's condition was essentially a statutory, codification of the common law writ of habeus corpus. However, in practice the review procedure was rarely invoked by patients due to cost and lack of information. It was usually only pursued it at the instance of the District Inspector on behalf of the patient. Two examples of the approach to be taken in s 74 applications are Re B, High Court Auckland Registry, M 2118/90, 23 October 1990 and Re Cameron, High Court Auckland Registry, M 30/89, 19 April 1989.

67 Section 55 made provision for the Superintendant to keep every committed patient's condition under review, and consider as often as possible whether the patient ought to be discharged. This was to be done at least yearly in the first two years but was seldom complied with.

68 For a discussion of this problem see 'Community Treatment Orders', Dawson, p 415 and 'Towards Mental Health Law Reform', p 45

69 Supra (Dawson) pp 416-417. The practice of discharging committed patients into the community "on leave", while subject to compulsory treatment was probably ultra vires the Act. Section 25 only authorised hospital staff to treat committed patients in hospital, not in the community.

choices about treatment [70] or that their right to consent was abrogated upon being committed. In practical terms it was felt that certain types of treatment which had serious or irreversible side effects were being adminstered to patients without their consent and without them being informed about the risks.[71]

(2) That it was too easy to get a person committed under the Act - there were insufficient safeguards in the system.
There were a number of concerns here: the inadequacy of medical certificates required for committal,[72] the inadequate definition of mental disorder,[73] the overuse of the emergency procedure under s 19, the wide police powers under s 35, and the cursory and superficial nature of the hearing itself - patients were seldom present at hearings to present their case, and therefore committal was usually ordered on the basis of the two certificates from medical practitioners required to have be produced to the Judge, rather than pursuant to the exercise of any independent judgment by the Judge. Hearings often took place on hospital premises with only the Judge and the psychiatrist present.[74] There was one instance in which the person being committed could not speak English and no interpreter was provided.[75]

(3) No specific provision in the Act for community treatment.
It was felt that the committal regime in the Act had failed to keep pace with clinical developments in the psychiatric field, in particular the

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70 'Towards Mental Health Law Reform', p 231. See also s 5 of the Protection of Personal and Property Rights Act 1988 which provides a presumption of competence, and s 22 of the Bill of Rights Act 1990 which provides for a right to refuse medical treatment.

71 Supra n 33

72 For a very comprehensive outline of the certification process and its inadequacies see 'The Process of Committal', ch 9. Some of the problems were: the certifying doctor never having met the patient previously in about 38% of cases observed by Dawson in 1984, inadequate length of examination (51% were less than 30 minutes), inadequate examination facilities, lack of psychiatric experience of certifying doctors, poor quality and legibility of information in certificates, frequent use of second or third hand hearsay, unclear diagnoses, and lack of involvement of family doctors.

73 Supra n 22

74 See 'The Process of Committal', ch 11 for a discussion of the inadequacies of committal hearings and their failure to comply with Natural Justice.

75 See 'The Process of Committal' (abridged version) in 'Mental Health: A Case for Reform' at p 40

presumption in favour of the "least restrictive treatment altemative",[76] and the move towards community care for the mentally ill both in New Zealand and overseas.[77]

(4) Inadequate appeal and review procedures for committed patients. The main concern here was the lack of effective periodic review of a committed patient's condition (particularly in light of the indefinite life of reception orders) [78] by a multidisciplinary tribunal,[79] and the practical difficulties associated with bringing civil and criminal actions against officials for breach of the Act, such as lack of legal representation,[80] a 6 month limitation period during which leave to bring an action could be sought,[81] and protection from civil and criminal responsibility for persons acting in good faith under the Act.[82] It was felt that there was a need for a multi disciplinary review body along the lines of the Mental Health Review Tribunal in the U.K, to reflect the eclectic nature of the committal decision.[83]

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[76] The Least Restrictive Alternative principle had its genesis in the United States, where it has been adopted by numerous state jurisdictions in their mental health legislation (Cahfomia and new York for example). It may also have the status of an independent doctrine under the U.S Constitution, which requires that states adopt means to accomplish any legitimate purpose which are least restrictive of fundamental rights. The principle has also been adopted in some Canadian jurisdictions (notably Ontario and Saskatchewan) and more recently, by New South Wales and Victoria.

[77] See 'Towards Mental Health Law Reform', pp 109-115, 'Community Treatment Orders', J Dawson, and 'The Future of Community Care", an article by Helen Clark in the Dominion, 2 August 1989.

[78] Mental Health Act, s 28. See also The Process of Committal', pp 15 and 168.

[79] Many overseas jurisdictions (most notably the U.K and some Australian jurisdictions) have established such tribunals to adjudicate on the status of mental patients. In this respect, New Zealand was lagging behind the rest of the Commonwealth.

[80] Under the Mental Health Act there was no right to legal representation and thus it was seldom obtained by patients. See 'The Process of Committal', pp 116-117. Of the cases recorded by Dawson in 1984, the rate of legal representation at committal hearings was 1.6% (3.6%) at Carrington.

[81] Mental Health Act s 124(4). See 'Mental Health Law Reform' at p 324. The Health Department (in its submission to select committee) recommended repeal of this provision.

[82] Ibid, s 124

[83] See 'Towards Mental Health Law Reform', ch 19. The Taskforce identified the following inadequacies in the current review structure: in s 22 reviews by District Court judges, the application for committal is simply 'rubberstamped" by the judge without legal representation for the patient. In s 55 reviews of committed patients by the medical superintendant the superintendant or officer delegated the review function has no guidelines as to the procedures to be followed, and practices may differ

(5) Lack of ongoing care and supervision of committed patients. There was seen to be a lack of superintendence over committed patients by suitably qualified, fulltime personnel. While District Inspectors and Visitors were able to perform this function to a limited extent, there was seen to be a need for more comprehensive supervision and management of a patient's detention and treatment [84]

(6) Patient Rights. There was a serious concern that the rights of committed patients were, being eroded by the compulsory treatment regime under the Act. In addition to the denial of the right to refuse consent to treatment,[85] patients were having personal property, drivers licence and mail confiscated, and being denied access to visitors.[86] There was seen to be a need for a comprehensive charter of patient rights; enforceable at the suit of any committed patient [87]

The merits of the new regime must be assessed in light of these considerations.

III.COMPULSORY TREATMENT ORDERS - THE ASSESSMENT PROCESS

Tne new system of Compulsory Assessment and Treatment Orders is a much more protracted process than under the Mental Health Act. It has been divided into three distinct stages of assessment taking a minimum

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considerably depending on how well staffed and funded the institution is. Furthermore, the person carrying out the review is the very person who made the decision to admit the patient for compulsory treatment. Inquiries may be carried out by District Inspectors under s 58 but the District Inspector has no power do anything other than make recommendations in a report to the Director.

[84] See comments of Katherine O'Regan, Third Reading of the Bill, NZ Parliamentary Debates, 2 June 1992 at p 8456 and Helen Clark at p 8458.

[85] For a very comprehensive discussion of the jurisprudential objections to compulsory treatment see 'Towards Mental Health Law Reform', ch 15.

[86] Up until the Protection of Personal and Property Rights Act was passed in 1988 (repealing Part 7 of the Mental Health Act) the property of committed patients automatically vested in the Public or the Maori Trustee and patients had no control over their money or possessions whatsoever. See 'Towards Mental Health Law Reform', ch 16 for concerns about the lack of inpatient rights. The Taskforce was particularly concerned about access to the courts and to information about the patients' conditions, the use of seclusion and restraints such as straightjackets, and the use of patient labour in institutions.

[87] 'Towards Mental Health Law Reform', p 251

of 21 days before a Compulsory Treatment Order can be made, and is designed to protect the rights of persons alleged to be mentally disordered and to ensure that they are not made subject to the Act without a sufficiently rigorous assessment.[88] The process approach will also help to ensure that persons who should be subject to a CTO do not "slip through the cracks", because the assessment was not long or thorough enough to detect signs of mental disorder [89]. The process is as follows:

(1) Application for Assessment (s 8) - Any person over the age of 18 may apply to the Director of Area Mental Health Services for assessment of another person whom the applicant believes to be mentally disordered. The application must be in writing and accompanied by a medical certificate stating that the examining practitioner believes the person to be mentally disordered.

The Director must then arrange for an examination to be conducted[90] and appoint an assessing practitioner to conduct the assessment [91]

(2) Preliminary Assessment (s 9) - The Director must notify the patient of the time and place of the examination and conduct the examination. The assessing practitioner must then decide whether there are reasonable grounds for believing that the patient is mentally disorded and should undergo further assessment. He must record his findings in a certificate of preliminary assessment to be sent to the patient and a number of other people,[92] and send full particulars of the decision to the Director of Area Mental Health Services.

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88 See comments of Helen Clark during the Second Reading of the Bill, 12 March 1992, NZ Parliamentary Debates at p 6865: "It seems to me... that [the Bill) may provide a better and more thorough process than we have at present". See also 'Towards Mental Health Law Reform' at pp 56-57, in which the Taskforce advocates the "process" approach to committal.

89 See comments of Helen Clark during the Third Reading of the Bill at p 8457: "In some ways the old committal process was far too quick but it also had the disadvantage that some people could slip through the cracks completely and not be committed when they should have been."

90 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 9

91 Ibid, s 9(3)

92 Certificates at all three stages of the process must be sent to the applicant, the patient, any welfare guardian of the patient, the patient's principal caregiver and the medical practitioner who usually attends the patient. At the stages of further assessment the certificates must be sent to the District Inspector or Official Visitor (see ss 10, 12 & 14)

(3) Further Assessment for 5 Days - If the medical practitioner's finding is that there are reasonable grounds for believing the patient to be mentally disordered, the responsible clinician appointed under s 7 must conduct a further assessment for 5 days and then record his findings in a certificate of further assessment.[93] At this stage the District Inspector in receipt of the certificate is under a duty to consider whether there should be a review of the patient's condition by a District Court Judge under s 16 [94]

(4) Final Assessment for 14 Days - If the RC again finds evidence of mental disorder he or she must conduct a final 14 day assessment and record these findings in a certificate. If after the 14 days he or she still considers that there is convincing evidence of mental disorder he or she may apply to the Family Court for the making of a **compulsory treatment order** in respect of the patient.[95] Once again the District Inspector must consider at this stage whether to apply for review of the patient's condition.[96] The Family Court may make one of two kinds of Compulsory Treatment Order in respect of the patient in question; an **inpatient order** [97] or a **community treatment order.**[98] There are a number of potential problems with the new assessment process:

1. The Role of the Responsible Clinician

First, the Director of Mental Health has been charged with appointing a 'Responsible Clinician' ("RC") under s 7, to oversee every patient being assessed or treated under the Act. This person need not be a qualified psychiatrist; they can be some other kind of registered health professional who, in the opinion of the Director, is suitably qualified in the assessment, care and treatment of persons with mental disorder. In the writer's view the need for a clear and unambiguous criteria for compulsory treatment necessitates either a much clearer statutory definition than the Act contains at present, or a high degree of control by the psychiatric profession over the assessment of mentally disordered

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[93] The Act, s 12
[94] Ibid, ss 9 & 10
[95] Ibid, s 14(4)
[96] Ibid, s 14(6)
[97] Ibid, ss 28 and 30
[98] Ibid, ss 28 and 29

persons under the Act; whereby certain recognised standards are applied to determine whether a person is mentally disordered, rather than having different occupational groups with different standards assessing persons for mental disorder. Opening the process up to professions such as social workers and counsellors could result in a loss of specialist knowledge and expertise, and a deterioration in the quality of assessment and treatment of the mentally ill.[99]

Secondly, although it is clear that a policy decision has been made to widen the range of professions able to participate in the treatment of the mentally disordered under the Act,[100] doubts must arise as to whether RCs should conduct assessments singlehandedly, and whether this provides a sufficient safeguard against wrong diagnoses or mistaken interpretation of symptoms. RCs will be required to apply the behavioural criteria of dangerousness or inability to look after oneself in determining whether a person is mentally disordered, and to make predictions about the patient's behaviour in the community accordingly. This would seem to require more than simply the opinion of one person, and thus it is submitted that additional psychiatrists and the patient's family or caregiver should be involved in the assessment process to a greater degree.

The ability of psychiatrists to make decisions on mental disorder has led to litigation in the United States, where the courts have held psychiatrists civilly liable when patients have been released and have subsequently harmed others.[101] The RC should be obliged to consult families and caregivers prior to and during assessment.

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[99] See Towards Mental Health Law Reform at pp 46-48. The Taskforce recommended that a special register of qualified mental health professionals be set up to carry out the assessment process. These professionals would not necessarily need to hold a psychiatric qualification, but would require a relevant mental health qualification.

In a recent unpublished article by Sylvia Bell, Legal Officer for the Mental Health Foundation (unable to be cited here) the comment is made that similar changes to both the definition of mental disorder and the persons responsible for treatment in other jurisdictions have met with considerable opposition from psychiatrists who see the changes as eroding their traditional therapeutic role.

[100] See comments of Helen Clark during the Third Reading of the Bill, 2 June 1992, NZ Parliamentary Debates at p 8458: "the issue was to break the absolute dominance of psychiatry as the lead profession in the care and supervision of this particular category of mental health patients"

[101] See for example Semler v Psychiatric Institute of Washington DC 538 F 2d 121 (1976) and Durflinger v Artiles 673 P 2d 86 (Kan 1983)

2. The Role of the Mental Health Review Tribunal

The Act sets up a new multidisciplinary body to determine appeals relating to the condition of patients subject to Compulsory Treatment Orders - the Mental Health Review Tribunal.[102]
However, there is no right of appeal to this body during the assessment process; only a right of review by a District Court Judge. In view of the perceived inadequacies of the court structure in making responsible committal decisions, the Act should provide for a right to review by the Tribunal in the later stages of assessment. There is no sensible reason to permit the Tribunal to assess a patient's condition after they have been committed,[103] but not at the assessment stage. The Tribunal is likely to develop and exhibit more expertise in dealing with the idiosyncratic problems associated with mental health care than a District or Family Court Judge who has to deal with a myriad of different issues daily.

3. The District Inspector

The inclusion of the District Inspector at the assessment stage is important. He will be required to discuss with the patient being assessed whether to apply for review, and thus he or she will be acting explicitly as an advocate for the patient prior to the patient being committed. Under the 1969 Act the involvement of District Inspectors was limited to patients who had already been hospitalised or committed.[104] However while it is important that there be an advocacy service for patients at both the pre and post committal stages it is questionable whether District Inspectors are adequately resourced to effectively fulfill this function. They may not have the training or expertise in mental health law and practice, and may not be able to devote the time and energy required to the needs of individual patients.[105] With the restructuring of the health system into health districts, District Inspectors may have to cover a wide area and a number of different hospitals. In these circumstances they

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102 Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 101-108. See also ss 79-83 for an outline of the review functions of the tribunal.
103 Ibid, s 79
104 See Mental Health Act ss 56-65
105 The Oakley Committee of Inquiry made the following comment about District Inspectors, at para 17.11 of their report: "there are limits to the impositions of time which can be placed on busy professional people; especially in a task such as this which is not adequately remunerated and which involves considerable burdens"

cannot be expected to provide a comprehensive advocacy service for each patient. They now have a plethora of different functions under the Act, including acting in review proceedings[106] and Mental Health Review Tribunal Proceedings[107] and investigating breaches of patient rights under the Act,[108] in addition to their traditional function of visiting hospitals within their designated areas and investigating breaches of the Act.[109]

The advocacy "hat" seems to have placed rather uncomfortably on District Inspectors in substitution a fulltime advocacy service and legal representation as of right as recommended by the Taskforce.[110] The appeal and review procedures may be rendered ineffective in safeguarding the rights of patients if adequate personal representation is not guaranteed under the Act. Ideally legal counsel should be appointed by the Director at the stage when the decision to assess the patient is made. Neither the District Inspector nor the patient's family can really perform this function adequately.

4. Compulsory Treatment During Assessment

Perhaps the most serious criticism of the assessment regime from a civil rights perspective is that it enables patients to be compulsorily treated during the period of assessment as if they were a committed patient,[111] whereas patients subjects to CTOs have the right to refuse treatment.[112] This is particularly anomalous in that it effectively presumes that the a patient is mentally disordered and requires treatment, without them ever having appeared before a Judge. It also places the patient who is mentally disordered and subject to a CTO in a better position than a patient being assessed for mental disorder. There are some advantages in being able to treat patients during the assessment period; for instance, response to treatment may provide a better indication to the psychiatrist of what the condition is. However, it is submitted that the clinical advantages are outweighed by the jurisprudential objections to such a

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106 The Act, s 14(6)
107 Ibid, s 79(12)
108 Ibid, s 75
109 Ibid, ss 95 and 96
110 See 'Towards Mental Health Law Reform', chs 17 & 20.
111 The Act, s 58
112 Ibid, s 59. This is subject to a number of qualifications which are discussed below.

practice - it effectively constitutes a return to s 19 admissions under the old Act by which patients could be compulsorily treated before committal.

The provision for compulsory treatment during the assessment process may be justified by the fact that the process leading up to committal is now much more protracted, and there is no provision for fast tracking the procedure in emergency situations where the patient may present an obvious threat to him or herself or others, and requires immediate treatment. However it is submitted that the solution to this is to provide for the procedure to be truncated in emergency situations, so that the patient's legal status can be determined as quickly as possible and compulsory treatment can then (if necessary) be administered, rather than enabling compulsory treatment to be given to a person who technically has the same rights as a person of sound mind. While it is acknowledged that certain powers (such as the power to detain)[113] may need to be conferred on assessing practitioners to enable them to conduct a proper assessment under the Act, this justification cannot be extended to compulsory treatment of people who are undergoing assessment.

5. Overview of the New Assessment System

The strength of the 3 stage system is that it enables the patient's condition to be assessed with a much greater degree of accuracy; effectively dividing the crucial decision about mental disorder into three parts and giving the RC an opportunity to at three different stages to rethink his decision, and to re apply the statutory criteria. This can only result in greater fairness for the patient, and increased public confidence in a responsible committal regime. However, the process caters very much for marginal cases in which it is difficult to detemine whether mental disorder is present. One may inquire whether the period of assessment needs to be so prolonged;[114] at least in relatively clearcut

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113 Ibid, s 110. The medical practitioner carrying out an urgent assessment may call to his or her assistance a member of the police, who may detain the person on their premises to enable an assessment to be carried out, or escort them to some other place nominated by the practitioner for an assessment

114 Where the responsible clinician has applied for a CTO under s 14 , the period of further asssessment and treatment can be extended for up to 14 days pending determination of the application (s 15(2)), thus introducing more delay into the process.

cases of mental disorder, and whether the "staggered" assessment process may be an overreaction to the problem of wrongful committal.[115]

Admittedly the fact of a person's mental disorder is not a matter upon which any person can be expected to adjudicate instantly, as effectively occurred under the previous legislation, but with the additional safeguards that have been provided for in the Act, such as a stricter definition of mental disorder, better rights of appeal and review for the patient, and judicial hearings in accordance with the principles of Natural Justice, patients who feel they have been the victims of injustice have sufficient avenues of redress.[116]

The practical effect of the 3 stage approach may be that patients who are clearly mentally disordered and in need of treatment cannot be quickly dealt with under the Act - they could apply for judicial review [117] to forestall the making of a compulsory treatment order. Furthermore, it subjects patients to a long period of uncertainty, during which they have little or no control over his freedom or treatment - many may perceive this as a greater imposition than a relatively speedy process with adequate safeguards to ensure that decisions on mental disorder are not arbitrarily made. The U.K Mental Health Act provides that a person may be admitted to hospital either for assessment or for treatment.[118] The criteria for mental disorder are stricter in the case of admissions for treatment and thus provide a sufficient safeguard against wrongful committal.

A better solution may be to have an initial 5 day assessment carried out by two psychiatrists or suitably qualified persons, and enable them to apply for a CTO at this stage if they consider that the person is mentally

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115 In this regard, see the comments of the Taskforce, 'Towards Mental Health Law Reform' at p 55:
"We wish to state at the outset that we do not believe that the powers under the Mental Health Act to commit persons to psychiatric hospitals in New Zealand are being significantly abused...[f]amilies and members of the community more commonly complain that psychiatric hospitals deny admission too frequently and discharge patients too soon"

116 Note that the procedure is considerably more complex than that recommended by the Taskforce in its report. See'Towards Mental Health Law Reform', p 57. The recommendation was that there should be an initial committal on medical certificates, reviewable by the Mental Health Review Tribunal within 21 days to prevent lapse. This is not equivalent to a 21 day period of assessment.

117 Under s 16 of the Act.

118 Applications for admission for assessment are made under s 2, and for treatment under s 3.

disordered. Another option would be to adopt the process in the Victorian Mental Health Act 1986 in which there is no period of assessment, but the patient is certified by a legally qualified medical practitioner, examined by a psychiatrist on admission to hospital and then examined automatically by the Mental Health Review Board of they do not apply for review of their condition.[119] Only if they are unsure as to whether the person is mentally disordered should further periods of assessment be necessary.

IV. COMPULSORY TREATMENT ORDERS - THE HEARING

The new hearing procedures should be assessed in light of the degree to which they comply with the requirements of Natural Justice, and whether the Courts are the appropriate fora for making decisions on mental disorder.

1. Certification

The major change from the previous Act is that instead of two certificates by different medical practitioners being required, the committal hearing can proceed on the basis of only one 'certificate of final assessment' prepared by the RC assessing the patient.
The advantage of this is that certification can no longer be performed by a general medical practitoner - the RC is required to have relevant qualifications in mental health care, and thus the danger of lack of expertise is reduced. Furthermore, the problems associated with cursory and superficial examinations will disappear - the assessment process must take 21 days at least.
However, the concern about inadequate information on certificates remains. The only information required to be recorded in the certificate is the RC's finding of mental disorder and the legal consequences of that finding. The RC must send full particulars of his decision to the Director of Area Mental Health Services, but does not have to send full particulars to the patient or the court. Section 14 should require the RC to record full particulars of the decision (including a diagnosis) in the

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[119] See 'The Process of Civil Commitment under the Mental Health Act 1986', Neil Rees, for an outline of the Victorian legislation.

certificate, and to put this before the court. An actual form prescribed by the Act may assist the practitioner in performing his functions adequately.

The other problem with having only one certificate is that there is no requirement for a second opinion as to whether the person is mentally disordered as there was under the 1969 Act.[120]

The medical certificate accompanying the application (required by s 8) must state full particulars of the reasons the person is believed to be mentally disordered, but there is no requirement that the responsible clinician's final decision be checked by an independent practitioner. Unless the Family Court exercises its powers to order independent reports and call witnesses to attest to the mental condition of the patient, there will only be one medical viewpoint being presented at the hearing. Given the disagreement within the psychiatric profession relating to the diagnosis of certain conditions, it is submitted that where the RC's final recommendation is that the person is mentally disordered, he or she should be obliged to obtain a second opinion from a suitably qualified practitioner.

2. Family Court Jurisdiction

A major change under the new Act is that applications for CTOs are to be heard wherever practicable by a Family Court Judge.[121] This is a little disappointing in that the establishment of a new, multi discliplinary review tribunal could have enabled committal jurisdiction to be removed from the courts and conferred on the Mental Health Review Tribunal, with a right of appeal to the District Court. However, there are clearly a number of advantages in having committal decisions made by the Family Court rather than the District Court:

First, the Family Court deals to a greater degree than the District Court with delicate family situations and severely emotionally distressed people, and thus is likely to demonstrate more sensitivity and understanding towards mentally disordered persons than the District Court.

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120 Mental Health Act ss 19 and 21

121 The Act, s 17

These qualities will be particularly important in the context of the examination of and interview with the patient required to be carried out by the Judge under s 18 prior to the hearing.

Secondly, the rules of procedure and evidence in the Family Court are more relaxed; counsel are usually seated, and there is more scope for the Judge to inquire into matters of his own motion, rather than relying on counsel to adduce evidence.This is particularly important in the mental health context where legal counsel will not always be present, and relevant information about the patient's condition may not automatically be put before the court by the applicant or the responsible clinician. The committal procedure is widely perceived as adversarial, with the Judge and the doctor pitted against the patient.[122] The ability of the Judge to ask questions, commission independent reports on the patient's condition[123], and call for further evidence[124] and witnesses[125] will minimise the adversarial nature of the proceedings.

At the examination stage there is the additional safeguard that the Judge can discharge the patient if he or she considers that they are fit to be released from compulsory status.[126] This will ensure that the time and resources of the court and the responsible clinician are not wasted with a pointless hearing that will not result in a CTO being made, and that the patient is not subjected needlessly to the trauma of a hearing. However, it is submitted that the Judge at the examination should be under a duty to consult with the patient's usual doctor and his principal caregiver. Although he or she must consult with the Responsible Clinician and at least one other health professional involved in the case[127] it is crucial that persons familiar with the history and behaviour of the patient be consulted at this stage.

3. Natural Justice

The Mental Health Taskforce considered that it was vital that hearings should comply with the rules of Natural Justice. The most important requirement in this regard is that the patient should be present and have

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122 'The Process of Committal', Dawson.
123 Ibid, s 21
124 Ibid, s 22
125 Ibid, s 23
126 Ibid, s 17(5)
127 Ibid, s 18(4)

the right to be heard.[128] Patients are given this basic right under s 19, subject to a number of qualifications; namely that it would be in the patient's best interests not to be present,[129] that he wholly lacks the capacity to understand the nature of the proceedings[130], that being present would cause him severe physical, mental or emotional harm,[131] or that he would cause such a disruption that it would be impractical to continue with the proceedings.[132] The issue is whether these qualifications amount to a wholesale abrogation of the patient's right to a hearing held in accordance with Natural Justice.

It is submitted that provided the patient's views are obtained at some stage prior to committal, and that he has the opportunity to rebut any evidence adverse to his cause, the requirements of Natural Justice are fulfilled.[133] This does not necessarily entail that the patient is present at the hearing. Indeed, some qualifications to this right are both necessary and desirable, and do not amount to a breach of Natural Justice. They are necessary and desirable because a hearing cannot be successfully conducted, and justice delivered to the patient, in a situation where his presence is deletarious to proper resolution of the issues (he or she is disrupting the court or exhibiting great distress).

Similarly, the patient's own interests are not served by allowing him or her to be present at a hearing that may traumatise him or her, or worsen his condition, such that he is displaying more abnormal symptoms than usual, and thus is more likely to be committed. They do not constitute a breach of Natural Justice if the patient has already had the opportunity to put forward his view during the examination and interview by the Judge, and to convince the Judge that he or she does not require compulsory treatment.

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128 See 'Mental Health Law Reform', Dawson, p 325 and 'The Process of Committal', Dawson, pp 139-143. See also 'Towards Mental Health Law Reform', pp 327-328. The Taskforce states that this should include the right not to be overly sedated at the hearing, and the court being informed if the patient has been sedated.

129 The Act, s 19(1)(a)

130 Ibid, s 19(2)

131 Ibid

132 Ibid, s 19(3)

133 See 'The Process of Committal', Dawson, in 'Mental Health: A Case for Reform' at p 41-42 for an outline of the deficiencies of hearings: patients frequently receive no notice of them, and are not informed as to what the hearing is for. The word "committal" is never used by judges. Most patients are excluded from seeing or commenting on the medical evidence in favour of committal. No witnesses appear on the patient's behalf.

However, it is important that Judges take the patient interviews seriously, and do not regard them simply as a procedural formality that must be complied with for the hearing to proceed.

It is encouraging to note that the new Act particularises the matters a Judge must discuss with the patient during the interview. This will avoid the situation alluded to by Dawson, in which the patient interview simply consists of the Judge assuring the patient of the hospital's goodwill, and exhorting him or her to take the required medication.[134] It is acknowledged that there may be situations in which a thoughtless exercise of the discretion to exclude may amount to a breach of Natural Justice. Two such situations are where the Judge who examined the patient is not the Judge conducting the hearing[135] and where there are specific allegations made about the patient during the hearing which were not disclosed in any of the certificates of assessment, which he or she has not had the opportunity to rebut.[136]

In such situations the Judge should either enable the patient to be present at the hearing, hold another conference with the patient or accept an affidavit from the patient deposing against the various allegations made.

The duty of the responsible clinician to notify all persons specified in s 14 of the legal consequences of the final assessment is a step forward, but there should also be specific notification of the hearing date, so that the patient and his family or caregiver know when the hearing is on.[137]

The increase in the inquisitorial powers of the court in committal hearings will enable it to exercise a greater degree of independent judgment about whether mental disorder is present, rather than simply "rubberstamping" applications.[138] It is particularly important that if the court commissions a report on the patient's condition, this will now be paid for out of the public purse.[139] It is to be hoped that the court will

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134 Ibid, p 42

135 Section 18(6) provides that hearings shall, wherever possible, be conducted by the judge who examined the patient, but there is nothing to ensure that this occurs.

136 It is likely that the medical evidence against the patient will consist primarily of the certifiates of assessment, which the patient will already have seen, but new evidence could be admitted pursuant to the court's power under s 22 to receive any evidence it thinks fit, whether medical or otherwise.

137 Supra n 98 at p 41. Dawson states that many patients under the old Act did not know when the committal hearing was, or were informed immediately before the hearing.

138 See 'The Process of Committal', pp 124-126.

139 The Act, s 21

exercise its power to call further witnesses[140] in favour of a patient where it is evident that the patient is not being adequately represented. There should be a duty on the court to call further witnesses or call for a report if it considers that the information before it is inadequate.

Although the requirements of Natural Justice are much more likely to be observed under the new Act, there are a number of respects in which the new procedure fails to comply. The most obvious of these is the absence of an automatic right to legal representation during committal hearings - there is merely a right to seek representation under s 70. The absence of legal representation will entail that psychiatrists or doctors presenting evidence will not be crass examined or challenged in any way on that evidence and thus the court is more likely to accept it without demur. Furthermore, although the District Inspector is entitled to be present at the hearing,[141] and must discuss with the patient whether the Inspector should appear at the hearing[142] there is nothing requiring him or her to be present. Thus, the Act allows for the possibility not only that the patient may be unrepresented at the committal hearing,[143] but that there may be no witnesses called on his behalf.[144] Automatic legal representation is more likely to ensure that a more balanced view is presented to the court and that, wherever possible, witnesses in favour of the patient are called to present evidence.

Secondly, the Act continues to allow for hearings to be held informally on hospital premises.

These will occur where the patient has been transferred to a hospital during the assessment process.[145] There is an argument in favour of greater formality in committal hearings, to ensure that procedural justice is complied with. As Dawson points out, hospital hearings are dominated by the environment in which they are held; often Judges sit opposite patients in cramped side rooms of hospital wards, and there is no stenographer to take a transcript of the proceedings.

Witnesses are not sworn in nor subject to rigorous questioning, and doctors presenting medical evidence are often only seen "on the run"

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[140] Ibid, s 28(4)

[141] Ibid, s 19(6) - any person to whom a certificate of final assessment has been sent is entitled to be present at the hearing.

[142] Ibid, s 14(6).

[143] For a more extensive discussion of this problem, see p 44 below.

[144] Supra n 98, p 41: "With rare exceptions no witnesses appear on patients' behalf. Family members who attend usually favour committal"

[145] Under s 11 or s 13

between patients.[146] These hazards make hospital hearings highly unsatisfactory, and therefore it is submitted that hearings should be held, wherever practicable, in courtrooms.

Thirdly, the Act does not specifically require all information adverse to the patient's interests to be disclosed to the patient or his representative prior to the hearing.[147] It is important that patients should not be required to assimilate and respond to complex medical evidence on the actual day of the hearing, and the requirement is crucial in situations where the patient is not present at the hearing.

4. Criteria for a Compulsory Treatment Order

Section 27 of the Act sets out the criteria guiding the court's jurisdiction to grant a Compulsory Treatment Order. The Court must not only be satisfied that the person is "mentally disordered",[148] but that in all the circumstances of the case it is necessary to make a Compulsory Treatment Order. The factors relevant to the exercise of this discretion will be whether the patient's condition can be treated, whether the treatment provided is likely to be adequate, and whether it could be administered on a voluntary basis. The patient's social circumstances will be important, and in the case of inpatient orders, the ability of the hospital to care for and treat the patient in question.

Although courts will undoubtedly have regard to these factors, and it is desirable that they be imbued with some discretion as to the relevant circumstances, there should nevertheless be greater specificity in s 27 as to the "circumstances" which may be relevant to the exercise of the discretion, so that the potential for arbitrariness is diminished, and a consistent jurisprudence for committal is able to develop. For instance, the requirement that it be necessary for a CTO to be made should refer specifically to a duty on the court to satisfy itself that treatment could not be administered on a voluntary basis. The Victorian Mental Health Act 1986 specifically provides as one of the criteria for committal that the person has refused or is unable to consent to the treatment,[149] and in

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146 'The Civil Committal Process', John Dawson, in 'Mental Health: A Case for Reform', Legal Research Foundation Seminar, pp 41-42.

147 See 'Towards Mental Health Law Reform, p 325. The Taskforce states that generally, information should only be withheld for exceptional reasons (for example, harm to the patient)

148 See discussion in Part 1 as to the definition of 'mental disorder'

149 Section 8.

California a person cannot have a petition filed against him unless he has refused voluntarily to undergo evaluation.[150]

Secondly, in considering whether to grant a Community Treatment Order[151] a Judge must have regard to whether adequate care and treatment can be provided on an outpatient basis.[152] This is important - many commentators have expressed concerns about "deinstitutionalisation" on the grounds that there are insufficient resources in the community to ensure that treatment can be effectively carried out.[153] There is no such caveat attached to inpatient orders. It cannot safely be assumed that inpatient resources are any more adequate than community resources. Indeed the cynic's view would be that the lack of inpatient resources is the real impetus behind the pressure in recent years for community mental health care. The Act should require the court to consider whether treatment or care in the designated institution would be appropriate to the patient's needs.

Section 28(2) provides a statutory presumption in favour of Community Treatment Orders, unless the person cannot adequately be treated as an outpatient. This presumption is also reflected in the fact that where an inpatient order has been made the responsible clinician can change it to a community treatment order automatically,[154] whereas in the case of a community treatment order, the patient must undergo reassessment and rehearing before an inpatient order can be made in respect of him.[155] There would seem little point in subjecting the patient to reassessment before an inpatient order is made - he has already been found to be mentally disordered, and the assessment process does not deal with the type of order that should be made.

Nevertheless, it is a welcome change from the previous legislation, in which the definition of mentally disorder effectively created a presumption against outpatient treatment - indeed there was no provision

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150 See discussion in 'Mental Health Law: Major Issues', Wexler, p 78

151 Under s 29

152 The Act, s 28

153 See for example 'Community Treatment Orders', Dawson, p 412 and 420: "the Bill is not a funding statute and will not ensure that one extra dollar is channelled into community mental healh services"; 'The Future in Community Care', feature article by Helen Clark in the Dominion, 2 August 1989; comments of Helen Clark during the Second Reading of the Bill, 12 March 1992, NZ Parliamentary Debates; 'The Mental Health (Compulsory Assessment and Treatment) Act 1992', Sylvia Bell (Mental Health Foundation).

154 The Act, s 30

155 Ibid, s 29

for it whatsover in the Act. The provision amounts to a codification of the principle that any intervention with the rights of the mentally ill should be pursuant to the *least restrictive alternative* available to that person.[156] However as Dawson points out the jurisdiction to make Community Treatment Orders must be exercised with care; bearing in mind the need to ensure the safety of the community.[157]

The fact that the Act does not address funding for community treatment is a deficiency in the writer's view; experience in the U.K has shown that the notions of community care and "revolving door policies" have not been met by increased provision of residential accommodation, hostels, trained social workers, community nurses or community care teams.[158] However, perhaps a note of optimism should be sounded in the New Zealand context - the combination of an open market for health provision and a presumption in favour of community treatment may evoke a positive response in the market for mental health care; private half way houses and psychiatric nurses may be a reality in the future.

5. Discharge from a Compulsory Treatment Order

There are a number of ways in which a patient subject to a CTO can be discharged:

(1) By automatic expiry of the CTO after six months.[159]

The order may be renewed by the responsible clinician if he or she conducts a clinical review under 76, and then applies to the court for extension of the order for another six months.

The court must conduct a further hearing in accordance with ss 17 to 33.[160]

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156 Supra n 45.

157 See 'Community Treatment Orders', pp 423-424. Dawson points out that New Zealand should draw on the experience of other jurisdictions such as North Carolina, Arizona and Hawaii in the United States which have had community treatment regimes in place for years in determining the clinical indicators for the use of community treatment in individual cases. See also 'Patient Rights and Public Hazard', Joseph Kirby at p 42 for some of the problems associated with community treatment orders in Victoria (enormous labour input involved in getting patients to accept medication, and lack of funding) Some community treatment orders have failed, and the police have become involved in restraining the patients.

158 See 'The Recent Mental Health Act in the U.K', Blugrass, in Psychiatry, Human Rights and the Law, Roth and Blugrass (eds), 21; 27.

159 The Act, s 33

160 Ibid, s 34

(2) By release from compulsory status by the responsible clinician.[161]

If the responsible clinician considers at any time that the patient should no longer be subject to compulsory treatment, he or she is obliged to direct that the patient be released.

Similarly, if following a six monthly clinical review the responsible clinican considers that the patient is fit to be released he or she must order release of the patient.[162]

(3) By order of the Mental Health Review Tribunal.[163]

The Tribunal may at any time, either of its own motion or pursuant to an application by any person to whom the certificate of clinical review has been sent, review the condition of any committed patient and discharge them if it thinks fit.[164]

(4) By order of the District Court or the High Court.

The patient may be discharged pursuant to an appeal to the District Court from a decision of the Mental Health Review Tribunal,[165] or an inquiry by a High Court Judge at any time.[166]

This is a vast improvement on the previous Act, in which committal orders were indefinite and the only means of discharge were by the superintendant,[167] or by review by a District Court[168] or a High Court Judge.[169]

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161 Ibid, s 35
162 Ibid, s 76(5)
163 Ibid, s 79
164 Ibid, s 79(8)
165 Ibid, s 83
166 Ibid, s 84
167 Under s 55 of the Mental Health Act 1969 the superintendant was under a duty to review every committed patient "as often as practicable" and under s 73, was required to discharge a patient when he was fit to be discharged. See 'Towards Mental Health Law Reform' pp 310-311 for a discussion of the inadequacies of this duty - there were no guidelines regulating how the review was to be conducted, and no duty to actually examine the patient. Review frequently did not occur due to staffing shortages.
168 Mental Health Act, s 73. This remedy required a petition to the Minister of Health, who could then decide (in his or her discretion) whether to permit an inquiry.
169 Ibid, s 74. This section provided the Judge with an original power of review, but depended upon the patient persuading the Judge that a review should be conducted.

(i) Discharge by Expiry

This is perhaps the most important change from the previous legislation - patients are no longer faced with indefinite committal and the onus is on the responsible clinician to seek renewal of the order, not on the patient to seek review of his status. The expiry of the CTO will coincide with the mandatory half yearly clinical review of the patient's condition under 76.

However after the first 18 months expiry is not automatic, and the RC no longer has to apply to the court to extend the currency of the CTO. After 18 months the CTO is indefinite and the patient can only be discharged following a clinical review or pursuant to one of the review mechanisms. It is submitted that there is no justification for indefinite CTOs, whether during the first 18 months or thereafter. In all cases expiry of the CTO should occur automatically after 6 months and the onus should be on the institution to renew the CTO by application to the Mental Health Review Tribunal. The patient should not have to undergo another judicial hearing to determine his status.

While this procedure may suffer from a certain degree of administrative inconvenience experience in Victoria indicates that automatic reviews of detention can be carried out on an infomal basis in the hospital or centre where the person is detained. Matters are resolved expeditiously, with input from family members and others.[170] Such automatic review by the Tribunal should not derogate from the RC's obligation to discharge the patient if he or she considers that the patient is no longer mentally disordered.

(ii) Discharge by the Responsible Clinician

The same arguments against enabling the RC to conduct assessments singlehandedly dictate that he should not be solely responsible for discharging a patient, for this involves a decision as to whether the patient is mentally disordered within the meaning of the Act - a decision which should only be made by a legally qualified person such as a Judge or by a multi disciplinary body such as the Tribunal. Enabling

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[170] See 'Patient Rights and Public Hazard', Joseph Kirby, p 42

RCs to make discharge decisions creates a greater risk of wrong decisions being made, and the public being endangered.[171]
Parkin argues that the reason for the ability of responsible medical officers in the U.K to discharge patients is that after the pateint has been in their care, they are likely to be in a better position than anyone else to assess whether the patient is mentally disordered.[172] This may well be true, but it must be borne in mind that the definition of 'mental disorder' incorporates behavioural criteria which require predictions to be made about the patient's future conduct, not simply medical criteria, therefore the clinician is not equipped to adjudicate on mental disorder. This is not to say that his opinion should not carry considerable weight with the tribunal making the decision to discharge, but it should not be permitted to be decisive of the issue.[173]

(iii) Discharge by the Mental Health Review Tribunal

The Tribunal's powers to review a patient's condition are governed by the First Schedule to the Act, and are virtually identical to the powers of the Court to conduct hearings under ss 17-24.
The power to conduct reviews of its own motion is to be welcomed, and will help ensure that patients are released if they are no longer mentally disordered. However, there should be an automatic review by the Tribunal every 6 months, taking into account, but not being bound by, the recommendations of the responsible clinician following the clinical review.
Only thus can justice be done to patients, who are in a relatively powerless position in relation to hospitals and community health care services.[174] As the Taskforce stated, a patient's ability to invoke the

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171 See 'Discretion and Resources in Mental Health Provision', Allan Parkin. The author states that concerns have been expressed in the U.K about the powers of responsible medical officers to discharge patients. He cites an incident in Doncaster in 1991 in which a woman was discharged by her psychiatrist and then bludgeoned to death a young girl in a shopping centre.
172 Ibid, p 1454
173 Research conducted into mental health review tribunals in the U.K revealed that tribunals were unlikely to differ from the opinion of the responsible medical officer in charge of the case, but where they did, the reasons related to the riskiness of the RMOs decision to release the patient - 'Mental Health Review Tribunals after the Mental Health Act 1983', Peay J, Centre for Criminological Research, University of Oxford.
174 See 'Towards Mental Health Law Reform' p 322, in which it is stated that the "burden of coming forward" should be on the party most able to bear it - the

procedure may be hampered by lack of knowledge, illiteracy, the debilitating effects of mental disorder, isolation, apathy, and the possibility of sedation by drugs or other treatment.[175] Similarly, it is submitted that the institutional environment itself militates against a patient seeking review of his condition - it may simply be more comfortable, convenient and safe for the patient to remain committed. Under s 68 of the U.K Mental Health Act 1983, the manager of a hospital to which a patient has been committed is under a duty to refer the patient's case to the Tribunal within 6 months of admission if the patient has not done so, and thereafter every 3 years. Although these time frames are not ideal, the U.K legislation at least provides for some form of automatic assessment by the Tribunal.

(iv) Discharge by District or High Court Judge

As stated previously in relation to review during the assessment process, in the writer's view there is no role for the courts in the review process except by way of appeal from, or judicial review of, the decision of the Mental Health Review Tribunal. The adversarial nature of the court structure is not suited to committal decisions, and Judges are not especially qualified or experienced in mental health law. Furthermore, in the case of a judicial inquiry under s 84 the Judge may inquire into such matters as he thinks fit. There is a danger that the procedure adopted may not comply with Natural Justice.[176]. It is submitted that the Tribunal should be the body which determines whether a patient is mentally disordered and should continue to be committed, to avoid confusion and uncertainty for patients, and ensure that a well balanced decision is made and that Natural Justice is complied with.

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authorities, not the patient....[t]he justification for detention lapses when those conditions upon which it is premised are no longer present"

175 Ibid, s 322

176 Ibid, s 323

V. CONSENT TO TREATMENT

The new regime is premised on the principle that no person is required to accept any form of treatment without that person's consent.[177] This is perhaps the most significant ideological shift from historic mental health legislation, under which patients detained in hospitals could be given both medical and psychiatric treatment without their consent.[178] As with any provision which purports to lay down a principle of general application, there are a myriad of exceptions and qualifications to the rule. However it is probable that no patient will be required to undergo any form of medical treatment for a disorder unrelated to the mental disorder without their consent;[179] the exceptions relate to treatment for the mental disorder, not to all types of treatment. In this respect therefore, mental patients will be treated exactly like any adult of sound mind.

1. Exceptions to the Right to Refuse Consent

First, persons undergoing assessment shall be required to accept such treatment for mental disorder as the RC shall direct.[180]
As stated previously, there is no sensible rationale for this exception, for it effectively presumes that the legal status of the person as mentally disordered has already been determined.
Secondly, patients are required to accept such treatment for mental disorder as the RC directs during the first month of the Compulsory Treatment Order.[181] This is clearly a recognition that the first month of the CTO is the crucial period for treatment, and the lack of consent of the patient must not be permitted to impede the ability of the RC to treat the patient's mental disorder. However, it does not accord in

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177 See supra n 41 and the submission to Select Committee of the Porirua Hospital Residents'
Association, p 2. The Auckland District Law Society however recommended that hospitals be given the power to act in emergency situations.

178 The definition of "treatment" in section 25 of the Mental Health Act did not differentiate between medical and psychiatric treatment; providing that the making of a reception order gave the hospital sufficient authority to detain and treat the person.

179 See also s 11 Bill of Rights Act 1990 which provides for a right to refuse consent to medical treatment.

180 The Act, s 58

181 Ibid, s 59

jurisprudential terms with the absolute principle of autonomy and self determination of mentally ill patients sought by the Mental Health Task Force, and supposedly reflected in the Act.[182]

After the first month patients have the right to refuse treatment for mental disorder

unless they have had the treatment explained to them and have consented to it in writing,[183] or it is considered to be in the best interests of the patient by a psychiatrist (not being the Responsible Clinician) who has been appointed by the Tribunal for the purposes of the section.[184] It is submitted that in most cases where treatment is clearly required the assent of a psychiatrist appointed by the Tribunal will be a mere formality, given that the patient's need for compulsory treatment has already been established by the court, and the RC who supervised him or her throughout the entire assessment process considers that treatment is necessary. Thus, in practical terms the patient's right to refuse treatment is non-existent.

A further qualification under s 62 is the preservation of the common law right of doctors to administer treatment that is immediately necessary to save a person's life or prevent serious damage to their health or to the health of another.

It is noteworthy that the provisions are modelled largely on ss 56-63 of the U.K Mental health Act 1983, which effectively provide that the patient has the right to refuse consent to treatment after the first 3 months, unless the treatment has been authorised by the responsible medical officer in consultation with two other qualified professionals who have been involved in the patient's case.[185] The purpose of these provisions was to:

> "strike a balance between protecting the rights of the patient and providing for him to receive the treatment he needs"[186]

One may wonder at the logicity and equity of a right to refuse treatment that is so severely qualified as to be almost nugatory. There must

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182 'Towards Mental Health Law Reform', ch 14.
183 The Act, s 59(2)(a)
184 Ibid, s 59(2)(b)
185 See in particular s 58(1)
186 White Paper on "Reform of Mental Health Legislation" (Cmnd 8405), Nov 1981 at para 35

certainly be doubts as to whether these provisions achieve the appropriate balance between conflicting rights. The inevitable conclusion is that any notional right to refuse treatment is a nonsense, given that the obvious purpose of Compulsory Treatment Orders is to enable a person who is mentally disordered and fulfills the criteria in the Act to be compulsorily treated for that disorder:
Section 29 (Community Treatment Orders) provides:

(1) A Community Treatment Order shall require the patient to attend at the patient's place of residence... for treatment by employees of the specified institution or service, and to accept that treatment.
(emphasis added)

Similarly, s 30 (Inpatient Orders) provides:

(1) Every inpatient order shall require the continued detention of the patient in the hospital specified in the order,
.... for the purposes of treatment, and shall require the patient to accept that treatment. (emphasis added).

Thus, compulsory treatment orders not only have the purpose of allowing for compulsory treatment, they must provide for it. Giving patients an option to refuse treatment is renders the entire process of assessment and hearing superfluous, and treats patients subject to CTOs as though they were voluntary patients. The drastic nature of the qualification to the consent principle is testament to this paradox.
It is submitted that there are good policy reasons for allowing mental patients to be treated for their disorder without their consent, and these are reflected in the criteria for committal which require that a person be dangerous to themselves or others before they can be committed. These social policy goals would be negated by giving patients a right to refuse consent.
Removing a patient's right to refuse consent to treatment for mental disorder does not deny that the patient may be competent to consent (thus violating the presumptions of competence implicit in the Bill of Rights Act and the Protection of Personal and Property Rights Act); it merely recognises that there in the case of committed patients there are

policy goals outweighing the patient's right to refuse consent. As Roth points out:

" The problem with principles and doctrines such as the right to refuse treatment is that they advance simplistic solutions to problems of a complex and obdurate nature. To take up just one thread in a whole web of causes and consequences, there are the human rights of dependent wives, children and parents to be considered as well as those of the patient."

Given that these competing rights have been weighed up at the committal stage and found to militate against the patient's rights, there seems no sensible reason to give the patient the power to refuse treatment. Consequently, the consent provisions should be excised from the Act, leaving only s 59(4), requiring the RC, wherever practicable, to seek to obtain the consent of the patient to any treatment. This is not to say however that there are sufficient safeguards in the legislation to ensure that the right to treat patients compulsorily is not abused. It is not enough to build checks and balances into the procedure of assessment and hearing - there must be an ongoing commitment on the part of mental health professionals to exercise their treatment powers responsibly in the interests of the patient. This would entail rigorous adherence to the charter of patient rights set out in the Act, including infoming patients about treatment and its side effects,[187] providing patients with treatment appropriate to their condition,[188] enabling them to seek independent psychiatric advice[189] and review of their condition, and ensuring that they are not subject to neglect or ill treatment.[190] Given that the entire responsibility of a patient's care and treatment is to be assumed by a single Responsible Clinician, rather than a team of qualified professionals, it may be desirable to include a provision in Part V to the effect that before administering any form of treatment to a patient for mental disorder, the Responsible Clinician must honestly believe, on reasonable grounds, that in all the circumstances the treatment is in the best interests of the patient.

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187 Ibid, s 64
188 Ibid, s 66
189 Ibid, s 69
190 Ibid, s 114. As in s 112 of the Mental Health Act 1969 it is offence to wilfully neglect or illtreat a patient.

Breach of such a provision would enable the patient or his representative to seek legal recourse in the form of a civil action, provided that it did not result in a 'personal injury by accident' within the meaning of the Accident Compensation legislation.[191] Furthermore, there should be provision for the patient or his representative to apply to the Mental Health Review Tribunal or the Director of Mental Health Services to have the Responsible Clinician replaced if he or she is acting contrary to the best interests of the patient, such as failing to inform the patient about the side effects of treatment or administering inappropriate or outmoded treatment.

2. Special Provisions for Electro-Convulsive Therapy and Brain Surgery

Section 60 provides that the patient's consent must be obtained before Electro-Convulsive Therapy (ECT) is administered, unless the treatment is considered to be in the best interests of the patient by an independent psychiatrist appointed by the Tribunal.[192] ECT is a treatment frequently administered for schizophrenia and depression, in which the patient is anaesthetised, electrodes are attached to his body and then he is given electric shocks which cause convulsions.

The convulsions appear to be the therapeutic part of the treatment. The dangerousness of ECT has been exaggerated - the main risk is from the anaesthetic, and ECT can cause transitory memory loss.[193] Indeed, many psychotropic drugs have more serious side effects than ECT [194], therefore it may be doubted whether there is justification in having more rigorous provisions dealing with ECT than for ordinary treatment.

The most common type of psychosurgery is the 'frontal lobotomy' - a procedure designed to sever the connection between the frontal lobe - the personality centre of the brain and the remainder of the brain. The operation often results in the patient having a 'flattened' personality, and

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191 Accident Compensation (Rehabilitation and Insurance) Act 1992, s 3.

192 The Act, s 60(b)

193 Discussions with Graham Mellsop, Clinical School of Medicine.

194 Ibid. For example, anti depressants can cause haedaches, stomach disorders and weight gain. A serious side effect of the anti psychotic drugs is a condition known as 'Tardive Dyskinesia', characterised by involuntary movements of the head, arms or legs. See Law, Behaviour and Mental Health: Policy and Practice, Smith and Meyer, p 100.

losing character and motivation.[195] In response to concerns about the dehumanising effect of psychosurgery, section 61 of the new Act provides that the patient must consent to brain surgery, and the MRHT, responsible clinician and an independent psychiatrist must consider that it would be in the patient's best interests.[196] This clearly provides a sufficient safeguard against the "One Flew Over the Cuckoo's Nest" scenario arising today, but creates a curious loophole in respect of patients who are legally incapable of consenting. Unless the Act permits a decision to be made by a welfare guardian appointed under s 12 of the Protection of Personal and Property Rights Act it seems that patients who lack capacity to consent cannot be subjected to brain surgery.[197]

VI. RIGHTS OF PATIENTS

Part VI of the Act is an important innovation in mental health legislation in New Zealand. For the first time a set of patient rights is provided for - conferring on mental patients some of the civil rights the rest of us take for granted. Briefly some of these rights are:

(1) To written information about patient rights, including the right to know his legal status, the right to have his condition reviewed, the right to appeal from decisions of the Tribunal or seek a judicial inquiry, and the functions and duties of the District Inspector.[198]

(2) To be treated with respect for the patient's cultural identity.[199]

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[195] Another procedure which has aroused concern is 'amygdalotomy', which is used to treat aggessive disorders and hyperactivity and can also result in loss of motivation and permanent alteration of brain function. See 'Practical Medical Ethics', ch 10, p 139.

[196] The inclusion of these provisions was the result of intense lobbying by mental health interest groups. See NZ Parliamentary Debates, Second Reading of the Bill, 12 March 1992 at p 6862 and 'Towards Mental Health Law Reform', ch 15 for concerns about ECT and brain surgery.

[197] This is certainly the position in the U.K; s 57 of the Mental Health Act 1983 provides that the patient must consent to "irreversible procedures". The Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983 (S I 1983/893) can only be waived where the treatment is necessary to save the person's life.

[198] The Act, s 64

[199] Ibid, s 65. See also s 5 of the Act which provides a more detailed outline of what those exercising powers under the Act must do to comply with s 65.

(3) To treatment appropriate to the patient's condition.[200]

(4) To be informed about treatment. Every patient is entitled to know the expected effects of any treatment.[201]

(5) To seek independent psychiatric advice.[202]

(6) To seek legal advice.[203]

(7) To the company of others, except when the patient needs to be secluded.[204] There are now strict guidelines for the use of seclusion.[205]

(8) To receive visitors and make telephone calls.[206]
(9) To receive letters and postal articles unopened,[207] and to send letters and postal articles unopened.[208]

The general problem with these rights is that they are expressed as rights rather than duties upon the hospital or mental health service.[209] Although the patient can complain to the District Inspector and trigger an investigation, and the complaint can then be referred to the Director of Area Mental Health Services and finally the Tribunal if the patient is unsatisfied with the outcome, there should be a positive duty upon anyone exercising powers under the Act to comply with patient rights, breach of which would be an offence under the Act if committed

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200 Ibid, s 66
201 Ibid, s 67
202 Ibid, s 69
203 Ibid, s 70
204 Ibid, s 71
205 For concerns sbout the use of seclusion under the Mental Health Act 1969 see 'Towards Mental Health Law Reform' at pp 257-259. There was particular concern about automatic seclusion of patients on arrival at Oakley Hospital - such treatment was likely to severely distress a patient and exacerbate their condition. The Taskforce recommended the promulgation of a national seclusion protocol.
206 The Act, s 72. See 'Towards Mental Health Law Reform' at p 252. The Taskforce stated that as the Mental Health Act had no specific provisions enabling hospitals to refuse visitors or telephone calls, any such unreasonable refusal would be unlawful.
207 The Act, s 73. This is subject however to s 123 of the Act which prescribes the circumstances in which mail can be vetted in the interests of the patient.
208 Ibid, s 74.
209 This problem is also alluded to be Sylvia Bell in 'The Mental Health (Compulsory Assessment and Treatment) Act 1992', unpublished version

deliberately and subject to civil action if a negligent breach. Several of the rights are worthy of more specific comment:

1. Legal Representation

One of the most serious concerns about the previous legislation was its lack of any reference to a right to legal representation. Most patients were not represented at committal hearings, and therefore judges placed an inordinate emphasis on medical evidence led by certifying doctors.[210]

Although there have been positive indications in recent years that the level of representation is in fact increasing,[211] the new Act does little to address the fundamental problem - lack of money to enlist the aid of a lawyer. The 1987 Mental Health Bill was roundly criticised for not including provision for an advocacy service,[212] and yet nothing has been done to rectify this in the 1992 Act. It is submitted that instead of just an ineffectual right to seek legal representation and have access to a lawyer, every patient undergoing further assessment under s 11 should have a lawyer appointed by the Director of Mental Health Services to represent them, paid for out of the public purse or by Legal Aid under the Legal Services regime.

The RC should be required to state on the Certificate of Further Assessment that a solicitor has been appointed to represent the patient. District Inspectors, who are required to visit a number of hospitals and attend to dozens of patients, cannot be expected to perform advocacy for individual patients effectively. However as Wexler points out, even

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210 See Submission to the Auckland District Law Society and 'The Process of Committal' at pp 116-117.
According to Dawson in The Process of Committal' at pp 117-118 in only two of the cases he surveyed in 1984 were the patients legally aided, and the general attitude of the Auckland Legal Aid Committee was hostile to legal aid applications by mentally disordered patients.

211 For example, the Wellington Community Law Centre now runs a roster of solicitors to advise mental patients at Porirua Hospital, and represent them at committal hearings. This often entails the solicitor meeting with the patient and his or her family or caregiver to determine how the patient can best be represented. Similarly, a roster system has been set up by the Auckland District Law Society to provide representation in committal hearings for patients at Carrington Hospital.

212 See for example the Westport News, 2/9/87, 'Mental Health Rights Extended', in which reference is made to a criticism of the Psychiatric Survivors Group that the changes to the Bill failed to provide an advocacy service, and that the Official Visitor System had fallen into disrepute and did nothing for patients.

jurisdictions which require legal representation of patients cannot guarantee effective representation - frequently counsel's lack of specialist knowledge in mental health law and the absence of any financial incentive in taking on committal cases can result in the patient being poorly represented.[213] A solution to this in the New Zealand context may be to place a duty on the Director of Area Mental Health Services to establish and maintain a register of lawyers qualified or experienced in the mental health area, from which counsel would be appointed upon receipt of an application for assessment.

A vexing issue which has arisen overseas in relation to legal representation is whether the appropriate role of counsel is as a zealous advocate for the patient, arguing strenuously for the liberty of the 'client', or whether the advocate is simply an officer of the court; appointed to assist the court in reaching a correct legal outcome.[214] The answer to the question depends primarily upon whether the proceedings are viewed as adversarial or inquisitorial - if they are adversarial then the advocate must necessarily argue for the liberty of the patient, even if the patient is clearly mentally ill and in need of treatment. If the proceedings are inquisitorial then the role of the advocate is in assisting the court to reach a just decision based on as much information as can reasonably be gathered. Under the new system the preponderence of medical evidence will be in favour of committal. Although the aim of court proceedings is to gather as much information as possible about the patient's condition and translate this into an accurate decision either to commit or not to commit, it is submitted that the evidence is weighted heavily against the patient from the outset - from family, doctors and the RC, and therefore the adversarial approach is more likely to lead to a balanced presentation of evidence; counsel will be required to produce evidence against mental illness or against dangerousness rather than simply taking the easy option of concurring with the applicant's case.

2. Right to Information about Treatment

The right to information about treatment and to appropriate treatment are important innovations in the Act, and reflect the emphasis of the Act on treatment rather than incarceration.

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213 See 'Mental Health Law: Major Issues', p 95.
214 Ibid, pp 96-97.

However there should be a specific right of access to medical records, to ensure that the information being provided to the patient accords with the information being recorded about him or her. The patient should not have to rely on the District Inspector's powers to access medical records[215] - his compulsory status should entitle him to know about and question the treatment being administered, in the spirit of "glasnost" in which the Act is intended.

The need for such a right is particularly important now that patients can be treated by private psychiatric institutions and services[216] rather than just Gazetted hospitals, which are subject to the Official Information Act. There is no reason why patients who are being treated in the pubhc sector should have the right to request access to medical records, whereas patients in the private sector cannot. The right to be informed about proposed treatment is not an adequate substitute for this.

3. Right to Respect for Cultural Identity

Section 65 provides that every patient is entitled to be dealt with in a manner which accords with the spirit and intent of s 5 of the Act. Section 5 provides (inter alia):

" Every court or tribunal that conducts any proceedings and any court, tribunal or person that or who exercises any power under this Act in respect of any patient shall do so -

(a) With proper respect for the patient's cultural and ethnic identity, language and religious or ethical beliefs;..."

This right is an innovation in mental health care, and is extremely important in the context of the exercise of compulsory treatment powers under the Act, for according to Dawson it may effectively preclude the administration of compulsory treatment where such treatment was directly contrary to an important cultural or spiritual value.[217]

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215 The Act, s 97(2)(a)

216 See s 2 of the Act. 'Hospital' includes a private hospital licensed as a psychiatric hospital pursuant to Part V of the Hospitals Act, and 'Service' includes a service provided by or managed by a private hospital licensed under Part V of the Hospitals Act.

217 Comments of John Dawson at a seminar on the new Act held at Buddle Findlay, 29 September 1992

At face value it would seem that "proper respect" for a cultural value may in some circumstances require the RC or other person exercising powers to take no action. However it is submitted that the provision is more akin to setting out considerations which must be taken into account. In the end the decision must be made by the mental health professional. This is reflected in the wording of s 5 which provides that the powers are to be exercised; it does not provide that the person shall refrain from exercising the power (for example the power to treat) if such exercise would not constitute proper respect for cultural values. However, given the large proportion of Maoris and Pacific Islanders in the mental health system RCs will not be able to exercise their new powers responsibly without familiarising themselves with the cultural and spiritual values of these ethnic groups. Indeed it would be sensible for Directors of Area Mental Health Services to adopt a policy of hiring RCs who can display particular experience and sensitivity in dealing with other cultures.

4. Independent Psychiatric Advice

The purpose of this provision was to ensure that a patient could receive independent advice if he were dissatisfied with a decision of the responsible clinician. However, no such assurance is available - the right is simply to seek independent advice, not to receive paid independent advice on request. Given that the RC has sole responsibility for the treatment of the patient there is a strong case for paid independent advice on demand.

4. Right to Send and Receive Mail Unopened

The Taskforce commented that the Mental Health Act contained an unfairly wide discretion to vet incoming and outgoing mail of patients, based on the likelihood that mail would interfere with the treatment of the patient or cause him or her unnecessary distress.[218] It recommended that New Zealand adopt provisions similar to those in the U.K, in which mail should not be withheld unless the patient has requested that it be withheld, or the superintendent considers that it would cause harm to the

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218 See 'Towards Mental Health Law Reform', pp 252-253.

patient.[219] However, the provisions of the 1969 Act have been re enacted in the new Act; mail can be withheld if there are:

"reasonable grounds for believing that the receipt of the letter or postal article by the patient could be detrimental to the interests of the patient and to his treatment"[220]

Although the responsible clinician must obtain the approval of the Director of Area Mental Health Services to withhold mail, it is submitted that these provisions are too wide - there only needs to be a reasonable possibility of detriment before the mail can be withheld. The provision is an anachronism from a past era in mental health legislation in which the underlying ethos was paternalism. It not sit well with the emphasis of the Act on patient autonomy and therefore ought to be removed.

5. Enforcement

Despite the best intentions of the drafters in relation to the new patient rights regime, it is doubtful whether there are adequate mechanisms in place to enable a patient or his representative to enforce these rights. Although the Act sets up a formal complaints procedure under s 75, there are considerable deficiencies in this procedure. For instance it fails to specify what remedies can be sought if a complaint is referred to the Director of Area Mental Health Services or the Tribunal. The section simply provides:

"the [Director] shall take all steps as may be necessary to rectify the matter"

The Director's action would probably involve issuing some kind of warning to the person concerned or perhaps removing them from employment, but he or she probably could not order a pecuniary penalty or injunction. Dawson is of the view that this provision places a duty upon the Director to comply with any recommendations of the District Inspector or the Tribunal, and thus represents a significant power of enforcement of patient rights. That view is, with respect, incorrect. The Director is in no way obliged to follow the recommendations of the

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[219] Mental Health Act 1983, s 134; Mental Health (Hospital Guardianship and Consent to Treatment) Regulations 1983, regs 17-18.
[220] The Act, s 123

Tribunal or District Inspector - his view of what constitute necessary steps may differ significantly from that of the District Inspector or Tribunal, and may include taking no steps at all and letting the parties resolve the situation themselves. The strength of the system will depend ultimately on the good faith and competence of Directors, and this is not, in the writer's view, sufficient.

Neither does the Tribunal have the power to order sanctions - it can merely conduct an investigation. Section 102(1) provides that the primary function of the Tribunal is to conduct reviews of the condition of committed patients - little thought seems to have been given as to the powers of the Tribunal in relation to breaches of rights.

Breach of a right does not create an offence under the Act. The only offences which may be relevant in respect of a breach of rights is that of wilfully obstructing a District Inspector during an investigation,[221] or including false information in a certificate.[222] It is submitted that to receive monetary compensation under the Act the patient would have to bring an action for negligence or breach of statute. An action for breach of statute would require the patient to establish that the right in question created a positive, correlative duty on the person alleged to have breached the duty, but would probably have the advantage of not requiring the plaintiff to prove loss. An action in negligence would require proof of loss, and would not be available for personal injury covered by the Accident Compensation legislation.[223]

In more general terms, abuse of the committal power could create civil liability in negligence, assault, battery or false imprisonment, as there are no longer procedural barriers to such actions.

However, it is submitted that is required is either a provision which creates an offence for breaching a patient right, punishable by a fine or imprisonment, depending upon the seriousness of the breach, or an augmentation of the powers of the Mental Health Review Tribunal, so that it can order fines, injunctions or other remedies. Only thus can the patient rights in the Act have any real effect.

Section 135 provides that the Governor General may make regulations for the purpose of, inter alia:

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221 Ibid, s 117

222 Ibid, s 118

223 See s 3 of the Accident Compensation (Rehabilitation and Insurance) Act 1992.

"... (b) Prescribing the powers and duties of District Inspectors and Official Visitors.." and,

(j) Providing for such matters as are contemplated by or necessary for giving full effect to this Act and for its due administration"

These provisions could allow for the promulgation of regulations setting out the powers of the Director, the District Inspectors and the Tribunal in relation to breaches of patient rights.
It is to be hoped that they will be used for this purpose, as the current enforcement provisions are unhelpfully vague and lacking in "teeth".

VII. MISCELLANEOUS PROVISIONS

There are several provisions which are worthy of comment and criticism:

1. Police Powers

Sections 109 and 110 of the Act prescribe police powers in relation to patients sought to be committed, and have been taken from ss 35 and 36 of the Mental Health Act 1969 with virtually no change. A major concern of the Taskforce was that police powers under the 1969 Act were too wide, and that police did not have an appropriate role in apprehending persons believed to be mentally disordered and taking them to a medical practitioner for examination. The main reasons for this view were that it was felt the Police did not have enough expertise in mental health care to be able to determine whether a person was mentally disordered, and that mentally ill people should not be treated like criminals when they had committed no crime, and locked up in police cells until they could be assessed.[224] Furthermore, police sometimes did not adhere to the terms of s 35, which provided that they could only apprehend persons found wandering at large, and arrested people on private property.[225]
Despite these reservations s 35 has been re enacted in s 109 of the new Act, substantially unchanged. It is submitted that the Police should not

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224 See 'Towards Mental Health Law Reform', pp 48-50. See also 'The Process of Committal', Dawson in 'Mental Health: A Case for Reform', pp 23-26.
225 See for example Hastwell v Police, M 49/83, High Court Nelson, Ongley J, 20 Nov 1984.

have the power to apprehend people "believed to be mentally disordered", without an application first being made to the Director for an assessment. This effectively treats mentally disordered persons like criminals, in situations where no crime has been committed. There is no appropriate role for the police in making determinations about mental disorder.

The same comments apply to s 110 of the Act, which retains the power of medical practitioners to call to their assistance a member of the police if they believe a person to be mentally disordered and to have them taken by the police to a place for assessment. This provision is both outmoded and inappropriate. There is no reason why the police should be involved when an application is made by a doctor, but not when it is made by anyone else. The provision is inappropriate for the same reasons that police should not be involved in apprehending people. Being placed in a police cell, even for 24 hours, [226] is traumatic for the patient, who may in some cases be placed with hardened criminals.

It is submitted that the solution is to allow the provisions of Part III of the Act (which set out the powers of **Duly Authorised Officers** to assist caregivers in applying for committal) to govern the extent of compulsion which may be exerted on the patient to get them to be assessed.

The new role of Duly Authorised Officers is an important one in the Act, and has been established specifically for the purpose of assisting families and other applicants to get a person suspected of being mentally disordered certified and assessed. There is no need to involve the Police who have no particular expertise or sensitivity on this area. In Dawson's view there is a danger that the Police will shift the burden of apprehending and transporting mentally ill people onto Duly Authorised Officers. Such an outcome would surely be desirable, and would reflect a welcome move to "de criminalise" the committal process.

Section 41 provides that a Duly Authorised Officer attempting to exercise his powers may call to his assistance a member of the police. However, this should be a last resort to be invoked if all else fails; the Act should make this clear.

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226 Sections 109 and 110 provide that a patient may only be detained by the police for 24 hours.

2. Transfer and Removal of Patients

Section 127 of the Act enables committed patients to be transferred within New Zealand to any hospital or service upon the direction of the Director of Mental Health. This provision does not accord with the spirit of the Act; any decision to transfer a patient should be made by the Mental Health Review Tribunal or by the court, after reconsideration of whether the patient needs to remain committed and whether adequate care or treatment can be provided in the new environment. Section 127 does not require the Director to give any consideration to these matters. Transfer of a patient without their consent is a considerable infringement of their civil liberties - they may be removed from family and friends, and from surroundings in which they have grown up. Such a decision should not be made lightly, and proper regard should be given to the social and psychological consequences of such transfer.

Section 128 is even more drastic in its effect; providing that a patient may be removed from New Zealand upon the direction of the Minister of Health. Furthermore, the section provides that the expenses of travel and relocation can be paid for out of the patient's funds if the Minister directs.[227] The decision to remove a patient should be made by the Tribunal or the Court after submissions by the patient, his family or caregiver and other interested persons. Ministerial approval should then be sought, and in no case is payment out of the patient's funds without his consent justified. Since the repeal of Part VII of the Mental Health Act in 1988 and the enactment of the Protection of Personal and Property Rights Act, mental patients have had the right to deal with their property as they see fit, unless they are incompetent, in which case a welfare guardian can be appointed under the PP&PR Act.[228] This right must not be eroded by outdated transfer and removal provisions.

VIII. THE COMMITTAL PROCESS AND THE NEW ZEALAND BILL OF RIGHTS ACT 1990

An interesting issue arises as to the relationship between the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the New Zealand Bill of Rights Act 1990. Some guidance may be derived from

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[227] S 128(2)(b).
[228] s 12

two recent High Court decisions under the old Act - Re M[229] and Re S.[230] In Re M, an application under s 74 of the Mental Health Act for judicial review of the patient's condition, it was contended that the continued detention of M was 'arbitrary' under s 22 of the New Zealand Bill of Rights (NZBOR) Act, because M had never been violent.
Gallen J, citing s 4 of the Act which provides that no provision of any enactment shall be impliedly repealed or invalid by reason only that it is inconsistent with any provision of the Act, held that the provisions of the Mental Health Act stood on their own, but were to be interpreted as far as possible in the light of the NZBOR Act. This view was affirmed by Barker J in the later case of Re S, in which Barker J cited s 6 of the NZBOR Act, which provides that wherever an enactment can be given a meaning that is consistent with the Bill of Rights Act that meaning should be preferred to any other meaning.
The effect of these decisions will be that the committal criteria in the new mental health Act will be interpreted strictly - wherever there is doubt as to whether a person is mentally disordered the presumption will be against such a finding. In the writer's view, the qualifications in Part V of the Act to the right to refuse consent to treatment are inconsistent with s 11 of the NZBOR Act, which provides that everyone has the right to refuse to undergo medical treatment. As stated previously the writer does not support a right to refuse consent to treatment for mental disorder, but in view of s 11 the restrictions on the right to refuse consent to treatment will have to be interpreted strictly, and s 11 will create an implied duty on mental health professionals to seek consent at all times. The considerable ambiguity in the Act (such as in the reference to "whether in all the circumstances of the case it is necessary to make a compulsory treatment order")[231], will necessitate interpretations which accord with the NZBOR Act.

CONCLUSIONS

The compulsory treatment regime in the Mental Health (Compulsory Assessment and Treatment) Act is undoubtedly a giant step forward in the jurisprudence and practice of mental health care in New Zealand, and

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229 [1992] 1 NZLR 29
230 [1992]1 NZLR 363
231 The Act, s 27(3)

mirrors reforms that have been occurring throughout Commonwealth jurisdictions in the perception and treatment of the mentally ill.
The Act is certainly cause for celebration amongst civil libertarians, in that it moves decisively away from a purely 'medical' model of committal and places patient rights at the forefront of the mental health system, but in substantive terms it may have tipped the balance too far in favour of patient rights; both in the procedure leading up to compulsory treatment and in the ability of patients to refuse treatment. There is little evidence that committal powers have been abused in New Zealand as they were in the former Soviet Union under the Stalinist regime. The new rights based approach may result in patients being deprived of necessary treatment and families being subjected to considerable expense and inconvenience in getting a patient committed. As Mason McCall and Smith point out:

" An unequivocal commitment to the consensual rights of the mentally ill may result in their being denied treatment on civil libertarian grounds. It may also lead to unnecessary suffering by the families of those afflicted; calls for the recognition of the psychiatric patient's right to reject treatment may well sound hollow to those struggling to cope with their demands in a domiciliary situation"[232]

There is a lack of clarity in the crucial definition of mental disorder under the Act, and there will be a loss of control over the committal process by enabling professions outside psychiatry to be be involved in decisionmaking. In procedural terms, the system may be so complex and protracted that it frustrates the interests of patients, psychiatrists and the community.[233]
New Zealand could well learn from the considerable backlash in the States to the civil libertarian approach, resulting in calls for a reintroduction of compulsory paternalistic treatment.[234] In its anxiety to correct the iniquities of the previous regime the Legislature may have created a system which is both unwieldy and which prevents patients

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232 'Law and Medical Ethics', p 394.
233 See 'Patient Rights and Public Hazard', Joseph Kirby, p 43 in which the author comments that the Victorian Mental Health Act 1986 has erred too far on the side of civil liberties; in practice letting mentally ill patients fall through the cracks and cause harm to others.
234 See 'Deciding for Others' (1989), Buchanan and Brock, at p 312 for a discussion of this backlash, and the 1982 report of the American Psychiatric Association - 'Guidelines for Legislation on the Psychiatric Hospitalisation of Adults'.

from receiving the very treatment the law has determined that they require. The deficiencies in the Act must not be permitted to override the strengths, and the legislature in consultation with the profession and patient rights groups must continue to strive for the crucial balance between the mentally ill and the community.

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APPENDIX 1

CHAPTER 2

THE LAW

I. The Definition of Mental Disorder

To be lawfully committed a person must be 'mentally disordered'. This is defined in section 2 of the Mental Health Act[1]:

> **Section 2: 'Mentally disordered', in relation to any person, means suffering from a psychiatric or other disorder, whether continuous or episodic, that substantially impairs mental health, so that the person belongs to one or more of the following classes, namely:**
> **(a) Mentally ill — that is, requiring care and treatment for mental illness:**
> **(b) Mentally infirm — that is, requiring care and treatment by reason of mental infirmity arising from age or deterioration of or injury to the brain:**
> **(c) Mentally subnormal — that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of mind.**

There is no further definition of 'mental illness' or 'mental health'; but it is a closed definition in the sense that people who are committed should 'suffer' from one or other of the three named classes of disorder. There is no reference to personality or psychopathic disorders, alcoholism or drug addiction. Persons suffering the latter conditions may be committed under the Alcoholism and Drug Addiction Act 1966.

II. The Avenues of Committal

There are **four committal processes**, each invoking a different section of the act: **sections 16,19[2], 21 and 42.**

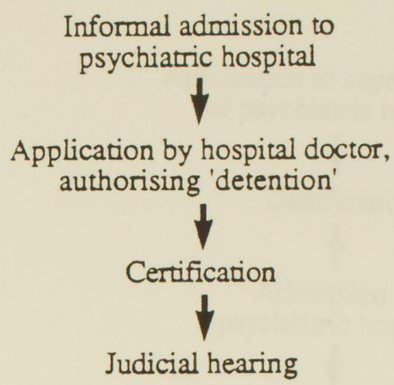
A. Section 16: Committal of Informal Patients

Under section 16 an application may be made for the committal (under section 21) of **a person who has entered hospital as an informal patient.** The application must be made by the superintendent or a medical officer of a psychiatric hospital. It is directed to a District Court judge or two justices[3]. Sending a completed application to the registrar of the court provides legal authority to **detain** the patient until the application is determined at a hearing. It provides no power to treat patients without consent in the interim. Before the hearing two doctors examine the patient to decide if they should be certified.

Section 16 is frequently invoked at **Carrington Hospital**, rarely elsewhere.

Some patients admitted on remand from the criminal courts are also subject to applications under this process.

The Process of Section 16



B. Section 19: Committal Directly To Hospital

Under section 19 a **request may be made directly to a psychiatric hospital** for the 'reception' of a patient. The request is directed to the superintendent. It should be accompanied by the certificates of two doctors who have recently examined the person and certified they are 'mentally disordered' within the meaning of the Act. One certificate is adequate if the doctor who signed it has completed the **Optional Addition** stating the admission is an **emergency**. This is defined in section 19(4) as any situation in which following the usual procedure:

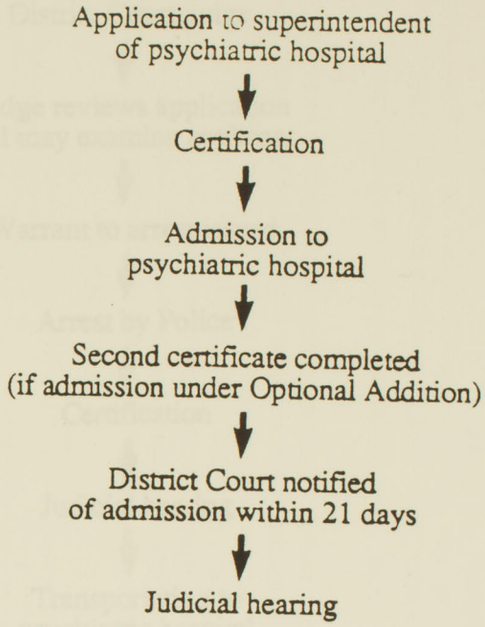
> **Section 19(4) ... would expose that person or any other person to hardship or danger, and that it has been impracticable, since the expediency of immediate admission became apparent, for any other medical practitioner to be consulted.**

The second certificate must be obtained by the hospital within 72 hours.

Section 19 itself grants no power of **arrest**, but it is linked to **section 35**, which grants a power to the Police or Medical Officers of Health to arrest patients found **'wandering at large'** and apply for their committal under section 19 or 21 in the usual way .

Upon receiving the required documents hospital staff may admit, detain and treat the patient. Unless the patient is sooner discharged the hospital must notify the court of their admission within 21 days. As soon as practicable a judge must hold a hearing at the hospital to determine their need for continued detention.

The Process of Section 19

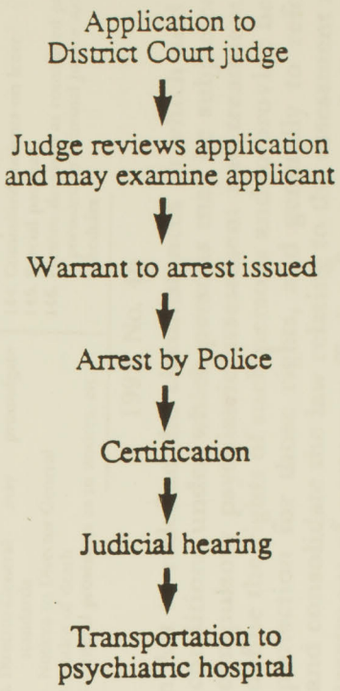


C. Section 21: Committal Through The District Court

Under section 21 the **application is made directly to a judge at the District Court.** The judge then reviews the application, and may interview the applicant, to determine whether a **warrant to arrest** the patient should be issued to ensure their examination by two doctors. If a warrant is issued it is given to the Police who arrest the patient and take them to the doctors for certification or the doctors are called in to examine them at the court or Police station. Alternatively, one or both certificates may be arranged by the applicant and handed to the judge. The patient may also be brought to the court so no arrest is required.

When the certification process is complete **the judge reviews the certificates and examines the patient** to determine whether a reception order should be made. An order authorises detention and treatment until the patient is discharged. If the order is made the patient is transported to the nearest psychiatric hospital, usually by the Police.

The Process of Section 21



D. Section 42: Committal Of Prisoners

Section 42 authorises the **committal of prisoners** and persons detained in 'licensed institutions' for the treatment of alcoholism or drug addiction. The superintendent of the institution may apply to a District Court judge for a reception order. This authorises **transfer** of the patient to a psychiatric hospital. People committed in this way have the status of **'special patient'** until their sentence or period of detention expires. Their status is then automatically changed to committed patient.

After the application under section 42 the patient is examined by two doctors for the purposes of certification. A judicial hearing is then held, at the court or prison. The documents are reviewed, the patient examined and the need for a reception order determined. There is no need for a process of arrest as people subject to applications under this section are already detained.

Committals under this section have **decreased markedly since 1983.** This is a result of changed admission policies at Oakley Hospital following the report of the Oakley Committee of Inquiry[4]. During the study only one man was committed under this section, from Paremoremo Maximum Security Prison to Oakley Hospital. His admission is treated throughout the study as a committal under section 21.

1992, No. 46

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

[*15 June 1992*

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

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

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

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

"Board" means an area health board:

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

"Court" means a District Court:

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

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

APPENDIX 2

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

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

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

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

"Hospital" means—

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

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

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

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

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

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

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

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

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

"Minister" means the Minister of Health:

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

"Patient" means a person who is—

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

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

(c) A special patient:

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

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

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

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

"Registrar" means the Registrar of a District Court:

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

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

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

(i) A board; or

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

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

"Special patient" means a person who is—

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

order for the detention of that person in a hospital made under the proviso to section 171 (3) of the Summary Proceedings Act 1957; or

(b) Is detained in a hospital pursuant to section 45 (4) (d) or section 46 of this Act and has not ceased, by virtue of section 48 of this Act, to be a special patient:

"Welfare guardian" has the same meaning as it has in section 2 of the Protection of Personal and Property Rights Act 1988.

(2) In this Act, unless the context otherwise requires, the expression "the statutory definition of mental disorder", in relation to any person, means the definition of the term "mental disorder" given in subsection (1) of this section in relation to persons of the age of that person.

Cf. 1969, No. 16, s. 2; 1972, No. 22, s. 2; 1982, No. 84, s. 2 (1); 1985, No. 22, s. 2

3. Act to bind Crown—This Act shall bind the Crown.

4. General rules relating to liability to assessment or treatment—The procedures prescribed by Parts I and II of this Act shall not be invoked in respect of any person by reason only of—

(a) That person's political, religious, or cultural beliefs; or
(b) That person's sexual preferences; or
(c) That person's criminal or delinquent behaviour; or
(d) Substance abuse; or
(e) Intellectual handicap.

Cf. Mental Health Act 1983 (U.K.), s. 1 (3)

5. Powers to be exercised with proper respect for cultural identity and personal beliefs—Every court or tribunal that conducts any proceedings, and every court, tribunal, or person that or who exercises any power, under this Act in respect of any patient shall do so—

(a) With proper respect for the patient's cultural and ethnic identity, language, and religious or ethical beliefs; and
(b) With proper recognition of the importance and significance to the patient of the patient's ties with his or her family, whanau, hapu, iwi, and family group, and the contribution those ties make to the patient's well-being.

6. Interpreters to be provided—Where—

(a) Any court or tribunal is conducting any proceedings, or any court, tribunal, or person is exercising any power, under this Act in respect of any patient; and
(b) The first or preferred language of the patient is Maori or any other language other than English, or the patient is unable, because of physical disability, to understand English,—

it shall be the duty of the court or tribunal, or that person, to ensure that the services of an interpreter are provided for the patient wherever practicable.

7. Obligation to assign patient to responsible clinician—For the purposes of this Act, the Director of Area Mental Health Services shall ensure that at all times there is assigned in respect of each patient a responsible clinician, who shall be—

(a) A psychiatrist approved by the Director of Area Mental Health Services; or
(b) Some other registered health professional who, in the opinion of the Director of Area Mental Health Services, has undergone training in, and is competent in, the assessment, treatment, and care, of persons with mental disorder.

PART I

Compulsory Assessment and Treatment

8. Application for assessment—(1) Any person (in this section referred to as the applicant) who has attained the age of 18 years may at any time apply to the Director of Area Mental Health Services for assessment of another person (referred to in this section and in sections 9 and 10 of this Act as the proposed patient) whom the applicant believes to be mentally disordered.

(2) The application shall be made in writing, and shall include a statement—

(a) Of the grounds on which the applicant believes the proposed patient to be mentally disordered; and
(b) Of the relationship or association of the applicant with the proposed patient; and
(c) That the applicant has personally seen the proposed patient within the 3 days immediately preceding the date of the application.

(3) The application shall be accompanied by a certificate given by a medical practitioner, who is related neither to the

applicant nor to the proposed patient, and who has examined the proposed patient within the 3 days immediately preceding the date of the application, stating—

(a) That he or she has examined the proposed patient, and the date of the examination; and

(b) That he or she considers that there are reasonable grounds for believing that the proposed patient may be mentally disordered; and

(c) Full particulars of the reasons for that opinion, explaining in what way he or she believes that the proposed patient's condition may come within the statutory definition of mental disorder; and

(d) That he or she is not related to the applicant or to the proposed patient.

(4) Where the applicant is a medical practitioner, he or she may give the certificate required by subsection (3) of this section.

9. Assessment examination to be arranged and conducted—(1) Where an application is made under section 8 of this Act, the Director of Area Mental Health Services, or a duly authorised officer acting with the authority of that Director, shall make the necessary arrangements for the proposed patient to undergo an assessment examination forthwith.

(2) The arrangements required by subsection (1) of this section shall include the following:

(a) Nominating, in accordance with subsection (3) of this section, the person by whom the assessment examination is to be conducted:

(b) Determining, in consultation with the person by whom the assessment examination is to be conducted, the time and place at which it is to be conducted:

(c) Giving to the proposed patient a written notice—

(i) Requiring the proposed patient to attend at the specified place and time for the purposes of the assessment examination; and

(ii) Explaining the purpose of the assessment examination; and

(iii) Stating the name of the person who is to conduct the assessment examination:

(d) Ensuring that the purpose of the assessment examination and the requirements of the notice given under paragraph (c) of this subsection are explained to the proposed patient in the presence of a member of the proposed patient's family, or a caregiver in relation to the proposed patient or other person concerned with the welfare of the proposed patient:

(e) Ensuring, where necessary, that appropriate arrangements are made to convey the patient at the required time to the place where the assessment examination is to be conducted, and, where it is necessary or desirable that the proposed patient be accompanied on the journey, ensuring that an appropriate person is available to do so.

(3) Every assessment examination shall be conducted by a medical practitioner (whether or not employed by the Board but not being the medical practitioner who gave the certificate referred to in section 8 (3) of this Act), being—

(a) A psychiatrist approved by the Director of Area Mental Health Services for the purposes of the assessment examination or of assessment examinations generally; or

(b) If no such psychiatrist is reasonably available, some other medical practitioner who, in the opinion of the Director of Area Mental Health Services, is suitably qualified to conduct the assessment examination or assessment examinations generally.

(4) For the purposes of subsection (1) of this section, an application shall be deemed to have been made in respect of any person if notice of it has been received, whether by telephone or otherwise, from a medical practitioner who has given a certificate in respect of that person for the purposes of section 8 (3) of this Act; but the assessment examination shall not take place until the written application and that certificate have been received by the Director of Area Mental Health Services or a duly authorised officer, or by the medical practitioner who is to conduct the examination.

10. Certificate of preliminary assessment—(1) After completing the assessment examination, the medical practitioner shall record his or her findings in a certificate of preliminary assessment, stating—

(a) That he or she has carefully considered the statutory definition of mental disorder and the proposed patient's condition in relation to that definition; and

(b) That—

(i) In his or her opinion the proposed patient is not mentally disordered; or

(ii) That there are reasonable grounds for believing that the proposed patient is mentally disordered and that it is desirable that the proposed patient be required to undergo further assessment and treatment.

(2) The medical practitioner shall send to the Director of Area Mental Health Services—

(a) The certificate of preliminary assessment; and

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

(c) A copy of any notice given to the proposed patient under section 11 (1) of this Act; and

(d) The application for assessment made under section 8 of this Act, and the supporting medical certificate, if these are in the possession of the medical practitioner.

(3) If the medical practitioner is of the opinion that the proposed patient is not mentally disordered, the proposed patient shall be free from further assessment and treatment under this Part of this Act (without prejudice to the making of a further application under section 8 of this Act in respect of the patient at some time in the future).

(4) Where the medical practitioner considers that there are reasonable grounds for believing that the proposed patient is mentally disordered and that it is desirable that the proposed patient be required to undergo further assessment and treatment, the medical practitioner shall—

(a) Give or send a copy of the certificate of preliminary assessment to each of the following:

(i) The patient:

(ii) Any welfare guardian of the patient:

(iii) The applicant for assessment:

(iv) The patient's principal caregiver:

(v) The medical practitioner who usually attends the patient; and

(b) Give or send, to each of the persons specified in paragraph (a) of this subsection, a statement of the legal consequences of the finding set out in the certificate of preliminary assessment, and of the

recipient's right to apply to the Court for a review of the patient's condition; and

(c) Otherwise deal with the case in accordance with section 11 of this Act.

11. Further assessment for 5 days—(1) If the medical practitioner's finding is of the kind described in section 10 (1) (b) (ii) of this Act, the medical practitioner shall, by notice in writing to the patient, require the patient to undergo further assessment and treatment in accordance with the terms of the notice and the succeeding provisions of this section throughout the first period of assessment and treatment, being a period commencing with the date on which the patient receives the notice and ending with the close of the 5th day after that date.

(2) Subject to subsection (3) of this section, in the notice the medical practitioner shall require the patient to attend at the patient's place of residence, or at some other place nominated in the notice, for the purposes of assessment and treatment throughout the first period of assessment and treatment.

(3) If the medical practitioner considers that the patient cannot be further assessed and treated adequately as an outpatient, the medical practitioner shall, in the notice, direct that the patient be admitted to and detained in a specified hospital for the purposes of assessment and treatment throughout the first period of assessment and treatment.

(4) Notwithstanding anything in subsection (2) of this section, if, at any time during the first period of assessment and treatment, the responsible clinician considers that the patient cannot continue to be assessed and treated adequately as an outpatient, that clinician may, by notice in writing, direct that the patient be admitted to and detained in a specified hospital for the purposes of assessment and treatment during the remainder of the first period of assessment and treatment.

(5) Notwithstanding anything in subsection (3) of this section, if, at any time during the first period of assessment and treatment, the responsible clinician considers that the patient can continue to be assessed and treated adequately as an outpatient, that clinician shall, by notice in writing,—

(a) Direct that the patient be discharged from the hospital; and

(b) Direct the patient to attend at the patient's place of residence, or at some other place nominated in the notice, for the purposes of assessment and treatment

during the remainder of the first period of assessment and treatment.

(6) If, at any time during the first period of assessment and treatment, the responsible clinician considers that the patient is fit to be released from compulsory status, that clinician shall direct that the patient be released from that status forthwith.

(7) Without limiting any of the foregoing provisions of this section, at any time during the first period of assessment and treatment, the patient, or any person specified in subparagraphs (ii) to (v) of section 10 (4) (a) of this Act, may apply to the Court to have the patient's condition reviewed under section 16 of this Act.

12. Certificate of further assessment—(1) Before the expiry of the first period of assessment and treatment, the responsible clinician shall record his or her findings in a certificate of further assessment, stating—

(a) That he or she has carefully considered the statutory definition of mental disorder and the patient's condition in relation to that definition; and

(b) That, in his or her opinion,—

(i) The patient is not mentally disordered; or

(ii) There remain reasonable grounds for believing that the patient is mentally disordered and that it is desirable that the patient be required to undergo further assessment and treatment.

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

(a) A copy of the certificate of further assessment; and

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

(c) A copy of any notice given to the patient under section 13 (1) of this Act.

(3) If the responsible clinician is of the opinion that the patient is not mentally disordered, that clinician shall direct that the patient be released from compulsory status forthwith (but without prejudice to the making of a further application under section 8 of this Act in respect of the patient at some time in the future).

(4) If the responsible clinician considers that there remain reasonable grounds for believing that the patient is mentally disordered and that it is desirable that the patient be required to undergo further assessment and treatment, that clinician shall deal with the case in accordance with the succeeding provisions of this section and section 13 of this Act.

(5) If the responsible clinician's finding is of the kind described in subsection (1) (b) (ii) of this section, that clinician shall forthwith give or send a copy of the certificate of further assessment to each of the following:

(a) The patient:

(b) Any welfare guardian of the patient:

(c) The applicant for assessment:

(d) The patient's principal caregiver:

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

(f) A district inspector:

(g) An official visitor.

(6) To each of the persons specified in paragraphs (a) to (e) of subsection (5) of this section, the responsible clinician shall also give or send a statement of the legal consequences of the finding set out in the certificate of further assessment, and of the recipient's right to apply to the Court for a review of the patient's condition.

(7) Any person specified in paragraphs (a) to (e) of subsection (5) of this section may, on receiving a copy of the certificate of further assessment, apply to the Court to have the patient's condition reviewed under section 16 of this Act.

(8) The district inspector who receives a copy of the certificate of further assessment shall, subject to subsection (11) of this section, after talking to the patient and ascertaining the patient's wishes in the matter (where that can be done), consider whether or not an application should be made to have the patient's condition reviewed under section 16 of this Act.

(9) If the district inspector considers that such an application should be made, the district inspector shall take whatever reasonable steps he or she thinks necessary to encourage or assist the patient, or any person specified in paragraphs (b) to (e) of subsection (5) of this section, to make such an application.

(10) If, in any case to which subsection (8) of this section applies, the district inspector considers that an application should be made to have the patient's condition reviewed under section 16 of this Act, but neither the patient nor any person specified in paragraphs (b) to (e) of subsection (5) of this section intends to make such an application, the district inspector may report the matter to the Court; and, in such a case, a Judge

may, of his or her own motion, review the patient's condition under section 16 of this Act as if an appropriate application for such a review had been made to the Court.

(11) Instead of performing personally the functions specified in subsections (8) to (10) of this section, the district inspector may in any particular case arrange for an official visitor to perform them.

(12) Notwithstanding any of the foregoing provisions of this section, at any time during the second period of assessment and treatment (as so defined), the patient, or any person specified in paragraphs (b) to (e) of subsection (5) of this section, may apply to the Court to have the patient's condition reviewed under section 16 of this Act.

13. Further assessment and treatment for 14 days—(1) If the responsible clinician's finding is of the kind described in section 12 (1) (b) (ii) of this Act, that clinician shall, by notice in writing to the patient, require the patient to undergo further assessment and treatment in accordance with the terms of the notice and the succeeding provisions of this section throughout the second period of assessment and treatment, being a period commencing with the date on which the patient receives the notice and ending with the close of the 14th day after that date.

(2) Subject to subsection (3) of this section, in the notice the responsible clinician shall require the patient to attend at the patient's place of residence, or at some other place nominated in the notice, for the purposes of assessment and treatment throughout the second period of assessment and treatment.

(3) If the responsible clinician considers that the patient cannot be further assessed and treated adequately as an outpatient, that clinician shall, in the notice, direct that the patient be admitted to and detained in a specified hospital for the purposes of assessment and treatment throughout the second period of assessment and treatment.

(4) Notwithstanding anything in subsection (2) of this section, if, at any time during the second period of assessment and treatment, the responsible clinician considers that the patient cannot continue to be assessed and treated adequately as an outpatient, that clinician may, by notice in writing, direct that the patient be admitted to and detained in a specified hospital for the purposes of assessment and treatment for the remainder of the second period of assessment and treatment.

(5) Notwithstanding anything in subsection (3) of this section, if, at any time during the second period of assessment and

treatment, the responsible clinician considers that the patient can continue to be assessed and treated adequately as an outpatient, that clinician shall, by notice in writing,—

(a) Direct that the patient be discharged from the hospital; and

(b) Direct the patient to attend at the patient's place of residence, or at some other place nominated in the notice, for the purposes of assessment and treatment during the remainder of the second period of assessment and treatment.

(6) If, at any time during the second period of assessment and treatment, the responsible clinician considers that the patient is fit to be released from compulsory status, that clinician shall direct that the patient be released from that status forthwith.

14. Certificate of final assessment—(1) Before the expiry of the second period of assessment and treatment, the responsible clinician shall record his or her findings in a certificate of final assessment, stating—

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

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

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

(a) A copy of the certificate of final assessment; and

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

(c) Where appropriate, a notice to the effect that he or she is applying to the Court for a compulsory treatment order in respect of the patient.

(3) If the responsible clinician is of the opinion that the patient is fit to be released from compulsory status, that clinician shall direct that the patient be released from that status forthwith (but without prejudice to the making of a further application under section 8 of this Act in respect of the patient at some time in the future).

(4) If the responsible clinician is of the opinion that the patient is not fit to be released from compulsory status, that clinician shall, before the expiry of the second period of assessment and treatment,—

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

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

(i) The patient:

(ii) Any welfare guardian of the patient:

(iii) The applicant for assessment:

(iv) The patient's principal caregiver:

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

(vi) A district inspector:

(vii) An official visitor.

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

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

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

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

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

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

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

(2) The examination shall be conducted—

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

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

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

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

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

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

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

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

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

(7) Where it is not practicable for a review under this section of a patient's condition to be conducted by a Family Court

Judge, that review may be conducted by any District Court Judge.

PART II

COMPULSORY TREATMENT ORDERS

17. Applications to be heard and determined wherever practicable by Family Court Judge—(1) Every application under section 14 (4) (a) of this Act for a compulsory treatment order and every application under section 34 (2) of this Act for an extension of the currency of a compulsory treatment order shall, wherever practicable, having regard to the time in which the application is required to be heard and determined, and to the availability of Judges and other personnel and resources, be heard and determined by a Family Court Judge.

(2) Where it is not practicable for an application of the kind referred to in subsection (1) of this section to be heard and determined by a Family Court Judge, that application may be heard and determined by any District Court Judge.

18. Judge to examine patient where compulsory treatment order sought—(1) Where an application is made under section 14 (4) (a) of this Act for a compulsory treatment order in respect of any patient, a District Court Judge shall examine the patient as soon as practicable and in no case later than 14 days after the application is filed in the Court.

(2) The examination shall be conducted—

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

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

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

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

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

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

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

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

(6) The Judge who examines the patient under subsection (1) of this section shall, wherever possible, conduct any hearing of the application under the succeeding provisions of this Part of this Act; and in no case shall any hearing of the application be held until the patient has been visited by a Judge in accordance with that subsection.

19. Attendance of patient and other persons—(1) The patient shall be present throughout the hearing by the Court of an application for a compulsory treatment order unless—

(a) The Judge who examines the patient in accordance with section 18 (1) of this Act certifies that it would be in the best interests of the patient to excuse the patient from attending the hearing; or

(b) The patient is excused or excluded by the Court under subsection (2) or subsection (3) of this section.

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

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

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

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

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

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

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

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

(6) Any other person to whom a copy of the certificate of final assessment is sent under section 14 (4) (b) of this Act shall be entitled to be present throughout the hearing, except as the Judge may otherwise order.

20. Right of patient and other persons to be heard and call evidence—(1) The patient shall be entitled to be heard by the Court, whether in person or through a barrister or solicitor or through some other person nominated by the patient, and to call witnesses, and to cross-examine any witness called by any other party to the proceedings.

(2) Without limiting anything in subsection (1) of this section, where the patient is present and appears capable of addressing the Court, the Court shall give the patient an opportunity to do so; and, in any such case, the Court may, if it thinks it desirable to do so, require any parent or guardian of the patient, or any other person with whom the patient is living, or any barrister or solicitor representing any such parent, guardian, or other person, to withdraw from the Court while the patient is addressing the Court.

(3) Any person referred to in section 19 (6) of this Act shall be entitled to be heard by the Court, whether in person or through a barrister or a solicitor, and to call witnesses, and to cross-examine any witness called by any other party to the proceedings.

21. Court may call for report on patient—(1) On an application for a compulsory treatment order, the Court may, if it is satisfied that it is necessary for the proper disposition of the application, request any person whom it considers qualified to do so to prepare a report on any relevant aspect of the patient's condition.

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

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

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

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

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

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

22. Evidence—In any proceedings on an application for a compulsory treatment order, whether by way of hearing in the first instance or by way of appeal or otherwise, the Court may receive any evidence that it thinks fit, whether it is otherwise admissible in a court of law or not.

23. Power of Court to call witnesses—(1) Without limiting anything in section 22 of this Act, on any application for a compulsory treatment order, the Court may, of its own motion, call as a witness any person whose evidence may in its opinion be of assistance to the Court.

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

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

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

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

24. Proceedings not open to public—(1) No person shall be present during the hearing of any proceedings on an application for a compulsory treatment order except the following:

(a) The Judge:

(b) Officers of the Court:

(c) Parties to the proceedings and their barristers and solicitors, and any other person nominated by the patient:

(d) Witnesses:

(e) Any other person to whom the certificate of final assessment was sent under section 14 (4) (b) of this Act:

(f) Any other person whom the Judge permits to be present.

(2) Any witness shall leave the courtroom if asked to do so by the Judge.

(3) Nothing in this section shall limit any other power of the Court to hear proceedings in private or to exclude any person from the Court.

25. Restriction of publication of reports of proceedings—(1) No person shall publish any report of proceedings under this Part of this Act except with the leave of the Court that heard the proceedings.

(2) Every person who contravenes subsection (1) of this section commits an offence against this Act and is liable,—

(a) In the case of an individual, to imprisonment for a term not exceeding 3 months, or to a fine not exceeding $1,000:

(b) In the case of a body corporate, to a fine not exceeding $2,500.

(3) Nothing in this section shall limit—

(a) The provisions of any other enactment relating to the prohibition or regulation of the publication of reports or particulars relating to judicial proceedings; or

(b) The power of any court to punish any contempt of court.

(4) Nothing in this section shall apply to the publication of any report in any publication that is of a bona fide and relevant professional or technical nature.

26. Court may dispense with hearing in certain circumstances—Notwithstanding any of the preceding provisions of this Part of this Act, the Court may determine an application for a compulsory treatment order without a formal hearing if it is satisfied that no person wishes to be heard in respect of the application.

27. Court to consider patient's condition—(1) On an application for a compulsory treatment order, the Court shall determine whether or not the patient is mentally disordered.

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

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

28. Compulsory treatment orders—(1) Every compulsory treatment order shall be either—

(a) A community treatment order; or

(b) An inpatient order,—

and on making a compulsory treatment order the Court shall specify the kind of order it is.

(2) Subject to subsections (3) and (4) of this section, the Court shall make a community treatment order unless the Court considers that the patient cannot be treated adequately as an outpatient, in which case the Court shall make an inpatient order.

(3) The Court shall not make an inpatient order if, at the time of making the order, the patient is undergoing assessment and treatment as an outpatient; but in such a case, the Judge may, instead of making a community treatment order, order that the patient be re-assessed in accordance with sections 11 and 12 of this Act, and the provisions of those sections, sections 13 to 27 of this Act, and this section shall apply with any necessary modifications.

(4) Before making a community treatment order, the Court shall satisfy itself that—

(a) The Board provides through the institution or service named in the order care and treatment on a outpatient basis that is appropriate to the needs of the patient; and

(b) The social circumstances of the patient are adequate for his or her care within the community.

(5) When the Court makes an order under this section, it shall give or send a copy of the order to the patient.

29. Community treatment orders—(1) A community treatment order shall require the patient to attend at the patient's place of residence, or at some other place specified in

the order, for treatment by employees of the specified institution or service, and to accept that treatment.

(2) Every employee of the institution or service specified in the order who is duly authorised to treat the patient may, at all reasonable times, enter the patient's place of residence or other place so specified for the purpose of treating the patient.

(3) If, at any time during the currency of the community treatment order, the responsible clinician considers that the patient cannot continue to be treated adequately as an out-patient, the responsible clinician may direct that the patient be re-assessed in accordance with sections 11 and 12 of this Act, and the provisions of those sections, and sections 13 to 27 of this Act shall apply with any necessary modifications.

30. Inpatient orders—(1) Every inpatient order shall require the continued detention of the patient in the hospital specified in the order, or (where the patient is being detained at some other hospital) the admission of the patient and his or her detention in the hospital so specified, for the purposes of treatment, and shall require the patient to accept that treatment.

(2) If, at any time during the currency of the inpatient order, the responsible clinician considers that the patient can continue to be treated adequately as an outpatient, that clinician shall, by notice in writing,—

(a) Direct that the patient be discharged from the hospital; and

(b) Direct the patient to attend at the patient's place of residence, or at some other place nominated in the notice, for the purposes of treatment;—

and, in such a case, the inpatient order shall thereafter be deemed to be and to have effect as a community treatment order as if the terms of the notice were the terms of the order.

31. Leave for inpatients—(1) This section shall apply to every patient, other than a special patient, who is in a hospital in accordance with an inpatient order.

(2) The responsible clinician may from time to time grant to any patient to whom this section applies leave of absence from the hospital for such period not exceeding 3 months, and on such terms and conditions, as that clinician thinks fit.

(3) The responsible clinician may from time to time extend any such period of leave for a further period not exceeding 3 months at any one time; but no patient shall be on leave under this section for a continuous period of more than 6 months.

(4) The responsible clinician may, at any time during the period of leave granted under this section to any patient, cancel the leave by notice in writing to the person who has undertaken to take care of the patient during the period of leave, or, if there is no such person, by notice in writing to the patient.

(5) Where leave is cancelled, the patient may be taken to the hospital, or to any other hospital, by any duly authorised officer acting under the authority of the Director of Area Mental Health Services, or by any person to whom the charge of the patient has been entrusted during the period of leave.

32. Absence without leave—(1) Any patient to whom section 31 of this Act applies who becomes absent without leave from the hospital in which he or she is detained may, on the day on which such absence commences, or at any time within 3 months immediately following that day, be retaken by any person.

(2) Any such patient who is so retaken may be returned to the hospital in which the patient was detained immediately before such absence, or may be taken to any other hospital.

(3) Any such patient who is not retaken within the period of 3 months specified in subsection (1) of this section shall be deemed to have been released from compulsory status on the expiration of that period.

(4) Notwithstanding anything in the preceding provisions of this section, any patient who is absent without leave from a hospital may at any time while the patient is so absent be released from compulsory status in accordance with this Act.

(5) Within 24 hours after the commencement of every such absence, and after such return or release, an entry shall be made in the appropriate register.

(6) Every patient who leaves his or her escort while being removed from any hospital in which the patient has been detained to any other hospital to which the patient is being lawfully transferred shall be deemed to be absent without leave, within the meaning of this section, from the first-mentioned hospital, and on being retaken in accordance with this Act may be conveyed to the hospital to which the patient was being removed, notwithstanding that the time limited by section 127 of this Act for complying with an order of transfer may have elapsed.

33. Compulsory treatment order to expire after 6 months—Subject to section 34 of this Act, every compulsory treatment order shall continue in force for a period of 6 months commencing with the day on which it is made, and shall then expire.

34. Court may extend order—(1) Within 14 days immediately preceding the date on which a compulsory treatment order is to expire, the responsible clinician may cause the case to be reviewed under section 76 of this Act.

(2) If, following that review, the responsible clinician is satisfied that the patient is not fit to be released from compulsory status, that clinician may apply to the Court for an extension of the currency of the order for a further period of 6 months commencing with the day after the date on which the order would otherwise have expired.

(3) The Court shall treat the application as if it were an application made pursuant to section 14 (4) (a) of this Act; and the provisions of sections 17 to 33 of this Act, with any necessary modifications, shall apply accordingly.

(4) If, on any such application, the Court extends the currency of the order for a further period of 6 months, on the expiry of that period the foregoing provisions of this section shall apply except that, if the Court then further extends the order, the extension shall have effect indefinitely and the patient shall remain subject to the order unless and until he or she is released from compulsory status.

35. Release from compulsory status—(1) If, at any time during the currency of a compulsory treatment order, the responsible clinician considers that the patient is fit to be released from compulsory status, that clinician shall direct that the patient be released from that status forthwith.

(2) If the responsible clinician considers that the patient is not fit to be released from compulsory status but a district inspector or an official visitor, or a friend or relative, is of the contrary opinion, the inspector or official visitor shall, or the friend or relative may, refer the case to the Review Tribunal for consideration under section 79 of this Act.

(3) Where a patient is directed to be released from compulsory status under this section, the compulsory treatment order shall be deemed to expire on the date specified in that behalf in the direction.

36. Compulsory treatment order to cease to have effect in certain cases—(1) Notwithstanding any of the preceding provisions of this Part of this Act, if, at any time while a compulsory treatment order is in force in respect of any person, that person becomes subject to an order made by a Court under subsection (2) (b) (ii) or subsection (11) of section 121 of the Criminal Justice Act 1985, the compulsory treatment order shall be suspended during the currency of that other order.

(2) Notwithstanding any of the preceding provisions of this Part of this Act, a compulsory treatment order in respect of any person shall cease to have effect if that person—

(a) Becomes subject to an order made under section 115 or section 118 of the Criminal Justice Act 1985; or

(b) Is sentenced by a court to be detained in a penal institution.

PART III

Assistance for Caregivers and Supervision of Outpatients

37. Advice and assistance of general nature—So far as practicable, duly authorised officers shall act as a ready point of contact for anyone in the community who has any worry or concern about any aspect of this Act, or about services available for those who are or may be suffering from mental disorder; and, at the request of anyone, they shall provide all such assistance, advice, and reassurance as may be appropriate in the circumstances.

38. Assistance where person may need assessment—(1) Anyone who is concerned in any way with the care of any person and who believes that that person may be suffering from mental disorder may request the assistance of a duly authorised officer.

(2) On any such request, a duly authorised officer—

(a) Shall investigate the matter to the extent necessary to satisfy himself or herself that the concern expressed by the person making the request is valid, and that there are reasonable grounds for believing that the person to whom the request relates may be mentally disordered; and

(b) May, in addition, take any of the following steps:

(i) Arrange or assist in arranging for a medical practitioner to examine the person with a view to the

Services, or by a duly authorised officer, or by any member of the Police, or by any person to whom the charge of the patient had been entrusted during the period of leave, and returned to the hospital from which the patient escaped or was on leave or to any other hospital specified by the Director.

Restricted Patients

54. Patients presenting special difficulties may be drawn to Director's attention—(1) If, on making any inpatient order under Part II of this Act, a Judge considers—

(a) That the patient presents special difficulties because of the danger he or she poses to others; and

(b) That, for that reason, it may be appropriate that an order be made under section 55 of this Act declaring the patient to be a restricted patient,—

the Judge may direct that the case be referred to the Director for consideration.

(2) If the Director of Area Mental Health Services considers—

(a) That any patient who is subject to an inpatient order presents special difficulties because of the danger he or she poses to others; and

(b) That, for that reason, it may be appropriate that an order be made under section 55 of this Act declaring the patient to be a restricted patient,—

the Director of Area Mental Health Services may refer the case to the Director for consideration.

(3) If the Director, whether from his or her own information and inquiries, or on reference of the case to him or her under subsection (1) or subsection (2) of this section, considers—

(a) That any patient who is subject to an inpatient order presents special difficulties because of the danger he or she poses to others; and

(b) That, for that reason, it would be appropriate that an order be made under section 55 of this Act declaring the patient to be a restricted patient,—

the Director may apply to the Court for an order under section 55 of this Act declaring the patient to be a restricted patient.

55. Court may make order declaring patient to be restricted patient—(1) Every application under section 54 of this Act shall be made to, and heard and determined by, the Court.

(2) Sections 19 to 25 of this Act, so far as they are applicable and with any necessary modifications, shall apply in respect of applications under section 54 of this Act.

(3) On any such application, the Court may make an order declaring the patient to be a restricted patient if it is satisfied—

(a) That the patient presents special difficulties because of the danger he or she poses to others; and

(b) That, for that reason, it is appropriate that the order be made.

56. Effect of application and order in respect of leave—While an application under section 54 of this Act is awaiting determination, and while a patient is a restricted patient, sections 50 to 53 of this Act shall apply in respect of the patient as if he or she were a special patient, and nothing in sections 31 and 32 of this Act shall apply in respect of that patient.

PART V

Compulsory Treatment

57. No compulsory treatment except as provided in this Part—Except as provided in the succeeding provisions of this Part of this Act, no person who is undergoing assessment and treatment under Part I of this Act, or is subject to a compulsory treatment order, shall be required to accept any form of treatment without that person's consent.

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

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

(2) Except during the period of 1 month referred to in subsection (1) of this section, no patient shall be required to accept any treatment unless—

(a) The patient, having had the treatment explained to him or her in accordance with section 67 of this Act, consents in writing to the treatment; or

(b) The treatment is considered to be in the interests of the patient by a psychiatrist (not being the responsible

clinician) who has been appointed for the purposes of this section by the Review Tribunal.

(3) Where, during the period of 1 month referred to in subsection (1) of this section, the responsible clinician is satisfied—

(a) That the patient will need further treatment of a particular kind beyond the expiry of that period; and

(b) That the patient is unlikely to consent to that treatment,—

the responsible clinician may, notwithstanding that the period has not expired, refer the case to the psychiatrist referred to in subsection (2) (b) of this section for consideration, so as to ensure that the opinion of that psychiatrist is available on the expiry of that period.

(4) The responsible clinician shall, wherever practicable, seek to obtain the consent of the patient to any treatment even though that treatment may be authorised by or under this Act without the patient's consent.

60. Special provision relating to electro-convulsive treatment—Notwithstanding anything in section 58 or section 59 of this Act, no patient shall be required to accept electro-convulsive treatment for mental disorder unless—

(a) The patient, having had the treatment explained to him or her in accordance with section 67 of this Act, consents in writing to the treatment; or

(b) The treatment is considered to be in the interests of the patient by a psychiatrist (not being the responsible clinician) who has been appointed for the purposes of this section by the Review Tribunal.

61. Special provision relating to brain surgery—Notwithstanding anything in section 58 or section 59 of this Act, no patient shall, for mental disorder, be subjected to any surgery or other treatment intended to destroy any part of the brain or brain function unless—

(a) The patient consents in writing to that surgery or other treatment; and

(b) The Review Tribunal has considered the case and is satisfied that the patient gave that consent freely, and in giving that consent, understood the nature, purpose, and likely effect of that surgery or other treatment; and

(c) That surgery or other treatment is considered to be in the interests of the patient by—

(i) The responsible clinician; and

(ii) A psychiatrist who has been appointed for the purposes of this section by the Review Tribunal and who has consulted with at least 2 health professionals (neither of whom is a medical practitioner) currently concerned in the patient's care.

62. Urgent treatment—Nothing in section 59 (2) of this Act shall apply to any treatment that is immediately necessary—

(a) To save the patient's life; or

(b) To prevent serious damage to the health of the patient; or

(c) To prevent the patient from causing serious injury to himself or herself or others.

63. Withdrawal of consent—Any consent given by the patient for the purposes of section 59 or section 60 or section 61 of this Act may be withdrawn at any time by the patient; and thereafter any further treatment given to the patient shall be deemed (unless the patient gives fresh consent) to be given without the patient's consent.

PART VI

RIGHTS OF PATIENTS

64. General rights to information—(1) Every person, upon becoming a patient, shall receive a written statement of his or her rights as a patient.

(2) Every patient is entitled to be kept informed of his or her rights as a patient, and, in particular,—

(a) Of his or her legal status as a patient; and

(b) Of his or her right, at any time during the first period of assessment and treatment or the second period of assessment and treatment, to have his or her condition reviewed by a Judge under section 16 of this Act; and

(c) Of his or her right, while detained in a hospital, to have his or her condition reviewed from time to time by the Review Tribunal in accordance with section 79 or section 80 of this Act; and

(d) Of his or her right to appeal under section 83 of this Act where the Review Tribunal decides under section 79 of this Act that he or she is not fit to be released from compulsory status; and

(e) Of his or her right to seek a judicial inquiry under section 84 of this Act; and

(f) Of all orders made by a Court or the Review Tribunal in respect of his or her case; and

(g) Of the functions and duties of district inspectors and official visitors appointed under section 94 of this Act.

65. Respect for cultural identity, etc.—Every patient is entitled to be dealt with in a manner that accords with the spirit and intent of section 5 of this Act.

66. Right to treatment—Every patient is entitled to medical treatment and other health care appropriate to his or her condition.

67. Right to be informed about treatment—Every patient is entitled to receive an explanation of the expected effects of any treatment offered to the patient, including the expected benefits and the likely side-effects, before the treatment is commenced.

68. Further rights in case of visual or audio recording—(1) Every patient is entitled to be informed where it is intended to make or use a videotape or other visual or audio recording of any interview with, or any other part of the treatment of, the patient.

(2) Nothing referred to in subsection (1) of this section shall be done without the prior consent of the patient or (where the patient is not capable of giving consent) the prior consent of the patient's personal representative (within the meaning of section 50 (7) of the Area Health Boards Act 1983).

69. Right to independent psychiatric advice—Every patient is entitled to seek a consultation with a psychiatrist of his or her own choice, and, if the psychiatrist agrees to the consultation, he or she shall be permitted access to the patient upon request.

70. Right to legal advice—Every patient is entitled to request a lawyer to advise the patient on his or her status and rights as a patient, or any other matters on which persons customarily seek legal advice, and, if the lawyer agrees to act for the patient, he or she shall be permitted access to the patient upon request.

71. Right to company, and seclusion—(1) Every patient is entitled to the company of others, except as provided in subsection (2) of this section.

(2) A patient may be placed in seclusion in accordance with the following provisions:

(a) Seclusion shall be used only where, and for as long as, it is necessary for the care or treatment of the patient, or the protection of other patients:

(b) A patient shall be placed in seclusion only in a room or other area that is designated for the purposes by or with the approval of the Director of Area Mental Health Services:

(c) Except as provided in paragraph (d) of this subsection, seclusion shall be used only with the authority of the responsible clinician:

(d) In an emergency, a nurse or other health professional having immediate responsibility for a patient may place the patient in seclusion, but shall forthwith bring the case to the attention of the responsible clinician:

(e) The duration and circumstances of each episode of seclusion shall be recorded in the register kept in accordance with section 129 (1) (b) of this Act.

72. Right to receive visitors and make telephone calls—(1) Every patient is entitled, at reasonable times and at reasonable intervals, to receive visitors and to make telephone calls, except where, in the opinion of the responsible clinician, such a visit or call would be detrimental to the interests of the patient and to his or her treatment.

(2) Nothing in this section shall limit or affect anything in section 69 or section 70 of this Act.

73. Right to receive letters and postal articles—Subject to section 123 of this Act, every patient is entitled to receive unopened any letter or other postal article addressed to the patient.

74. Right to send letters and postal articles—Subject to section 124 of this Act, every patient is entitled to the prompt dispatch unopened of any letter or other postal article put out by the patient for posting.

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

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

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

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

PART VII

Reviews and Judicial Inquiries

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

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

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

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

(a) Examine the patient; and

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

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

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

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

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

(a) The certificate of clinical review; and

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

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

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

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

(a) The Review Tribunal; and

(b) Each of the following persons:

(i) The patient:

(ii) Any welfare guardian of the patient:

(iii) The patient's principal caregiver:

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

(v) A district inspector:

(vi) An official visitor.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The Review Tribunal; and

(b) The Director; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The Director:

(b) The Director of Area Mental Health Services:

(c) The responsible clinician:

(d) The patient:

(e) Any welfare guardian of the patient:

(f) The patient's principal caregiver:

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

(h) A district inspector:

(i) An official visitor.

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

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

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

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

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

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

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

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

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

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

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

(ii) Decline to revoke that declaration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART VIII

Special Provisions Relating to Children and Young Persons

85. Application—In respect of any patient or proposed patient who is under the age of 17 years, the other provisions of this Act shall be read subject to the provisions of this Part.

86. Assessment examination—Wherever practicable, an assessment examination of a person who is under the age of 17 years shall be conducted by a psychiatrist practising in the field of child psychiatry.

87. Age of consent—Notwithstanding anything in section 25 of the Guardianship Act 1968 or any other enactment or rule of law to the contrary, in respect of a patient who has attained the age of 16 years, the consent of a parent or guardian to any assessment or treatment for mental disorder shall not be sufficient consent for the purposes of this Act.

88. Brain surgery—Notwithstanding anything in Part V or section 87 of this Act, brain surgery shall not be performed for mental disorder on any person who is under the age of 17 years.

89. Membership of Review Tribunal—Wherever practicable, for the purposes of a review by a Review Tribunal of the condition of a patient who is under the age of 17 years, 1 member of the Tribunal shall be a psychiatrist practising in the field of child psychiatry.

90. Review of patient about to attain age of 17 years—(1) This section applies to every patient who is subject to a compulsory treatment order and who will attain the age of 17 years before the expiry of the compulsory treatment order.

(2) Not earlier than 2 months and not later than 1 month before the date on which the patient will attain the age of 17 years, the responsible clinician shall review the patient's condition.

(3) The provisions of subsections (3) to (9) of section 76, and the succeeding provisions of Part VII, of this Act, so far as they are applicable and with any necessary modifications, shall apply in respect of every review under this section.

PART IX

Administration

Officials

91. Director and Deputy Director of Mental Health—(1) There shall from time to time be appointed under the State Sector Act 1988 the following officers in the Department of Health:

(a) A Director of Mental Health, who shall be responsible for the general administration of this Act under the direction of the Minister and the Director-General of Health:

(b) A Deputy Director of Mental Health, who shall, under the control of the Director, perform such general official duties as the Director may from time to time require.

(2) On the occurrence from any cause of a vacancy in the office of Director, whether by reason of death, resignation, or otherwise, and in case of the absence from duty of the Director from whatever cause arising, and so long as the vacancy or absence continues, the Deputy Director shall have and may exercise and perform all the powers, duties, and functions of the Director.

(3) The fact that the Deputy Director exercises or performs any of the Director's powers, duties, and functions shall be conclusive evidence of the Deputy Director's authority to do so, and no person shall be concerned to inquire whether the occasion has arisen requiring or authorising the Deputy Director to do so.

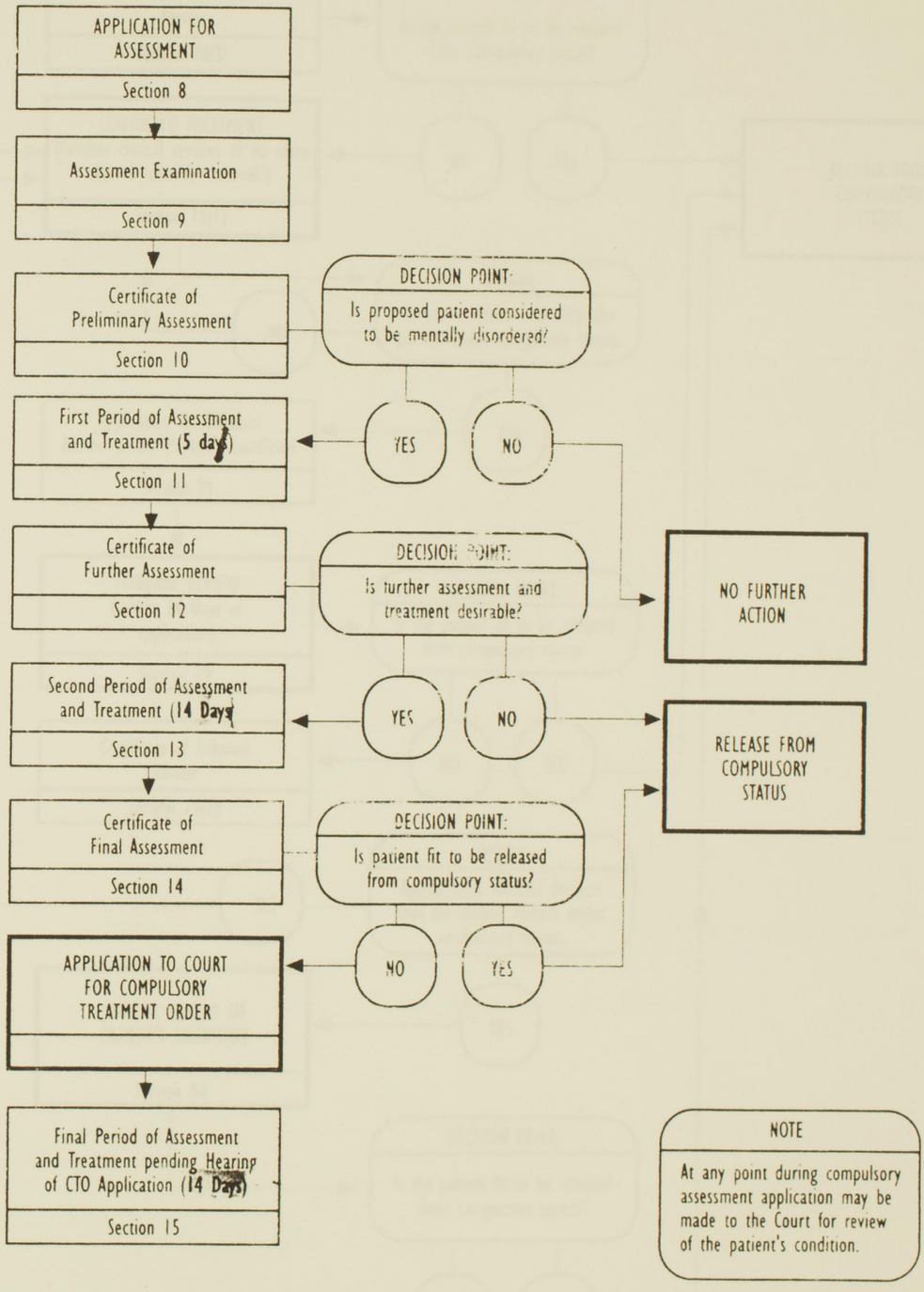
(4) The Director may from time to time delegate to any person employed in the Department of Health all or any of the powers, duties, and functions conferred or imposed on the Director by this Act, to be exercised by that person whenever, or on any specified occasion when, there is not present in Wellington a person holding or acting in the office of Director or of Deputy Director.

(5) Every delegation under subsection (4) of this section shall have effect according to its tenor.

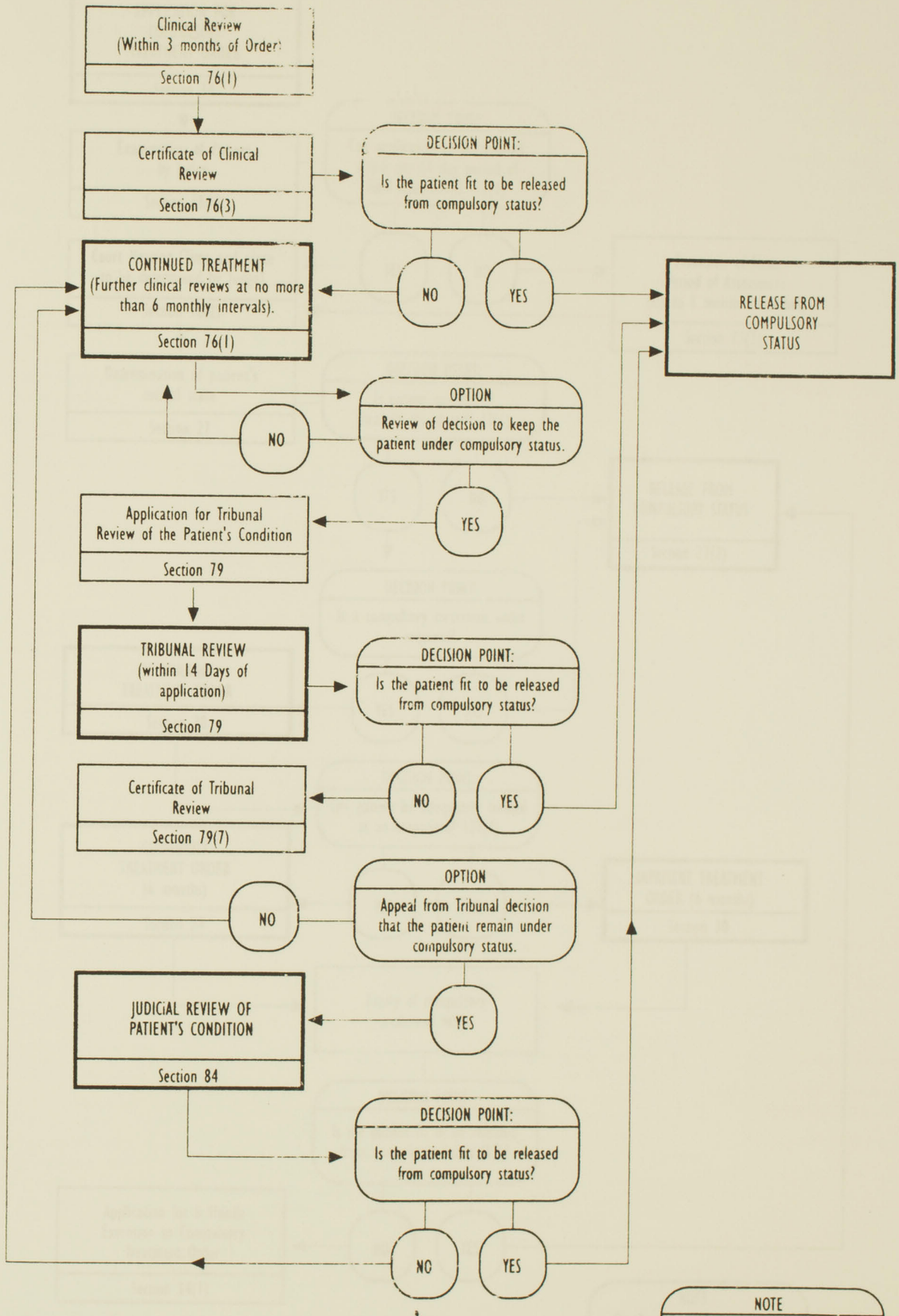
APPENDIX 3

COMPULSORY ASSESSMENT AND TREATMENT

- KEY POINTS -



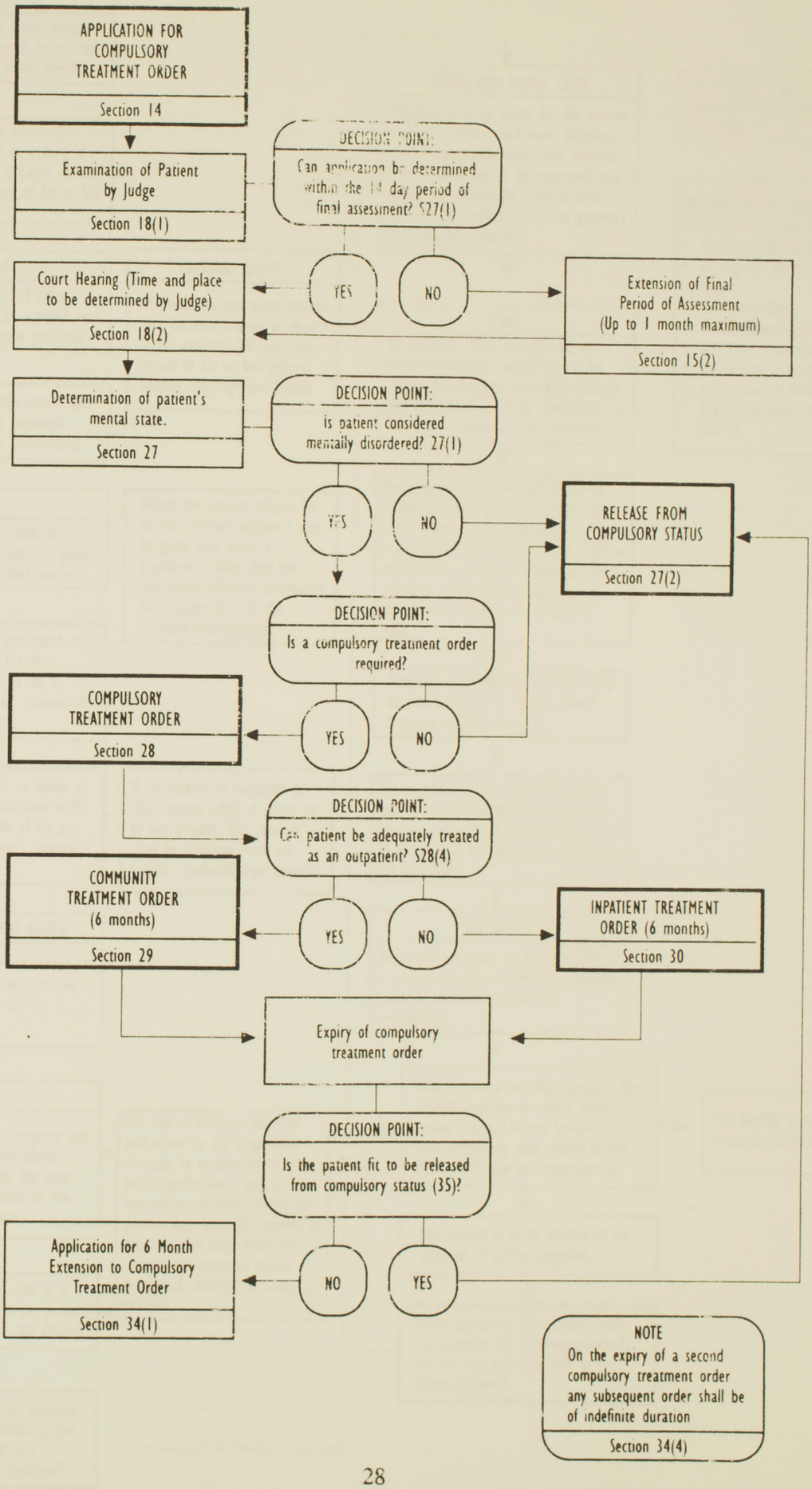
REVIEWS AND JUDICIAL INQUIRIES
(Persons Subject to Compulsory Treatment Orders)
- KEY POINTS -



NOTE

A judge of the High Court may, of its own motion, or on application by any person, determine whether that patient is being detained illegally or is fit to be discharged.

COMPULSORY TREATMENT ORDERS
- KEY POINTS -



PATIENT RIGHTS
- KEY POINTS AND PROCEDURES -

INFORMATION

On becoming a patient every person is to be advised in writing of his or her legal status and rights under the Act.

While under compulsory status the patient is to be advised in writing of all the orders made by a Court or the Review Tribunal in respect of his or her case.

TREATMENT

The patient's psychiatric and other health care needs shall be assessed and appropriate treatment made available.

CULTURAL IDENTITY

All treatment and other health care decision making in respect of the patient shall have due regard to his or her cultural identity, language and beliefs.

The patient must have the nature and effects of any treatment explained before that treatment is commenced.

CONSENT

Except during the first month of treatment no treatment shall be given without the patient's written consent.

Where the patient refuses his or her consent, treatment may be given only when a psychiatrist other than the responsible clinician determines that treatment is in the patient's best interest.

Even though compulsory treatment may be authorised under the Act, the responsible clinician shall as far as possible seek to obtain the consent of the patient to treatment.

If it is intended to make an audio or a visual record of any interview with the patient, or any aspect of his or her treatment, that patient's consent must be obtained.

If the patient is incapable (in this instance only) of giving his or her consent, that consent must be obtained from the patient's personal representative.

ACCESS TO INDEPENDENT ADVICE

If the patient has engaged a lawyer or independent psychiatrist such persons shall be permitted access to the patient on request.

SECLUSION

The patient is entitled to company and must not be secluded from others, except where necessary for the care and treatment of the patient or the protection of other patients.

The use of seclusion must be authorised by the responsible clinician. In an emergency any health professional with an immediate responsibility for the patient may place the patient in seclusion, but must bring the case to the attention of the responsible clinician as soon as possible.

A patient shall only be secluded in a room or area designated for the purpose by, or with the authority of, the DAMHS.

Where a patient is placed in seclusion the circumstances and duration of the seclusion is to be recorded in a "Register of Restraint and Seclusion".

VISITORS AND PHONE CALLS

Provision is to be made for the patient to receive visitors and make telephone calls at reasonable times and intervals. Calls or visits are to be restricted only where the responsible clinician believes them to be detrimental to the patient's interests and treatment.

The patient's right of access to independent and legal advice shall not be restricted.

MAIL

The patient's mail shall be sent or received unopened except where the responsible clinician reasonably believes that the letter would be detrimental to the patient's interests and treatment.

No letter to the patient shall be withheld if it is sent by or on behalf of:

- A Member of Parliament;
- a judge or officer of any judicial body;
- an ombudsman;
- The Director-General of Health
- a district inspector or official visitor;
- the person in charge of the hospital;
- a barrister or solicitor; or
- any psychiatrist engaged by the patient.

Any incoming mail withheld from the patient is to be returned to the sender. If the name and address of the sender is not known, the letter is to be sent to the district inspector or offical visitor, or produced to the district inspector or official visitor when he or she next visits.

Outgoing mail which is withheld shall be sent or produced to the district inspector or official visitor.

The patient is to be advised whenever mail is withheld, unless the responsible clinician considers that to do so would be detrimental to the patient and his or her treatment.

COMPLAINTS

Any complaint made by or on behalf of a patient is to be referred to a district inspector or official visitor for investigation.

Where a complaint has substance the district inspector or offical visitor (or Review Tribunal where Review has been requested) must report to the DAMHS with any recommendations.

The DAMHS is to take all steps necessary to rectify the situation.

The patient is to be advised of the outcome of the investigation.

If the patient is not satisfied, with the outcome of the investigation he or she may refer the case to the Review Tribunal.