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DISABILITY RIGHTS AND COMPULSORY PSYCHIATRIC TREATMENT:
The Case for a Balanced Approach under the Mental Health (Compulsory Assessment and Treatment) Act 1992

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Abstract

This paper argues the New Zealand government's current approach to compulsory psychiatric treatment is unjustifiable in a human rights context. Under s 59 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, clincians are empowered to administer compulsory psychiatric treatment to individuals without, or contrary to, their consent. This paper analyses s 59, and its underlying justifications, in light of the New Zealand government's commitments under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). Further, it analyses the approach for compulsory psychiatric treatment advocated by the UNCRPD in light of New Zealand's mental health context to evaluate whether this approach would be more desirable than the current approach under s 59. The paper then advocates for a more balanced approach to compulsory psychatric treatment which puts the rights of disabled individuals at the forefront and also ensures there are limits to these rights which are justifiable within a human rights context.

Keywords: “mental health”, “human rights”, “United Nations Convention on the Rights of Persons with Disabilities”, “Mental Health (Compulsory Assessment and Treatment) Act 1992”.

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I Introduction

New Zealand has some of the most concerning mental health statistics in the OECD. Every year, around one in five people experience a diagnosed mental illness or significant mental distress, and around 20,000 people attempt to take their own lives.[1] In 2015 alone, 525 New Zealanders took their own life.[2] Mental illness, and especially suicide, impacts the individual who is suffering, their family and whanau, and the community as a whole.[3]

One strategy the New Zealand government address these troubling mental health statistics is to make individuals with mental illnesses subject to compulsory psychiatric treatment under s 59 the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHCAT). S 59 allows a responsible clinician to administer psychiatric treatment to an individual under a compulsory treatment order (CompTO) without, and sometimes contrary to, their consent.[4] This treatment is justified on what the responsible clinician believes to be the "best interests" of the individual.[5]

S 59 of MHCAT is arguably inconsistent with the rights affirmed under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).[6] S 59 allows the denial of an individual's right to consent to treatment on the basis they meet the conditions of "mental disorder".[7] This process of denying individual rights on the basis of a "legally defined border" being crossed is known as substituted decision-making.[8] The United Nations Committee on the Rights of Disabled People (the Committee) General Comment

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[1] "He Ara Oranga: Government Inquiry into Mental Health and Addiction" (November 2018), at 8.

[2] At 8.

[3] At 8.

[4] A responsible clinician, in relation to a patient, means the clinician in charge of the treatment of that patient.

[5] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 59(2)(b); Ministry of Health "Guidelines to the Mental Health (Compulsory Assessment and Treatment Act) 1992" (September 2020) at 2.

[6] United Nations Convention on the Rights of Persons with Disabilities UTS 2515 (opened for signature 30 March 2007, entered into force 3 May 2008), art 12; and *Committee on the Rights of Persons with Disabilities General Comment No. 1* XI CRPD/C/GC/1 (2014), at [7].

[7] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 2 and 27(3).

[8] Geneva Richardson "Mental Disabilities and the Law: From Substitute to Supported Decision-Making?" (2012) 65 CLP 333 at 337.

No. 1 (the Comment) argues substituted decision-making models are discriminatory and unacceptable.[9] Further, the Comment advocates for abolishing substituted decision-making,[10] which centres on "best interest" assessments, and advocates for supported decision-making processes, which centres around the individual's "will and preference".[11] The "will and preference" assessment allows for the individual's agency to be at the centre of any decision in their lives, including decisions about psychiatric treatment.[12] Therefore by embracing a substituted decision-making model under s 59 of MHCAT, the New Zealand government is not living up to its commitments under the UNCRPD.[13]

This paper evaluates New Zealand's current practice under s 59 of MHCAT and the encouraged practice under the Comment, and assesses whether New Zealand should abandon all substituted decision-making when it comes to psychiatric treatment under MHCAT. Previous studies have discussed an individual's right to refuse treatment whist under a CompTO and evaluated MHCAT in a human rights context.[14] However, no study has yet evaluated s 59 specifically in light of the Comment.[15] Further, there has been a lack

[9] *Committee on the Rights of Persons with Disabilities General Comment No.* 1, above n 6, at [7].

[10] At [7].

[11] At [26].

[12] At [26].

[13] The New Zealand government have recently announced that they are going to repeal and replace MHCAT and have suggested that while this repeal is in process clinicians take into account supported decision-making practice when exercising their powers under s 59. See Ministry of Health, above n 5, at 2; and Ministry of Health "Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992" (September 2020).

[14] See Jeremy Skipworth "Should Involuntary Patients with Capacity Have the Right to Refuse Treatment?" in John Dawson and Kris Geldhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 229; and Kris Gledhill "A 'Rights' Audit of the Mental Health Act" in John Dawson and Kris Geldhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 285.

[15] There have been discussions of the Comment in relation to mental health law generally. See for example John Dawson "A realistic approach to assessing mental health laws' compliance with the UNCRPD" (2015) 40 Int'l J L and Psych 70; and Tina Minkowitz "Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities" in Bernadette McSherry and Penelope Welter (eds.) Rethinking Rights-Based Mental Health Laws (Hart Publishing, Portland, 2010) 151.

of discussion around substituted and supported decision-making models in a New Zealand mental health context.[16]

An assessment of New Zealand's current practice under s 59 is needed to assess whether it is adequately protecting the rights of some of the most vulnerable in New Zealand society, or whether a new model is needed to do this. Approximately 104 people in every 100,000 are currently subject to compulsory psychiatric treatment under s 59, with these numbers only projected to increase absolutely and proportionally to the population.[17] A reason for this is due to the number of people who are under indefinite orders, making them subject to compulsory treatment for the rest of their lives.[18] If New Zealand's current practice under s 59 was effective in helping individuals who are mentally ill these numbers should be decreasing, not increasing.

This paper argues our current practice under s 59 of MHCAT cannot be legitimately justified in a human rights context, and that working towards an approach that is a balance between our current practice and the practice advocated in the Comment is the best way forward for mental health law in New Zealand. Part One explains how a CompTO is issued under MHCAT, the substituted decision-making process within s 59 of MHCAT, and the

[16] In New Zealand subsituted and supported decision-making models have been discussed in reference to other areas of the law. See for example B. Mirfin-Veitch *Exploring Article 12 of the United Nations Convention on the Rights of Persons with Disabilities: An Integrative Literature Review* (Donald Beasley Institute, 2016); and Alison Douglass *Mental Capacity: Updating New Zealand's Law and Practice* (New Zealand Law Foundation, July 2016). Further, there have been discussions in overseas juridstictions on these decision making models and mental health law. For example Michael Bach and Lana Kezner *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity* (Law Commission of Ontario, October 2010); Sacha Callaghan and Christopher J Ryan "Rising to the human rights challenge in compulsory treatment – new approaches to mental health law in Australia" (2012) 46 Australia & New Zealand Journal of Psychiatry 611; Michael C Dunn and others "Constructing and Reconstructing 'Best Interests': An Interpretive Examination of Substitute Decision-making under the Mental Capacity Act 2005" (2007) 29 J Soc Wel & Fam L 117; Raymond Lang and others "Implementing the United Nations Convention on the rights of persons with disabilities: principles, implications, practice and limitations" (2011) 5 Alter – European Journal of Disability Research 206; and Geneva Richardson, above n 8.

[17] Sarah Gordon "The Recovery of Compulsory Assessment and Treatment" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 268, at 277.

[18] At 277.

current justifications behind this process. Part Two identifies the development of case law on the justifications of the compulsory treatment process under s 59 to show how these justifications are applied in practice and to create a better understanding on what standards need to be met for an individual's rights to be limited under s 59. Part Three introduces the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the Comment and discuss how adopting the suggestions in the Comment would impact New Zealand's mental health regime. Finally, Part Four evaluates New Zealand's current practice and the proposed practice by the Comment, and presents a more balanced approach to psychiatric treatment under MHCAT.

II CompTOs in New Zealand

A CompTO, which is issued under s 27 of MHCAT, is an inpatient or outpatient order issued by the District or Family Court.[19] This order allows a responsible clinician to administer psychiatric treatment on an individual without their consent under s 59 of MHCAT. CompTOs expire after 6 months from the date the CompTO was issued.[20] The responsible clinician, two weeks before the expiry of the original CompTO, can apply to the Court for an extension of the order for a further 6 months.[21] If the responsible clinician applies for a further extension after the previous extension has been issued, the order will be indefinite, and the individual will be subject to compulsory psychiatric treatment unless or until they are released from compulsory status.[22]

This part of the paper explains the process in which a CompTO is issued, the process for administering compulsory psychiatric treatment under s 59, and the justifications behind administering said treatment.

[19] S 27(3).
[20] Ss 28(1) and 33.
[21] Ss 34(1) and (2).
[22] S 34(4).

A Issuing a CompTO

Any person who believes an individual is suffering from a mental disorder may at any time fill out a form asking the Director of Area Mental Health Services (the Director) for an assessment of the individual.[23] This form requires a certificate by a health practitioner, who can be a medical practitioner, a nurse practitioner, or a registered nurse practicing in mental health, stating there is reasonable ground to believe an individual has a mental disorder after they have examined the individual.[24]

After the application form has been received by the Director and before a CompTO can be legally issued, the individual must go through three different assessment stages. The first stage is a preliminary assessment examination conducted by a health practitioner.[25] This health practitioner needs to be a psychiatrist approved by the Director or, if no such psychiatrist is readily available, a medical practitioner or nurse practitioner who, in the opinion of the Director, is suitably qualified to conduct the assessment examination.[26] After this assessment examination, the health practitioner will issue a certificate of preliminary assessment stating whether, in their opinion, the individual falls within the definition of mentally disordered under MHCAT.[27] 'Mental disorder' is defined under MHCAT as:[28]

> … 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

[23] S 8A.
[24] S 8B.
[25] S 9(1).
[26] Ss 9(3)(a) and 9(3)(b).
[27] S 10(1).
[28] S 2.

If the health practitioner believes the individual does have a mental disorder, the individual will go under compulsory treatment and assessment for five days.[29]

The second stage involves issuing a certificate of further assessment. Within the five days of compulsory assessment and treatment the responsible clinician will issue a certificate concluding whether, in their opinion, they believe an individual has a mental disorder as defined under MHCAT.[30] If the responsible clinician believes they do meet this definition, the individual will be subject to compulsory assessment and treatment for a further 14 days.[31] Within the first and second stages the individual, or any other person of interest stipulated in ss 10(4) and 12(5), have the right to get the court to review the individual's condition.[32]

The final stage involves the responsible clinician assessing whether the individual is fit to be released from compulsory status. If they do not believe the individual is fit to be released from compulsory status, due to their mental disorder, the responsible clinician must apply for a CompTO under Part 2 of MHCAT.[33] Once this application is received the Judge must examine the patient, as well as consult with the responsible clinician and one other health practitioner in the case.[34] When the application is heard the individual, or their representatives, have the right to be heard and call evidence.[35] After the hearing, the Court will consider whether a patient is mentally disordered or not.[36] If they believe the patient is mentally disordered, they must decide, having regard to all the circumstances, that a CompTO is necessary and should be issued.[37]

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[29] S 11.
[30] S 12(1).
[31] S 13.
[32] S 16.
[33] S 14(1).
[34] S 18.
[35] S 20.
[36] S 27(1).
[37] S 27(3).

B S 59 and substituted decision making: treatment while subject to a CompTO

S 59 is the main provision utilised by a responsible clinician when administering treatment under a CompTO. This provision empowers responsible clinicians to administer any psychiatric treatment, excluding electro-convulsive therapy or brain surgery, to an individual under a CompTO.[38] It falls under Part 5 of the Act which outlines what processes a responsible clinician needs to go through to administer certain types of treatment. Although the parts which come before Part 5 are of importance to clinicians as they outline the assessment process before a CompTO is issued, once the CompTO is issued these parts are no longer of relevance. Further, the parts which come after Part 5 are not of importance to responsible clinicians as they are directed at the individual who is subject to a CompTO and provide the individual with information on their rights and the process to get their CompTO judicially reviewed.

S 59 outlines the process that a responsible clinician has to go through when administering compulsory psychiatric treatment under a CompTO and shows the low level of consent needed for treatment to be administered. Within the first month of a CompTO, s 59(1) allows the responsible clinician to administer treatment without needing to explain the treatment to the individual or seek the individual's consent. After the first month, s 59(2) puts a requirement on the responsible clinician to explain the treatment to the individual and attempt to get the individual's written consent.[39] The Ministry of Health Guidelines (the Guidelines) around seeking consent under s 59(2) explain the consent is not interpreted as free, prior and informed consent.[40] Instead, consent is interpreted as "assent", which allows for a level of coercion.[41]

If the individual refuses to consent to the treatment, the proposed treatment will then be reviewed by a psychiatrist, appointed by the Mental Health Review Tribunal (the Tribunal), for a second opinion.[42] The psychiatrist will assess whether the treatment being proposed

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[38] See ss 60 (electro-convulsive therapy) and 61 (brain surgery).

[39] S 59(2)(a).

[40] Ministry of Health, above n 5, at 90.

[41] At 90.

[42] S 59(2)(b).

by the responsible clinician is in the individual's "interests".[43] The psychiatrist is not in a position to assess whether the patient should remain under a CompTO or not, they are only required to consider whether they believe the treatment is appropriate.

If the psychiatrist believes the treatment is in the "best interests" of the patient, the treatment will go ahead.[44] The Guidelines sets out what this second opinion needs to consider. The psychiatrist will look at the individual's history and view and assess the relative risks and benefits of the potential treatment approaches.[45] Concerning the treatment proposed by the responsible clinician, the psychiatrist will look at whether this is the least restrictive treatment, whether it is of maximal benefit to the individual's condition and whether the treatment is necessary to achieve the purpose of compulsory treatment.[46]

The process stipulated by s 59 is an example of substituted decision-making. Substituted decision-making is when decisions are made in the "best interests" of an individual who has crossed a "legally defined border".[47] In the context of the MHCAT, this border is the definition of "mental disorder".[48] S 59 entails processes which allow a responsible clinician to administer psychiatric treatment if they, and/or a psychiatrist, believes it is in the "interests" of the individual.[49] This substituted decision-making process will not stop unless, or until, the individual is released from compulsory status under MHCAT.

C Justifications behind substituted decision-making under s 59

There are two main ways substituted decision-making, and the restriction of an individual's autonomy under s 59 may be justified under MHCAT. Firstly, the protection of the individual and others in the community from harm. Secondly, the concept of *parens patriae* which stipulates the government's responsibility to help people who cannot help

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[43] S 59(2)(b).
[44] S 59; and Ministry of Health, above n 5, at 2 and 91.
[45] Ministry of Health, above n 5, at 92.
[46] At 92.
[47] Geneva Richardson, above n 8, at 337.
[48] Defined in s 2.
[49] Ministry of Health, above n 5, at 91.

themselves. This section explains the historical origin of these justifications and where these justifications present themselves within MHCAT.

1 Protection from harm

In relation to health risks, preventing harm, is one of the most politically compelling reasons to limit an individual's autonomy.[50] This justification can be traced back to the liberal philosopher, John Stuart Mill, and his Harm Principle.[51] Mill explains this principle by arguing:[52]

> … The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant …

Despite Mill making it clear the State can only intervene with an individual's liberty to prevent harm to others, the definition of the Harm Principle has been expanded to justify State intervention to prevent harm to one's self. Since Mill does not define what "harm to others" means in this principle, it has been open to interpretation and expansion.[53] Theoretically, there is not much individual conduct which does not harm other people indirectly.[54] In the mental health context, it has been proven that suicide, which is a harm to one's self, negatively impacts family, whanau, and the community as a whole.[55]

In MHCAT, both the traditional and expanded definition of the Harm Principle is present in its justification of s 59. To fall under a CompTO, and thus receive compulsory treatment, an individual must meet the definition of "mental disorder".[56] MHCAT stipulates the first

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[50] Thaddues Mason Pope "Balancing Public Health against Individual Liberty: The Ethics of Smoking Regulations" (2000) 61 U Pitt L Rev 419 at 433.

[51] See John Stuart Mill *On Liberty* (Batoche Books, Ontario, 2001) (1859).

[52] At 13.

[53] "Limiting the State's Police Power: Judicial Reaction to John Stuart Mill" (1970) 37 U Chi L Rev 605 at 621.

[54] Pope, above n 31 at 447; see also Isiah Berlin "Two Concepts of Liberty" in *Four Essays on Liberty* (Oxford University Press, Oxford, 1969) 118 at 155.

[55] Government Inquiry into Mental Health and Addication, above n 1, at 8.

[56] See generally Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 2, 27(1) and s 59.

limb of this definition is that an individual "poses a serious danger to the health or safety of that person or of others".[57] The traditional definition of the Harm Principle is applicable because one justification for putting an individual under a CompTO is if they pose a serious danger to others. This traditional aspect can also apply to the part of the definition which stipulates an individual has a "mental disorder" if they pose a serious danger to themselves. Under the Guidelines, serious danger to the individual may arise when the mental state of that person can make them vulnerable to violent or sexual exploitation from others.[58] However, the literal meaning of "danger to … that person" embraces the more expansive definition. Acts such as self-harm may make someone fall under a CompTO as this is a danger to the individual that may indirectly harm the people around them.

2 Parens patriae

Parens patriae is another doctrine the State uses to justify compulsory psychiatric treatment under MHCAT. The doctrine is inherently paternalistic and requires the State to act as a protector of individuals who are too vulnerable to protect themselves.[59] It allows the State to make decisions in the "best interest" of the person, overriding their autonomy, to promote and protect their wellbeing.[60] In MHCAT, the doctrine of *parens patriae* is present under the definition of "mental disorder".[61] If an individual does not meet the requirement of posing a serious danger to themselves or others, the second limb of "mental disorder" stipulates an individual can still be subject to compulsory psychiatric treatment if their mental state "seriously diminishes the capacity of that person to take care of himself or herself".[62] This definition allows an individual to be subject to compulsory psychiatric treatment if the person does not have the opportunity to have a minimally accepted standard of life.[63]

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[57] S 2.

[58] Ministry of Health, above n 5, at 15.

[59] Bruce J Winick "On Autonomy: Legal and Psychological Perspectives" (1992) 37 Vill L Rev 1705 at 1772.

[60] At 1772.

[61] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2.

[62] S 2.

[63] Matthew McKillop "Seriously Diminished Capacity for Self-Care" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 77 at 77.

III Judicial development of s 59 justifications

The justifications for treatment under s 59 have been open to interpretation by the Courts due to the wording of these justifications in MHCAT. This part will explain how the justifications have been interpreted by the Courts and how the justifications apply in practice. By explaining how these justifications work in practice it will allow for a better analysis of MHCAT in light of the New Zealand government's commitments under the UNCRPD by creating an understanding of what standards need to be met in order for an individual to have their rights limited under s 59.

A Development of the serious danger standard

Within the first few years of case law surrounding the interpretation of MHCAT, the "serious danger" standard was contested between the Courts with some interpretations holding "serious danger" to a high standard and others holding it to a lower and more holistic standard. The "serious danger" standard, which is present within the definition of "mental disorder", embraces the Harm Principle justification for compulsory psychiatric treatment under s 59. Overall, the Courts ended up settling this standard to be a lower standard which as a result justifies compulsory psychiatric treatment under s 59 if an individual presents a less serious and less imminent threat of danger.

The first few cases which tackled with MHCAT interpretation held "serious danger" in s 2 of MHCAT meant a serious imminent threat of physical violence to the individual or others. In the case of *Re O*, the District Court held that 'serious danger' meant "imminent or demonstrable" and that the inclusion of the adjective "serious" meant the test needed to be a strict one.[64] In *Re M*, Gallen J concluded that 'serious danger' meant a "risk of serious physical violence" and not a "mere nuisance" to ensure that detention under a CompTO was not arbitrary.[65] This risk of physical violence was also emphasised in *In the matter of JK* where Judge Ellis held that physical violence could be actual violence "of such a level of seriousness as to require the detention of the subject irrespective of his state of mind" or

[64] *Re O* [1993] NZFLR 545 (DC) at 546.
[65] *Re M* [1992] 1 NZLR 29 (HC) at 39.

potential violence that was "imminent and sufficiently likely as to justify preventative action by way of detention".[66]

This higher standard was contested, and eventually overruled, in other cases which interpreted "serious danger" to be a lower standard that could justify non-consensual psychiatric treatment based on less serious and less imminent threats of danger. In *In the matter of T*, the Tribunal rejected the interpretation of "serious danger" in *JK* as they believed that compulsory treatment would only be restricted to people who were likely to be incarcerated in the criminal justice system.[67] The Tribunal shifted the focus of the "serious danger" assessment from detention to treatment. This is due to the nature of a CompTO making an individual subject to compulsory psychiatric treatment, not always compulsory detention.[68] They ruled the test for "serious danger" was "danger … likely to happen at any moment in the foreseeable future".[69] This prediction of the future was to be assessed by reference to four questions concerning the nature of the harm, its imminence, its magnitude, and its frequency.[70] In this case, T had not exhibited any recent incidents of dangerous behaviour, but the Tribunal held that the danger test was met.[71] The Tribunal held that although the lack of recent incidents was a significant factor, it needed to be balanced against the preventative effects of the medication given, the likelihood of deterioration of T's condition if medication was not voluntarily taken and the likelihood of relapse into dangerous behaviour which posed harm to others, even if this behaviour was not criminal.[72]

B Development of the self-care standard

Like the "serious danger" standard, the "self-care" standard was also open to interpretation by the Courts and it was decided this standard embraces an objective test with a subjective element. The "self-care" standard is present within the second limb of the definition of

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[66] *In the matter of JK* [1994] NZFLR 678 (FC) at 702.
[67] *In the matter of T* [1994] NZFLR 946 (MHRT) at 953.
[68] At 953.
[69] At 955.
[70] At 951.
[71] At 957.
[72] At 957.

"mental disorder" under s 2 of MHCAT and embraces the *parens patriae* justification for compulsory psychiatric treatment under s 59. The standard allows for compulsory psychiatric treatment if an individual's mental illness seriously diminishes them from having a minimally accepted standard of living. On its face, a minimally accepted standard of living may mean access to the mere necessities of life. However, due to no concrete definition of a minimally accepted standard of living, the Courts have extended this definition to include other aspects of modern living such as family, social relationships, maintaining housing, employment, and physical and mental health.

Re C demonstrates how the courts assess a minimally accepted standard of "self-care". The Court stated that although it is important to gain evidence on how an individual had been functioning properly in their social realm compared to how they are functioning now, the Court "should objectively assess what an ordinary citizen would find acceptable as a minimum standard of effective self-care for a person of the patient's circumstances and background".[73] It, therefore, shows an objective standard with a subjective element. However, the Tribunal has suggested that, in practice, there is a commonality in cases that fall under the self-care provision.[74] This suggests that an objective standard alone is sufficient, and there is usually no need to engage with the subjective element.[75]

The case of *KBLG* shows how this assessment is applied in practice.[76] G had previously demonstrated danger to others and himself when acutely unwell. The Tribunal did not see this as necessary to constitute a 'serious danger'. However, the Tribunal still put G under a CompTO justifying this based on the 'self-care' provision. G would go through periods of self-isolation which the Tribunal held would seriously diminish the capacity for self-care if his mother and others withdrew their support. Therefore, it was G's inability to maintain relationships which made him subject to a CompTO.[77] Overall, this shows that

[73] *Re C* DC Auckland CAT 132/99, 28 August 2000 at 9.
[74] *Re AVHM* MHRT 08/110, 3 September 2008 at [39].
[75] McKillop, above n 63, at 85.
[76] *Re KBLG* MHRT 12/090, 15 August 2012.
[77] At 47.

the *parens patriae* justification goes beyond ensuring an individual has the mere necessities of life but extends it to other aspects of modern living.

Overall, the interpretations of these standards through case law shows how limitations on an individual's autonomy, by making them subject to compulsory psychiatric treatment under s 59, are justified in practice. Both the "serious danger" standard which embraces the Harm Principle and the "self-care" standard which embraces *parens patriae* have the effect of making it easier to justify the limitation of an individual's rights. The next part of this paper will explain what rights are directly affected by the justifications under MHCAT by introducing the UNCRPD, the rights affirmed under the UNCRPD and how s 59 of MHCAT would be viewed in light of the UNCRPD.

IV United Nations Convention on the Rights of Persons with Disabilities

By signing the UNCRPD, the New Zealand government committed to protecting and providing resources to ensure that disabled people are afforded the same rights as non-disabled people. The UNCRPD was drafted at a time when disability activists were promoting a shift in perception of people with disabilities from being seen as welfare-receivers to humans with inherent rights.[78] At this time there was also a shift in the definition of disability. Instead of defining disability based on a medical model, which viewed disability as an individual problem that prevented people from performing tasks in a 'normal way', a social model was preferred.[79] It viewed disability as socially created rather than an individual issue and began to consider how environmental factors did not cater to a diverse range of individuals, which disabled them.[80] This social model is evident in New Zealand's Disability Strategy 2016-2026, which defines disability as: [81]

[78] Jerry Alan Winter "The Development of the Disability Rights Movement as a Social Problem Solver" (2003) 23 DSQ 33.

[79] Winter, above n 78.

[80] Collin Barnes "A working social model? Disability, work and disability politics in the 21st century" (2000) 20 Critical Social Policy 441 at 444.

[81] Office for Disability Issues "New Zealand Disability Strategy" (November 2016) at 12.

> Something that happens when people with impairments face barriers in society; it is society that disabled us, not our impairments, this is the thing all disabled people have in common. It is something that happens when the world we live in has been designed by people who assume everyone is the same.

The UNCRPD arguably does not create any new rights. However, it shows that the State may need to commit more resources to disabled people to ensure their rights are as effectively enforced as non-disabled people.[82]

This part of the paper will explain article 12 of the UNCRPD and the Comment released by the Committee concerning the application of this article when it comes to decision-making models for disabled individuals. It then looks at how the Committee views s 59 of MHCAT in relation to the Comment.

A Article 12: equal recognition before the law

Article 12 of the UNCRPD reaffirms that the State will recognise disabled individuals equal to non-disabled individuals under the law.[83] This places an obligation on the State to have appropriate and effective safeguards to prevent abuse in accordance with international human rights law.[84] This ensures that disabled individuals are be able to exercise their rights without undue influence and following their will and preference.[85] In relation to decision-making regarding medical treatment, this would mean that a disabled individual's right to refuse medical treatment should be protected by the State to the same extent it is protected for non-disabled individuals. Further, if this right has been limited by the State, this limitation should apply for the shortest time possible and be subject to regular review by an independent and impartial authority or a judicial body.[86]

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[82] Raymond Lang and others, above n 16, at 209.

[83] United Nations Convention on the Rights of Persons with Disabilities, above n 6, art 12.

[84] Art 12(4).

[85] Art 12(4).

[86] Art 12(4).

Article 12 of the UNCRPD has been arguably the most contentious article when it comes to implementation, especially in a mental health context.[87] As the interpretation of article 12 remained subject of debate, the Committee released the Comment in attempts to reconcile the ambiguity.[88]

B General Comment No. 1 and supported decision-making

The Comment begins by stating that legal capacity is a universal attribute and should not be denied based on someone's mental or decision-making capacity.[89] The State should provide ways to help support people with diminished mental or decision-making capacity to exercise their legal agency.[90] This support "should *never* amount to substituted decision making".[91] Further, if there are decisions that need to be made to intervene in an individual's exercise of their legal capacity, this decision should *never* be made in the "best interests" relating to a person.[92] Instead, third parties should attempt to interpret their "will and preference" as far as possible.[93] It concludes by stating that all policies which "allow or perpetrate forced treatment" should be abolished, as they contravene this inherent right.[94] Treatment decisions should only be made with the prior and informed consent of the individual.[95]

The Comment calls for a shift in decision-making models from substituted to supported decision-making. However, the Comment does not define what a supported decision-making model is. Drawing from disability and mental health literature, supported decision-making is a support system or a framework that allows for the legal agency of the individual to be respected regardless of their mental or decision-making capacity.[96] It puts the

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[87] Michael Bach and Lana Kezner, above n 16, at 29.

[88] See generally John Dawson, above n 15, at 72.

[89] *Committee on the Rights of People with Disabilities General Comment No. 1*, above n 8, at [8].

[90] At [12].

[91] At [16] (emphasis added).

[92] At [17].

[93] At [17].

[94] At [42].

[95] *Committee on the Rights of People with Disabilities General Comment No.* 1, above n 6, at [42].

[96] Alison Douglass, above n 16, at 51.

individual's "will and preference" at the centre of the decision-making process, effectively engaging their legal agency and autonomy.[97] It encompasses a range of formal and informal supports to disabled individuals to help them make important decisions.[98] These supports overall attempt to create a relationship between third parties and a disabled individual, provide them with as much information before they make their decision, and attempt to ascertain their "will and preference".[99]

C MHCAT and General Comment No. 1

As stated above, s 59 of MHCAT employs a substituted decision-making model which, in light of the Comment, is the exact opposite of what States should be employing to fully recognise the rights of disabled individuals. This was highlighted in the Committee's first review of New Zealand's compliance with the UNCRPD when the Committee stated New Zealand should:[100]

> … take immediate steps to revise the relevant laws and replace substituted decision-making with supported decision-making. This should provide a wide range of measures that respect the person's autonomy, will and preferences, and is in full conformity with article 12 of the Convention, including with respect to the individual's right, in his or her own capacity, to give and withdraw informed consent, in particular for medical treatment … consistent with the Committee's general comment No. 1 (2014) on equal recognition before the law.

Since this recommendation by the Committee in regard to New Zealand's compliance with the Comment, New Zealand has not taken any action to employ supported decision-making models.[101] New Zealand is currently in the midst of its second review of its compliance with the UNCRPD. The independent monitoring mechanism (IMM) set up in New Zealand,

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[97] Alison Douglass, above n 16, at 51.

[98] At 51.

[99] Terry Carney "Participation and Service Access Rights for People with Intellectual Disability: A Role for the Law?" (2013) 38 J Intell Devel Disab 59 at 66.

[100] United Nations Committee on the Rights of Persons with Disabilities *Concluding observations on the initial report of New Zealand* CRPD/C/NZL/CO/1 (2014) at [22].

[101] This position has now changed, see above n 13.

which reports to the Committee,[102] highlighted that the Government needs to urgently review relevant laws, in particular mental health legislation, to ensure that supported decision-making is employed and reflects article 12 of the UNCRPD.[103] In particular, they recommend the New Zealand Law Commission review MHCAT, with a particular focus on compliance with article 12 of the UNCRPD.[104]

If MHCAT were to move away from substituted decision-making to a supported decision-making framework, a paradigm shift from "best interests" assessments to "will and preference" assessments is needed. The first is to separate the concepts of legal and mental capacity.[105] The next part of this paper will focus its analysis of the paradigm shift from "best interests" to "will and preference" and evaluate whether this shift is desirable.

V Analysis: towards a balanced approach

Neither the current approach under the MHCAT and the approach proposed by the Comment provides balance. This part shows why adopting either the current approach under MHCAT or the approach proposed by the Comment will be inappropriate for a New Zealand mental health context. It then advocates for a balanced approach which puts rights at the centre of the decision-making process, unlike the current approach under MHCAT, but has more protective measures in place and more diverse perspectives on autonomy than present in the approach proposed by the Comment.

A Evaluating MHCAT in light of New Zealand's commitments under the UNCRPD

From the Committee's standpoint, MHCAT is not compliant with New Zealand's commitments under UNCRPD due to the limitations substituted decision-making and "best interest" assessments have on a disabled individual's autonomy and their right affirmed under article 12 of the UNCRPD. However, New Zealand law recognises that limitations

[102] The IMM consists of representatives from the Human Rights Commission, Office of the Ombudsmen and the Disabled Person's Organisation Coalition.

[103] Independent Monitoring Mechanism of the Convention on the Rights of Persons with Disabilities *Making Disability Rights Real Whakatūturu Ngā Tika Hauātanga* (June 2020) at 83.

[104] At 86.

[105] B. Mirfin-Veitch, above n 16, at 12.

can be placed on rights so long as such limitations can be "demonstrably justified in a free and democratic society".[106] Proportionality is at the heart of this assessment.[107] As Tipping J noted in *Moonen v Film and Literature Board of Review* "a sledgehammer should not be used to crack a nut".[108]

This section concludes the justifications for "best interest" assessments under s 59 are not strong enough to legitimately restrict the rights affirmed under article 12 of the UNCRPD. Further, it will show that the safeguards New Zealand committed to putting in place under UNCRPD, when restricting a disabled individuals' rights, are lacking under MHCAT. Overall, it shows that the "best interest" standard can no longer legitimately be used under MHCAT and that a new decision-making regime is needed.

1 Protection from harm and the "serious danger" standard

In his analysis of "serious danger", Kris Gledhill highlighted that the current interpretation taken by the courts and the Tribunal can be discriminatory to people with mental illnesses which directly contravenes New Zealand's commitments under Article 12 of the UNCRPD.[109] He shows that when looking at normal ways to prevent harm from third parties in a criminal law context, although actual harm is not always necessary to establish, the criminal law works on a basis that incarceration "should be reserved for situations where the level of harm caused or risked is high, which justifies the loss of liberty involved".[110] He further argues the loss of liberty under the MHCAT may be more significant than under the criminal law due to the potential of CompTO becoming indefinite.[111] This makes the interpretation of "serious danger" in earlier case law such as *JK*, more attractive to rationalise compulsory treatment as the standard for state intervention is the same for disabled and non-disabled individuals.

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[106] New Zealand Bill of Rights Act 1990, s 5.

[107] *R v Hansen* [2007] 3 NZLR 1 (SC) at [70].

[108] *Moonen v Film and Literature Board of Review* [2000] 2 NZLR 9 (CA) at [18].

[109] Kris Gledhill "Risk and Compulsion" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Law in Practice* (Victoria University Press, Wellington, 2013) 62 at 69.

[110] At 69.

[111] At 69.

This discriminatory treatment of mentally ill individuals' can also be seen when comparing when comparing the government's response to Covid-19 to treatment under s 59 of MHCAT. With Australia's proposal to make a Covid-19 vaccine as mandatory as possible,[112] the New Zealand government discussed whether it would follow suit.[113] Analysing the consequences of Covid-19 in light of the test for "serious danger" under MHCAT, there is an arguable case that a compulsory vaccine could be justified. If an individual chooses not to be vaccinated, there is a high chance they could face the serious health impacts of Covid-19 and spread this disease to other people, also impacting their health. Overall, the "serious danger" standard to justify compulsory treatment would be met. However, Jacinda Ardern confirmed that the vaccine will not be mandatory, and that those who do not choose to be vaccinated will be doing so at their own risk.[114]

When comparing the response to people with mental illness, and the response to the general population with Covid-19, a majority of this population not being disabled, it shows this "serious danger" standard is discriminatory. It works on the basis of a diagnosis of mental illness, as in other aspects of life when this "serious danger" test is met, a non-disabled person would not be subject to some form of state intervention. Overall, it shows that disabled and non-disabled individuals are treated differently under the law, going against the rights affirmed in article 12 of UNCRPD.

2 Parens patriae *and the "self-care" standard*

The "self-care" standard contravenes the commitments under the UNCRPD as the standard embraces discriminatory models of disability. Both the UNCRPD and New Zealand's Disability Strategy 2016-2021 have affirmed that disability is not a strict medical issue, it is what happens when environmental factors do not cater for a diverse range of

[112] "Covid-19 vaccine likely to be mandatory in Australia" (19 August 2020) RNZ <www.rnz.co.nz>; and "Covid-19: Experts say laws allow vaccine to become mandatory in Australia" (20 August 2020) RNZ <rnz.co.nz>.

[113] Claire Breen "Should a COVID-19 vaccine be compulsory – and what would this mean for anti vaxxers?" (7 August 2020) The University of Waikato <www.waikato.ac.nz>.

[114] "Mandatory Covid-19 vaccine: NZ and Australia's different approaches" (19 August 2020) 1 News <www.tvnz.co.nz>.

individuals.[115] The "self-care" standard converts areas of social dysfunction into individual problems, embracing older discriminatory models which describe disability, which is now recognised as an environmental issue, an individual issue.

The objective standard which is apparent under the "self-care" standard can be discriminatory against mentally ill individuals. Social theorists have highlighted an issue called "liquid" modernity, in which social and economic contexts change at a rapid rate.[116] The World Health Organisation has described this state of affairs as a challenge to health promotion as these changes can affect working conditions, learning environments, family patterns and the cultural and social fabrics of communities which can overall impact the wellbeing of individuals.[117] Using this idea of "liquid" modernity, Matthew McKillop has observed that in a "liquid life" societal changes may impact an individual's social functioning, meaning shifts in external factors affect their need for compulsory treatment.[118] Therefore, the "self-care" standard means that environmental factors will be viewed as an individual problem, opposed to a societal problem. This overall goes against modern models of disability and promotes discriminatory treatment.

Further "best interests" assessments cannot be legitimately justified by the "self-care" standard as "best interests" assessments do not protect vulnerable individuals. As earlier explained the "self-care" standard can be traced back to *parens patriae* which puts an obligation on the state to protect those who cannot protect themselves. Recent evidence suggests that making people subject to involuntary treatment have only exacerbated concerning behaviours, whilst supported decision-making models have positive impacts on outcomes.[119] Further, Sarah Gordon, when reflecting on her own personal experiences under compulsory treatment, highlighted that when she was subject to substituted decision-

[115] United Nations Convention on the Rights of Persons with Disabilities, above n 6, at 1; and Office for Disability Issues, above n 81, at 12.

[116] Zygmunt Bauman *Liquid Times: Living in an Age of Uncertainty* (Polity, Cambridge, 2007) 1-4.

[117] Bangkok Charter for Health Promotion in a Globalized World (agreed by participants at the 6th Global Conference on Health Promotion, 7-11 August 2005).

[118] McKillop, above n 63, at 90.

[119] Mirfin-Veitch, above n 16, at 28.

making and forcefully given medication, it had long-term negative impacts on her mental wellbeing.[120] On the other hand, when she experienced collaboration with her responsible clinician, and was engaged in the decision-making process, she had a much more positive experience.[121]

3 Safeguards under MHCAT

S 59 under MHCAT also cannot be justified in a human rights context due to the lack of safeguards in place for individuals' who are subject to compulsory psychiatric treatment. Under article 12 of the UNCRPD, the New Zealand government made a commitment that if they were to restrict a disabled individual's right to be recognised as equal under the law to their non-disabled peers this would be for the shortest time possible with regular independent review. [122]However, under MHCAT there is a lack of independent review.

Once a CompTO is issued, there is no independent review of the individual for at least 6 months. As outlined in Part One, there are three different review stages before a CompTO is issued but once the CompTO is issued there is no review by an independent body for six months.[123] The first month of this six-month period an individual's rights under article 12 of the UNCRPD are the most restricted as there is no engagement with their decision-making capacity or legal agency.[124] However, within this first month there will be no review from an outside body.[125] After this month, the individual under a CompTO needs to consent to treatment and if not, then the treatment will be reviewed by a psychiatrist.[126]

Although it is arguable that the second opinion done by a psychiatrist is an adequate review on the treatment of an individual under a CompTO, the review given is far from independent due to the bias towards approving the proposed treatment. An audit of second opinions given under s 59 of the Act, found most second opinions approve treatments

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[120] Gordon, above n 17, at 269.
[121] Gordon, above n 17, at 269.
[122] United Nations Convention on the Rights of Persons with Disabilities, above n 6, art 12(4).
[123] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 33.
[124] 59(1).
[125] S 59(1).
[126] S 59(2).

recommended by the responsible clinician.[127] This audit highlights that the silence of the MHCAT as to what happens if a psychiatrist does not approve the treatment creates a bias towards approval.[128] This is firstly because if treatment is denied, under the CompTO the responsible clinician is still under an obligation to treat the patient and therefore puts the responsible clinician under increased pressure to find an alternative treatment.[129] This extra pressure would be known to the psychiatrist giving the second opinion.[130] Secondly, the second decision can be reviewed, and thus reversed, by another psychiatrist that will be appointed by the Director of Area Mental Health Services.[131] Finally, the psychiatrist giving a second opinion does not have an ongoing obligation to the patient, like the responsible clinician, and may not have as much knowledge on the patient's needs.[132] This may make them more likely to approve the treatment recommended by the responsible clinician.

An individual under a CompTO has the right to get their compulsory treatment under s 59 judicially reviewed which arguably fulfills New Zealand's commitments under the UNCRPD but barriers prevent individuals under a CompTO from doing so. According to the United Nations Working Group on Arbitrary Detention, despite legal advice being guaranteed under the MHCAT, people undergoing compulsory assessments are often unrepresented as they do not have access to legal aid.[133] This lack of access to independent review of an individual's condition, and the restriction of their rights, shows New Zealand is not fulfilling its obligations under the UNCRPD.

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[127] John Dawson and others "Mandatory Second Opinions on Compulsory Treatment" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 229 at 245.

[128] John Dawson and others, above n 127, at 235.

[129] At 234-235.

[130] At 234-235.

[131] At 234-235.

[132] At 234-235.

[133] Sarah E Gordon and Anthony O'Brien "New Zealand's mental health legislation needs reform to avoid discrimination" (2014) 127 NZ Med J 55 at 58.

4 Summary

In summary, substituted decision-making and "best interest" assessments cannot be justified in a human rights context. The justifications for these "best interest" assessments are inherently discriminatory. Further, MHCAT also does not live up to New Zealand's commitments under the UNCRPD. Not only do the justifications allow for unequal treatment of disabled and non-disabled individuals under the law, but the limitations put on this right do not have regular independent review.

B Evaluating the Comment in a New Zealand mental health context

Even if we agree that New Zealand's current approach is unacceptable, the New Zealand government should not adopt the Comment completely. The Comment takes an absolutist approach and tends to miss the reality of mental health in New Zealand. This part will explain why New Zealand should not completely adopt the Comment by evaluating the Comment in a New Zealand mental health context.

The Comment fails to recognise that limitations on an individual's liberty can be justified and failing to recognise this can be dangerous when applied to a mental health context as it could potentially create worse situations for mentally ill individuals. Limitations on an individual's liberty can be justified and this happens in everyone's life regardless of disability status.[134] For example, if a mentally ill individual exhibits behaviours which creates an imminent and serious threat of physical harm to themselves or others, it could be justifiable to make them subject to compulsory treatment to ensure society is protected from harm. This is justifiable, as people without mental illnesses will be subject to similar preventative treatment if they exhibit those same behaviours and thus non-discriminatory. If, like the Comment advocates, substituted decision-making models and 'best interest' assessments are never used in a mental health context, it could mean that people suffering mental illnesses could refuse treatment to help control their dangerous behaviours and could potentially act in a way that creates a worse situation than compulsory psychiatric treatment (e.g. being criminally convicted).[135]

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[134] New Zealand Bill of Rights Act, s 5.

[135] John Dawson, above n 15, at 72.

The Comment also does not seem to take into account the decision-making capacity of an individual. In some situations, it may not be appropriate to allow individuals to make decisions due to their limited decision-making capacity.[136] If an individual cannot process the information given to them in regard to a decision, it would be inappropriate for them to make that decision themselves. This is another reason why the Comment should not be fully adopted in New Zealand.

The Comment is also silent on indigenous perspectives of autonomy. The most recent report on mental health services in New Zealand highlighted that Māori were disproportionately overrepresented in compulsory assessment and treatment under MHCAT.[137] Therefore, when it comes to decision-making processes under MHCAT Māori perspectives need to be taken into account. The UNCRPD and the Comment recognise that indigenous people are a vulnerable group within the disability community.[138] However, the UNCRPD and the Comment do not include indigenous perspectives, taking a Western view on autonomy.[139] The Comment expresses autonomy, and the right of legal capacity in individual terms. Indigenous perspectives recognise collective rights alongside individual rights.[140] In a Te Ao Māori view, family and whanau are the building blocks of Māori society.[141] Decisions are not always made by the individual who is affected, but as a group. This would be seen as substituted decision-making, and unacceptable in light of the Comment. However, in a Te Ao Māori view, this would be a tikanga practice which raises the wellbeing, capability and resilience of whanau.[142] This would be important for the individual's recovery.

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[136] John Dawson, above n 15, at 73.

[137] Ministry of Health "Office of the Director of Mental Health and Addiction Services Annual Report 2017" (February 2019) at 34.

[138] Huhana Hickey and Deinse Wilson "Whānau Hauā: Reframing disability from an indigenous perspective" (2017) 6 Mai Journal 82 at 87.

[139] At 87.

[140] See *Decleration on the Rights of Indigenous Peoples* GA Res 61/295 (2007), art 1.

[141] Te Puni Kōkiri *Understanding whānau centred approaches: Analysis of Phase One Whānau Ora research and monitory results* (2015) at 17.

[142] Government Inquiry into Mental Health and Addiction, above n 1, at [3.4.3].

Overall, the Comment has pitfalls which makes adopting it completely an inappropriate decision if we want to protect vulnerable individuals in a New Zealand mental health context. Any approach going forward needs to put rights at the centre like the Comment suggests, but still allow for justified limitations on an individual's rights to ensure protection of the individual and a Te Ao Māori perspective to ensure that those who are impacted by mental health are adequately represented in any strategy moving forward.

C A balanced approach

A balanced approach which puts rights at the centre but still has justified limitations to these rights and a Te Ao Māori perspective present is needed to help mentally ill individual's in New Zealand. For the reasons stated above neither the current approach under s 59 of MHCAT or the approach proposed by the Comment achieve this balanced approach. This section will describe what this balanced approach entails, how it is similar to the two approaches discussed and how it differs.

This approach is different to the current process under s 59 of MHCAT as substituted decision-making would not be the default approach when making decisions about psychiatric treatment. Under this approach, the default model to use under this framework would require free, prior and informed consent of the individual before any treatment is administered. In order to obtain this consent formal supports will be put in place to guide the decision and ascertain the individual's "will and preference". This should include informing the individual about potential treatment options, effects of this treatment and how this may help them improve their condition. Other external support mechanisms should also be put in place. This includes ensuring other aspects of modern living are designed to ensure that diverse groups of individuals can access them. This would include housing, education and employment programmes to help those with mental illnesses to have a minimally acceptable standard of life. This would help combat the negative impacts of "liquid" modernity and prevent individuals from being subject to compulsory psychiatric treatment due to social dysfunction. These suggestions embrace the supported decision-

making framework the Comment calls for and align New Zealand's mental health laws with their obligations under the UNCRPD.

However, this balanced approach would also differ from the suggestions in the Comment by still allowing for substituted decision-making in specific circumstances. It embraces the justifications for substituted decision-making under MHCAT but increase the standards for these justifications to ensure they are non-discriminatory and legitimate. A substituted decision-making framework should be adopted if an individual's "will and preference" would result in behaviour which creates imminent and serious harm to themselves or others. This harm should be actual, or threatened, physical harm. Therefore, it would adopt earlier interpretations of "serious danger", such as the interpretation in *JK*.[143] This would make the "serious danger" test non-discriminatory as the same standard can be applied to people without mental illnesses.

Further, substituted decision-making should be used if upholding an individual's "will and preference" will prevent them from caring for themselves. However, the interpretation of "self-care" should take into account the idea of "liquid" modernity. Health professionals when assessing an individual's condition should consider whether the individual cannot care for themselves due to their condition or whether it is social dysfunction which is preventing an individual from having a minimally accepted standard of living. This would require a holistic approach from all social services but would ensure that individuals are not being subject to compulsory treatment due to social dysfunction. If it is external factors that are preventing an individual from having a minimally accepted standard of living, there should be a support system set up to help individuals with these barriers to accessing modern life.

Finally, substituted decision-making should be used if an individual's decision-making capacity is so significantly impaired that they cannot perform specific tasks, such as processing the information given to them in a supported decision-making process. This restriction would only be applicable to approximately one third of patients under a

[143] *In the matter of JK*, above n 66, at 702.

CompTO.[144] Within this limitation, if there has been any prior "will and preference" communicated by the individual before their disability deteriorated their decision-making capacity, this should be reasonably ascertained.

If any of the circumstances explained above arise, and substituted decision-making is justified then there should be more scrutiny and independent review in place than there is currently under MHCAT. MHCAT should stipulate what happens if the psychiatrist providing a second opinion does not agree, and biases towards agreement should be combated. Further, reviews by the Tribunal and the Court should be allowed more often. Although there is an argument that this could exhaust judicial resources, if "best interests" and supported decision-making assessments are only allowed in limited circumstances, then arguably the amount of cases that need to be reviewed will be reduced. This would arguably make regular review more achievable.

Within this balanced approach there should be constant communication with family and whanau, and an explicit Te Ao Māori approach taken where appropriate as well as constant independent review of an individual under a CompTO. In order to develop a Te Ao Māori approach, partnership with Māori is essential to ensure the indigenous perspective is represented.

VI Conclusion

This paper has shown New Zealand's current approach to psychiatric treatment does not promote and protect the rights of some of the most vulnerable people in our society. However, it has highlighted the dangers of completely adopting the approach proposed by the Comment. The approach this paper proposes helps set a balance between the two, ensuring that mentally ill individuals have the right to make decisions under mental health law but may have limitations imposed on these rights if these decisions create a serious danger to themselves or others, significantly impact their standard of living, or would be

[144] Jeremy Skipworth, above n 12, at 218; and Human Rights Commission "Mental health and human rights in New Zealand" (2018) <www.hrc.co.nz>.

inappropriate to follow due to the individual's decision-making capacity. Further this approach allows for more independent scrutiny and a Te Ao Māori perspective. New Zealand has a responsibility to help those who need it, but ensure their rights are still upheld.

This paper, excluding non-substantive footnotes, is exactly 8,055 words.

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