THE MENTAL HEALTH ACT 1969

Until the beginning of this century society's attitude to those of its number who suffered from mental disorder was reflected in the Latin translation of a line from Euripides: *Quem deus vult perdere, prius dementat*—"he whom a God wishes to destroy, he first makes mad". The attitude was one of fatalism, of ignorance and of abhorrence. Today however, the attitude is changing. The advances of medical science have helped to arouse a greater social awareness of, and sympathy for, the problems of the mentally disordered. It is against this background that the new mental health legislation must be considered.

The provisions in the Mental Health Act 1969 which bring about the major changes contemplated by the framers of the Act are directed towards rationalising and streamlining matters of organisation and administration. Thus section 7 of the Act authorises the transfer of control of mental hospitals from the Department of Health to hospital boards; section 4 (4) enables superintendents of mental hospitals to delegate to their medical staff all or any of the powers conferred upon them by the Act, thus allowing for the realistic sharing of responsibility; and the Act in general eliminates many administrative processes which were found to be both time-consuming and unnecessary. Although these changes will undoubtedly, in time, have a great effect, they will not be discussed in this note; for their effect has not yet been felt and they are not of great concern to the lawyer. The note will concentrate on those provisions which may interest and concern lawyers and upon which lawyers may be able to offer some advice.

THE BACKGROUND

Sir Richard Wild has said that in a society such as ours

> the principal function of the law is to protect the citizen not only against the wrong-doer but also against injustice from state and public authorities. ("Human Rights in Retrospect", *Essays on Human Rights* ed. Keith, Sweet & Maxwell 1968 p. 9.)

Thus while most New Zealanders do not deny that the state may legitimately deprive an individual of his liberty they require that there exist safeguards to prevent the abuse of this power. For example, before the state may imprison a person for the commission of a crime it must prove in accordance with strict procedural requirements that the person has committed a specific illegal act. In short, the state is bound by the rule of law. However, with regard to the civil commitment of the mentally disordered the position is somewhat different. For although the effect of being declared mentally disordered may be the same as that of being punished for a crime, in that the individual may be deprived of his liberty, there are in the former case no strict procedural requirements or precisely worded definitions comparable with those of the criminal law. Moreover, the basic justification for the imprisonment of a criminal, that of guilt, does not exist with

respect to the mentally disordered; more utilitarian justifications must be found. The rule of law has, it seems, little effect upon the manner in which the mentally ill are treated.

> Although the civilly committed patient has broken no laws, he may suffer a serious loss of civil rights, often being declared legally incompetent, suffering invasions of his person and body, being held without free communication to the outside world and, perhaps most important of all, being incarcerated against his will. (Gene R. Moss—"Szarsz: a review and criticism"—Vol. 31 (1968) *Psychiatry* p. 184 at p. 188.)

With these considerations in mind the definition of "mentally disordered" given in the Act and the admission and review procedures established under it will be examined.

THE DEFINITION OF "MENTALLY DISORDERED"

The definition of "mentally disordered" given in section 2 of the Act replaces and substantially revises the definition of "mentally defective person" in the Mental Health Act 1911. The Act defines "mentally disordered" in relation to any person as meaning that he is:

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

Two further categories, namely

> (d) Epileptic—that is, suffering from epilepsy associated with episodic disorders or behaviour in the course of which the person may be a danger to himself or others.
>
> (e) Psychopathic—that is, persistently suffering from a form of mental disability and by reason thereof repeatedly behaving in a manner that is abnormally aggressive or seriously irresponsible,

which were to replace those of "epileptic" and "socially defective person" in the 1911 Act were excluded from the final draft of the Bill.

It is possible to question the value of the three classes set out in the definition on the ground that they do not relate to the substance of the Act and have, therefore, no real function to perform. By comparison, the definitions given in the Mental Health Act 1959 (U.K.) have a readily ascertainable value; for the type of mental disorder from

which a person suffers may determine how he is to be treated under that Act. For example, section 26 (2) (a) provides that an application for admission for treatment may be made in respect of any person who is suffering from a mental illness or from severe subnormality but only in respect of those under 21 where the disorder is a psychopathic one or subnormality; and section 44 provides special review procedures for those patients in the latter two categories. Since there is no such interrelation between individual classifications and substantive provisions in the New Zealand Act it could be said that the former are superfluous. However, it is clear that these three classifications do have some function to perform; they are designed to place some restriction upon the concept of mental disorder and upon the powers conferred by the Act. For example, section 31 (c) requires every medical practitioner who gives a medical certificate for the purposes of a magistrate's examination under section 22 of the Act to state in the certificate the class of the mentally disordered to which the person belongs. Before a magistrate is able to issue a permanent reception order he must have before him two medical certificates stating that the person is mentally disordered. Thus, before a person can be committed by a magistrate he must be mentally disordered within the meaning of one of the classes. To evaluate more precisely the restrictions imposed by these three classifications it is necessary to consider them individually.

Mentally Ill

The first classification lays down two requirements—(i) that the person suffers from a mental illness and (ii) that he requires care and treatment for it. These appear to place precise limitations upon the application of the classification; but on analysis these disappear. Nowhere in the Act is the term "mental illness" defined and in view of the widespread disagreement among psychiatrists as to what constitutes mental illness it may not be possible for an adequate definition to be found. Therefore a mentally ill person is one who suffers from a mental illness. The circularity in this is obvious. As to the second requirement, that of a need for care and treatment, it is scarcely more helpful, for one who is suffering from a mental illness may almost by that fact alone be said to be in need of care and treatment. Moreover, psychiatric opinion is divergent as to what constitutes care and treatment. Detention on a purely custodial basis may, in one sense, be called care and treatment. The Act provides no guide as to what the phrase is to mean.

The imprecision inherent in this classification gives the psychiatrist a large degree of flexibility. Whether this is desirable is to be doubted: for the circular nature of the classification is such as to allow the psychiatrist to shoehorn into the class of mentally ill a large number of people. Thus those who would have been dealt with as psychopaths or epileptics can probably still be dealt with under this classification. The limitation that was to have been placed upon the concept of mental disorder by the exclusion of these two classes may therefore be

apparent rather than real. Perhaps the only satisfactory solution would be to indicate that certain disorders were not to be regarded as mental illnesses or that certain forms of behaviour (for example, anti-social or eccentric behaviour, immoral conduct) were not *by themselves* to be taken as evidence of mental illness.

Mentally Infirm

The second classification is more satisfactory than that of mentally ill as the scope of its application is comparatively clear. Once again there are two requirements—(i) that the patient suffer from mental infirmity arising from age or deterioration of or injury to the brain and (ii) that there be a need for care and treatment. The first requirement does not place as much emphasis on subjective evaluation as the first requirement in the mentally ill classification. For age and deterioration of and injury to the brain are physical conditions whose existence is more readily ascertainable than that of a mental illness. Normally a doctor can look only at his patients' behaviour to gain some insight into his mental condition. Here, however, he has not just behaviour to guide him, he also has a physical condition. The connection between mental condition and behaviour is, for this reason, easier to make, although inevitably it involves an element of subjective evaluation. The second requirement is, as was pointed out with regard to the definition of mentally ill, vague and offers the medical practitioner little guidance.

Mentally Subnormal

The third class is defined in a manner scarcely more satisfactory than mentally ill. The formulation is wide and could, as stated, conceivably include a substantial part of the population. The corresponding classifications in the U.K. Act seem better. Section 4 (2) of that Act provides that severe subnormality means:

> a state of arrested or incomplete development of the mind which includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation or will be so incapable when of an age to do so,

and subs. (3) of that section provides that subnormality means:

> a state of arrested or incomplete development of the mind (not amounting to severe subnormality) which includes subnormality of intelligence and is of a nature or degree which requires or is susceptible to medical treatment or other special care or training of the patient.

These classifications look to the effect of the disorder upon a person (and in this way indicate the purposes to be served by the committal) and do not, as the New Zealand classification does, look merely to the fact of its existence. They are much more precise than the New Zealand classification and offer some guidance to the doctor in making his decision. Thus their field of application is narrower.

It could be argued that to import into the New Zealand Act a classification such as that found in the U.K. Act is unnecessary since even when a person is found to be mentally disordered under the New

Zealand Act he cannot be committed until there has also been a finding that there exists a need for detention. Since one of the grounds for detention is the welfare of the patient it could be said that factors such as those contained in the U.K. classification will be relevant in this regard and need not therefore be considered at an earlier stage. Such an argument is unconvincing. The inclusion of the more detailed classification would give the opportunity for consideration of the patient's actual capabilities at two points in the procedure: once when the doctor makes the decision as to a person's mental state and once when the magistrate considers whether there is a need for detention. It would narrow the definition of the mentally subnormal class, it would highlight the reasons for the detention of those falling within the class and would reduce the opportunities for abuse.

The definition of mentally disordered given in the Act is, as has been pointed out, couched in wide terms, and it places a great deal of emphasis upon the knowledge and experience of the practitioner. This gives him a great deal of freedom, allowing him to use the classifications to cover the great variety of circumstances that he is likely to encounter. However, such flexibility inevitably gives rise to the possibilities of grave error and abuse. Where the freedom of the individual is involved, as it is here, it is important to keep such opportunities to a minimum. Therefore it is suggested that the class of "mentally ill" be redefined so that certain types of behaviour may not by themselves be taken as evidence of mental illness and that the detailed U.K. classifications of severe subnormality and subnormality by adopted in preference to the single wide New Zealand classification.

Many of the disadvantages inherent in the use of this vague definition may be overcome by the provision of admission and review procedures which contain adequate safeguards against erroneous detention. The admission and review procedures set out in the Act will therefore be examined with a view to ascertaining whether they contain such adequate safeguards.

ADMISSION AND REVIEW PROCEDURE

Admission

There are two principles to be kept in mind when discussing admission procedures. The first is that, where possible, admission and treatment should be voluntary and informal. The second is that some provision should be made for those who must for some reason or other be detained against their will but at the same time their rights should be respected.

There is a growing trend overseas towards admission policies based upon consent rather than upon coercion. For where a patient voluntarily goes to a mental hospital the treatment he receives is likely to be at its most effective. However, the position with regard to voluntary admission under the present Act is vague. As compared with the previous Act the informal admission procedures set out in section 15

have been relaxed so that they fall more into line with procedures used in general hospitals. However, it is not clear that an informal patient admitted or treated under the section has to give his assent to either his admission or his treatment. Moreover, under section 16 a superintendent may apply for a reception order in respect of an informal patient and has the power to detain him until the application is finally determined. Thus a person who has voluntarily entered a mental hospital for treatment may find that he is unable to leave it when he wishes to: he may be detained against his will. The voluntary nature of the detention would surely be better served if an informal patient had an explicit right to leave when he wished. Where a superintendent thought a patient who had exercised his right would benefit from further treatment or was dangerous he could apply for a reception order in the normal manner, perhaps having the power in the latter case to detain the patient in the interim. As these provisions stand they do little to encourage the use of voluntary admission procedures and this is most unfortunate.

Compulsory admission and detention procedures are dealt with in Part III of the Act. Under section 19 any person who is 21 or over may apply to the superintendent of a psychiatric hospital or a licensed institution for the compulsory admission of any individual; the applicant does not have to state his interest in the case nor in fact does he have to have any interest in it. The application must usually be accompanied by two certificates in the proper form from registered medical practitioners; there is no requirement that either of the practitioners have any special psychiatric training or experience although usually one of them will have to be the patient's normal doctor.[1] Although the 1911 Act specifically limited the signing of medical certificates to doctors who had no connection with the institution into which the patient was to be received, the present Act, at least as regards doctors attached to psychiatric hospitals, contains no such provision.[2] Within 21 days or, if the patient or a relative so requires, within 48 hours of the patient's reception the superintendent must forward to the Registrar of the nearest Magistrate's Court written notification of the reception. Under the 1911 Act such notification had in every case to be given within 24 hours of the patient's reception. "As soon as practicable" after the receipt of this notification the magistrate must "make inquiry" and consider whether he will issue a reception order. He may rely upon the original medical certificates notwithstanding the fact that they may have been given some weeks previously.

1. The position is not entirely clear in this latter regard. Section 20 (3) requires that the medical practitioners be competent to give certificates for the purposes of s. 22. Subsection (2) of that section provides that one of the medical practitioners called by a magistrate shall be the patient's normal medical attendant unless there is sufficient reason to the contrary. It is assumed that this applies with respect to s. 20.
2. It should be noted that the provisions concerning doctors attached to psychiatric hospitals and those attached to licensed institutions differ in this regard: ref. s. 32.

The procedure outlined obviously allows for the prompt admission and thus (hopefully) the rapid and early treatment of a patient: but it is also susceptible to abuse. To require that the applicant state his interest in the case, that where practicable one of the doctors have some special psychiatric training or experience, that where practicable neither doctor have any connection with a psychiatric hospital into which the patient is to be received, that the patient and his relatives be informed of their right to request prompt notification of the reception, that the magistrate make inquiry within a certain period of time after notification and that he seek further medical certificates where the original ones are more than 7 days old at the time of the inquiry would do little to slow up the procedure but would limit the scope for abuse.

Under section 21 any person who is 21 or over may apply in writing for a reception order; he must state his interest in the case and also the ground for his application and must submit at least one medical certificate in the proper form. Application may also be made under this section by Medical Officers of Health or members of the police on certain grounds, the most interesting being that there is reasonable cause to believe that the person is mentally disordered and "acts in a manner offensive to public decency" (section 35). The magistrate must then examine the person alleged to be mentally disordered and must seek the opinion of two medical practitioners, one of whom must, unless there is sufficient reason to the contrary, be the person's usual medical attendant (section 22). If the medical certificates states that the person may be mentally disordered, or if both or either say that he is mentally disordered, the magistrate may adjourn the determination of the application for a maximum of two one-month periods and order that the patient be kept for observation. A patient may thus be detained for up to two months even where one of the medical certificates states that he is not mentally disordered or, if he is, that he need not be detained (section 23). Where both certificates state that the patient is mentally disordered the magistrate may, if he is satisfied not only that the person is mentally disordered but also that he requires detention, either for his own good or in the public interest, make an order for the patient's reception (section 24). Once again, there is no requirement that either of the doctors must have had some special psychiatric training, nor is there any provision dealing with the doctors' connections with a receiving psychiatric hospital. Moreover, there is no requirement that the medical certificates agree with respect to the type of mental disorder from which the patient suffers. It seems desirable that before a reception order is issued there be unanimity in this regard. Where there was no such agreement provision could be made for the patient to be detained for observation under section 23.

There are two grounds upon which a magistrate may order that a mentally disordered person be detained. They are that it is "in the public interest" or "for the welfare of the patient". The former ground is obviously a very wide one. It requires the magistrate to balance competing interests, namely the freedom of the individual and the need to protect society. In view of the importance of these interests it is desirable that

the Act should give some indication of those matters that are to be regarded as important. Thus it could provide that the phrase was to include only those cases where there was a *real* likelihood of injury to others or of serious damage to their property. This would limit its application to those people whose record or mental condition indicated that they were likely to be dangerous: it would prevent the detention of people on this ground merely because they had caused or might cause minor damage to property or because their behaviour was of nuisance value. The latter ground, that of the welfare of the patient, is usually invoked where the patient is liable to be dangerous to himself or where he is in need of care and treatment. The state does not generally interfere with people's activities solely on the ground that they might cause themselves some harm nor does it force those who are ill to seek treatment (except in the case of notifiable diseases). However, with regard to the mentally ill, the diminished responsibility of some mental patients and general benevolent and humanitarian ideals seem to justify the state's interference on this ground. It is probable that where a person is found to be mentally ill or mentally infirm a finding that it is in his interest to be detained will almost automatically follow since he must, to fall within either of these classes, be in need of care and treatment. Finally, the admission procedures contained in the Act draw no distinction between these various reasons for commital—the same basic procedure applies in all cases. However, it may be desirable to vary the procedures in accordance with the reasons for committal. Where a person is being committed in the public interest the procedures should be comparatively strict, somewhat akin to criminal procedures; but where he is being committed for his own welfare, more particularly for treatment, the procedures should be flexible, particularly where the detention is likely to be a short one, and should ensure that prompt treatment can be given.

It could be argued that a magistrate (or any person occupying a judicial position) is not the best person to make the final determination on whether a person should be detained or not. He may function merely as a rubber stamp, accepting uncritically the position as it is outlined in the medical certificates. It may be that over a period of years a magistrate can acquire some knowledge of the problems of the mentally disordered, but this is a long process and is one that by no means takes place in respect of every magistrate. In theory a magistrate could act as an intelligent amateur, providing a bulwark against error on the part of the experts. In practice, however, this has not always happened.[3] It seems that the position could be improved if the authority now vested in magistrates were to be vested in tribunals constituted along the lines of those set up under the U.K. Act. If these tribunals were made up of a medical practitioner with special psychiatric experience, a social worker and a magistrate they should be within New Zealand's manpower resources and would bring to bear upon the individual's case, not the experience of one layman, but the combined

3. ref. *R.* v. *Board of Control*: *Ex parte Rutty* [1956] 2 Q.B. 109; *Mitchell* v. *Allen* [1969] N.Z.L.R. 110 may also be an example of this.

experience of both expert and layman. Such tribunals could, and hopefully would, be more critical in their acceptance of medical certificates than some magistrates appear to be.

Review

Section 55 (1) of the Act places upon superintendents the duty to keep the case of every committed patient under review and to consider as often as is practicable whether that person should cease to be a committed patient. Moreover, they are required at certain times to write into the clinical record of a patient a description of his mental condition and a statement of the reason for his continuing to be a committed patient and to forward a copy of this to the Director of the Mental Health Division of the Department of Health. Where a superintendent is of the opinion that a committed patient is fit to be discharged he may, under section 73, discharge him. It is obvious that the superintendent's duty to review a patient's case is a very general one and it is questionable how effective it will be. In view of this it would be desirable that the Act provide that after a person had been detained for a certain period of time, for example three years, he have an automatic right to release. To detain him further the superintendent would have to go through the committal process again and justify the continued detention before some independent authority.

It would be desirable to provide for a regular independent review of every patient's case but unfortunately this appears to be impracticable. The only solution is to allow the patient or those interested in his case to have ready access to influential people and to independent authorities who can provide an impartial review of the matter. Thus section 63 (1) provides that letters from mental patients to certain classes of people, for example, Members of Parliament, must be forwarded unopened to the addressee. Also, section 34 gives the Director of the Division of Mental Health and the Attorney-General power to order a fresh inquiry or to authorise a patient's discharge in certain limited cases. It is doubtful whether this section will be much used.

The Act also lays down two review procedures besides that outlined above. Firstly, where a superintendent thinks that a patient is not fit to be discharged but an inspector, official visitor, relative or friend of the patient or the patient himself is of a different opinion, that person may refer the matter to the Minister of Health. The Minister must consider the matter and may, if he thinks it necessary, request a magistrate to hold an inquiry. If the magistrate is satisfied that the person is fit to be discharged (that is, "when his detention as a mentally disordered patient is no longer necessary either for his own good or in the public interest") he may discharge him. Secondly, under section 74 a judge of the Supreme Court may, upon the application of any person, order an inspector or other person or persons to inquire into the detention of any patient, he may order that the patient

be brought before him for examination and has the power to summon witnesses to give evidence. If he is satisfied—

(a) That the person is not mentally disordered; or

(b) That his state of mind does not require his detention or treatment as a mentally disordered person, either for his own good or in the public interest; or

(c) That he is illegally detained as a mentally disordered person;

the judge may order that the patient may be discharged.

It is doubtful whether both of these procedures are necessary. The procedure before a judge is more readily available than that before a magistrate. It comes into operation without the necessity of the intervention of the Minister of Health who, it is reasonable to expect, will rarely decide or be advised to disagree with a superintendent. Moreover, although the judge and the magistrate have substantially the same tasks to perform the Act stipulates that a judge may consider more factors (for example, the legality of the detention, the ability of relatives or friends to look after the patient) than a magistrate may. In view of these points it is likely that the procedure before the judge will be used more frequently and the value of having a review procedure before a magistrate may be questioned. However, if the only procedure available was that under section 74 it could be argued that a judge, who will probably have had less experience than a magistrate with regard to the mentally disordered, is not the person best qualified to determine matters of this sort. Indeed, in view of the medical and sociological considerations involved, the desirability of any purely judicial determination at this stage could be questioned. This problem could be overcome if the tribunals whose establishment is suggested above dealt with the review of cases. The determination in any case should thus be achieved as a result of a thorough consideration of the medical, social and legal problems involved by people who are competent to give such consideration.

The admission and review procedures set out in the Act do contain provisions designed to safeguard the individual against wrongful admission and detention. However, as has been indicated, there are a number of improvements that could be made which, while still allowing sufficient flexibility, would greatly limit the scope for abuse. An additional protection would be provided if the Act conferred a right to treatment.

A RIGHT TO TREATMENT

Before a person can be classified as either mentally ill or mentally infirm he must be in need of care and treatment. Also, where a patient is detained for his own welfare it is usually because he needs care and treatment. It seems desirable that where a person is found to need treatment and has been detained for this purpose that he in fact receive treatment. Under the present Act, however, there is no way for a patient, or some person acting on his behalf, to compel a mental

hospital to provide some treatment.[4] If the Act conferred a legally enforceable right to treatment a patient would be able to insist that the purpose of his detention be pursued. The courts in enforcing such a right would not be called upon to trespass into areas of medical concern and decide which form of treatment is best for a particular patient but would merely ensure that a bona fide course of treatment was being pursued. Obviously the conferring of such a right would not change the position in mental hospitals immediately; but it would at least emphasise the fact that the state had undertaken an obligation to treat a particular patient and should fulfil it. It might provide a justification for, or a lever by means of which there could be provided, more adequate provision for the mentally disordered.

CONCLUSION

The modern medical approach is to treat mental disorders on the same basis as physical disorders and to place more emphasis upon persuading people to seek treatment voluntarily. In view of this it is regrettable that the Act is not more explicit in upholding the ideal of voluntary admission with regard to informal admission procedures. This fault could be remedied in part if informal patients were given an explicit right to leave the mental hospital at their own convenience. For the still substantial number of people who must be detained compulsorily several safeguards are suggested, notably the use of more precise definitions, the provision of tribunals to replace magistrates and the conferring of a right to treatment in respect of some patients. It is important that the social and humanitarian ideals which provide the basis for the use of the committal process and the need for some flexibility so that prompt treatment may be given do not lead us to ignore too readily the principle of the freedom of the individual which our society is said to look upon as fundamental. The reforms suggested do not impose harsh or excessive burdens, nor do they limit too severely the flexibility that exists under the Act. They do, however, reduce the scope for abuse and for those who are jealous of the freedom of the individual this is a compelling reason for their implementation. Mental health legislation must be primarily concerned with medical rather than legal considerations: but this cannot justify an unnecessary infringement of civil liberties nor a lack of concern for minimum standards of care.

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4. Section 25 of the Act merely provides that a superintendent *may* give a patient care and treatment.