Mental Disorder and Human Rights: The Importance of a Presumption of Competence

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I: INTRODUCTION

1. General

The 1983 Gallen Report, precipitated by the death of a patient in Oakley Hospital, highlighted tensions between public security and the treatment of the mentally ill and identified the need to safeguard the rights of patients. [1] This report coincided with the declaration by the United Nations of the "Decade of Disabled Persons."[2] Although the UN did not propose an international treaty, the General Assembly adopted a resolution in December 1991 endorsing the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care ("the MI principles").[3] The decade saw major changes including a movement toward community care and debate about community safety expectations, patient rights and access to treatment and allocation of resources. Ten subsequent reports were produced in New Zealand investigating related issues.[4]

The need for greater respect for psychiatric patients' rights was recognised in passage of the Mental Health (Compulsory Assessment and Treatment) Act 1992

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1 *Report of the Committee of Inquiry into procedures at Oakley Hospital and Related Matters* (1983).

2 GA Res 52, UN GAOR, 37th Sess (1982).

3 GA Res 119, UN GAOR, 46th Sess, Supp 49, Annex at 188-92 (1991).

4 For a summary of these see: Law Commission Report NZLC R30 (1994) Appendix D, 143.

("the MHA"). The Act has been seen as a compromise between the needs for access to treatment in emergencies, adherence to fairer procedures in mental health proceedings and protection of the public from "dangerous" people.[5] Part VI of the MHA lists patient rights, a breach of which activates a grievance mechanism under s 75(2). Though the resolution of such grievances is ultimately a function of the Review Tribunal it has been suggested that the language used implies a parallel power for judicial enforcement.[6] While clearly there has been progress in respect of restatement of patient rights, there is also concern as to security within the community, often spurred by single events such as the escape and resultant offending of a forensic patient from a mental health institution accompanied by media sensationalism and political posturing.[7] Subsequent private members' bills introduced in Parliament have shown a preference for protecting society's interests over the rights of individual patients by legitimising "whistleblowing" [8] or decreasing the threshold for compulsory institutionalisation. [9]

Although significant gains have been made in human rights issues in the past decade, they remain tenuous for the mentally disabled. Domestic human rights statutes and international treaties and declarations are a defence against derogation of those gains.

2. International Treaties and Other Instruments

Relevant international instruments include the:

(i) International Covenant on Civil and Political Rights ("the ICCPR");
(ii) International Covenant on Economic Cultural and Social Rights;
(iii) UN Declaration on the Rights of Disabled People;
(iv) UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care; and
(v) European Convention for the Protection of Human Rights and Fundamental Freedoms.

International treaties are binding on signatories in international law. The first two covenants were ratified by New Zealand on December 28, 1978. These documents promote globalisation of human rights issues and provide for international monitoring. The commitment to the ICCPR is affirmed in the preamble to the New Zealand Bill of Rights Act 1990 ("the BORA"). The Human Rights Commission is generally responsible for monitoring the observance and implementation of human rights in New Zealand. The preamble to the Human Rights Act 1993 ("the HRA") states that the Act is to "provide better protection of human rights in New Zealand in general accordance with United Nations Covenants or Conventions on Human Rights". The Commissioner is able to report to the Prime Minister on any matter

5 Dawson, "The Mental Health (Compulsory Assessment and Treatment) Act 1992 - significant advance on previous law" (1992) 378 Law Talk, 3.

6 Ibid, 4.

7 Johns, "Ministers to Focus on Crimes by Mentally Ill" New Zealand Herald, 19 April 1991, Section 1, 1.

8 Whistleblowers Protection Bill 1994.

9 Mental Health (Amendment) Bill 1994.

affecting human rights, including recommending actions "to give better protection to human rights and *to ensure better compliance with standards laid down in international instruments on human rights*".[10] The Commission has interpreted its mandate as allowing it to refer to human rights instruments "such as those concerned with the rights of persons with disabilities or detained in mental health institutions, instruments which New Zealand has not or cannot yet ratify." [11] This allows the MI Principles to provide guidance for rights of the mentally disabled in New Zealand, despite their lack of formal recognition in domestic legislation.

3. Human Rights of People with Mental Disorder

In domestic and international law, mentally disordered individuals are entitled to the full range of human rights without discrimination.[12] The principle of non-discrimination does not require that all individuals must be treated alike. Distinctions are considered discriminatory if made *arbitrarily* or with the purpose or effect of restricting the equal enjoyment of human rights.[13] Measures catering for special needs of identifiable individuals are not considered discriminatory.[14] While the right of the mentally disordered to treatment is positive discrimination,[15] it does not offend rights legislation or instruments as these measures are considered necessary to enhance the enjoyment of rights by disadvantaged or vulnerable groups.[16]

Rights recognised by the ICCPR and by the BORA which are of particular importance to the mentally disordered include the right to freedom from cruel, inhuman or degrading treatment or punishment,[17] liberty and security of the person,[18] including the right to not be arbitrarily arrested or detained,[19] be treated with respect for dignity and with humanity if deprived of liberty [20] including the right to challenge the validity of such detention,[21] and the right to a fair hearing,[22] freedom of movement, association and choice of residence,[23] the right to freedom of opinion, expression and information,[24] and the right to vote and to be elected. [25]

10 Section 5(1)(h)(i) (emphasis added).

11 Mulgan, "Implementing International Human Rights Norms in the Domestic Context: The Role of a National Institution" (1993) 5 Canta LR 235, 238.

12 These rights may be statutory, particularly those enshrined within the BORA and the HRA; or common law rights, such as the right to enter into binding contracts.

13 Burdekin, *Human Rights and Mental Illness*, Vol 1, Report of the National Inquiry into Human Rights and Mental Illness, Human Rights and Equal Opportunities Commission of Australia (1993) 21.

14 Ibid.

15 The MHA, s 66.

16 United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, Principle 1(4).

17 Art 7 ICCPR; s 9 BORA.

18 Art 9 ICCPR.

19 Section 22 BORA.

20 Art 10 ICCPR; s 23(5) BORA.

21 Section 23(1)(c) BORA.

22 Art 14 ICCPR; s 27 BORA.

23 Art 12 ICCPR; ss 17 & 18 BORA.

24 Art 19 ICCPR; s 14 BORA.

25 Art 25 ICCPR; s 12 BORA.

The MI principles emphasise restriction on what a state may do to a person with mental illness, and establish some positive duties with the intention of maximising fundamental human rights. All persons who are mentally ill "shall be treated with humanity and respect for the inherent dignity of the human person" [26] and that "treatment shall be directed towards preserving and enhancing personal autonomy".[27] The principles have been described as articulating "a panoply of human rights that stress freedom, due process and non-discrimination." [28] Implicit within the Declaration is the philosophy that liberty, dignity, and autonomy can best be fulfilled by providing community-based services.[29] Institutional care is to be reserved for those individuals whose behaviour endangers their own safety or the safety of others.

Three features of the MI principles are worthy of emphasis. First, discrimination on the grounds of mental illness is proscribed.[30] This proscription is also contained within s 21(1)(h)(iii) HRA, and is affirmed in s 19 of the BORA. Second, a decision that a person lacks legal capacity by reason of mental illness "shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law".[31] Third, no treatment shall be given to a patient without his or her informed consent.[32] There are however two exceptions to this. Treatment without informed consent is permitted when "urgently necessary in order to prevent immediate or imminent harm".[33] Also, treatment is not prohibited where an involuntary patient, lacking the capacity for informed consent unreasonably withholds consent to treatment deemed to be in his or her best interests having regard to the safety of the patient and others.[34]

Underpinning the protection of autonomy in the Declaration there is a presumption of competence.

II: MENTAL DISORDER AND COMPETENCE

1. The Relationship Between Disorder and Competence

The concept of capacity is pivotal to protecting the rights of the mentally disordered. When patients lack the capacity to make decisions about treatment, their informed consent cannot be obtained. It is easy to assume that someone who is mentally disordered and involuntarily committed is incompetent to make treatment decisions. There is, however, a conceptual distinction between "mental illness" and "decisional capacity." The capacity to make a decision may be affected by many factors including mental illness, physical illness, mental or

26 Principle 1(2).
27 Principle 9(4).
28 Rosenthal and Rubenstein, "International Human Rights Advocacy under the 'Principles for the Protection of Persons with Mental Illness'" (1993) 16 Int J Law & Psych 257, 260.
29 Ibid.
30 Principle 1(4).
31 Principle 1(6).
32 Principle 11(1).
33 Principle 11(8).
34 Principle 11(6).

physical handicap, pain, fatigue, and boredom.[35] There is a further distinction between decisional capacity and competence. Decisional capacity is a functional and factual concept, referring to a person's actual decision-making ability.[36] Competency, by contrast, is a legal concept involving a conclusion applied to a person who has been determined, in accordance with legal requirements, to lack decisional capacity.[37] Therefore assessment of capacity/incapacity involves a legally determined test; if the standards of the test are not met by an individual, she or he lacks capacity and is legally found to be incompetent. There are two related features within the concept. First, a test of decisional-capacity is specific to the decision-type tested. Second, the result of that test is time specific. Therefore any concept of "global incompetence" is flawed.[38] Capacity depends upon understanding rather than wisdom; the essential feature is understanding, not how wisely it has been applied.[39] The common law test of capacity is that the person must at the relevant times understand in broad terms what she is doing and the likely effects of her actions, regardless of the quality of the decision.[40] In *Rogers v Okin*[41] it was held that "[t]he committed patient has a right to be wrong in his analysis of that information (that has been provided about treatment) - a right to be unwise - as long as the consequences of such error do not pose a danger of physical harm to himself, fellow patients or hospital staff." Central to this conclusion was the finding that a statutory presumption [42] of competence prevails until there has been an adjudication of incompetence by a court. In the absence of such a determination, a committed mental patient is presumed competent to make decisions in respect of their treatment in non-emergencies. This was clearly expressed in the Court's judgment: [43]

> [The] regulations do *recognise in absolute terms* the competence of committed persons to manage their affairs and participate in a variety of challenging activities. That recognition tilts the scales in favour of presuming, as well, the competence of a committed mental patient to make treatment decisions, absent an adjudication to the contrary.

35 Meisel, "Making Mental Health Care Decisions: Informed Consent and Involuntary Civil Commitment" (1983) 1 Behav Sci and Law 73, 79.

36 Ibid, 80.

37 Ibid.

38 Infra at note 89 and accompanying text.

39 *Schloendorft v Society of New York Hospital* (1914) 105 NE 92, 93 per Cardozo J; "Every human being of adult years and sound mind has a right to determine what shall be done with his own body..."; and *Smith v Auckland Hospital Board* [1965] NZLR 191, 219 per Gresson J, "right to decline operative investigation or treatment however unreasonable or foolish this may appear in the eyes of his medical advisers."

40 Law Commission (UK) Consultation Paper No. 119, *Mentally Incapacitated Adults and Decision-Making: An Overview*, HMSO, (1991), 20.

41 478 F. Supp 1342, (1979), 1367.

42 MGLA ch 123 § 25 and DMH Reg § 221.02 state unequivocally that, although committed, a mental patient is nevertheless presumed competent to manage their affairs, dispose of property, carry on a licensed profession, and even to vote.

43 Supra at note 41, at 1362 (emphasis added).

The Court was concerned (in obiter) that: [44]

> [L]abelling a person as incompetent has a profound effect on his life, and may well have some impact on that person's self-respect.

There is also a common law presumption that a person is capable/competent until proved otherwise.[45] Whether a particular individual is competent can ultimately be decided by the courts [46] or by a statutorily delegated administrative power. The problem is that the courts have the luxury of reserving a decision in such situations; in endeavouring to deal with exigencies at the therapeutic "coal-face", clinicians have to make non-formal assessments of capacity. Such assessments are made in the knowledge that while usually common sense provides the correct answer, if the wrong conclusion is reached, that clinician's decision may eventually be determined to be unreasonable.[47] Since 1992, pure mental injury from medical misadventure is not covered by accident compensation legislation.[48] Clinicians are therefore potentially liable in negligence.

2. The Case for Normalisation and a Presumption of Competence

The original impetus for the concept of normalisation came from a Swedish social philosophy that every person has "citizen's rights." One responsibility of organised society is to assist everyone, irrespective of disability, to enjoy these rights.[49] When expressed in this way it is reasonable to claim that normalisation is one of the implied aims of the HRA proscriptions on discrimination. Normalisation involves two major themes.[50] First is "citizenhood" with its inherent rights and obligations; second is the "pupilhood" or "developmental model". Originally related to the mentally handicapped,[51] it asserts that they possess the capacity to learn, and develop emotionally and socially, provided they are given appropriate conditions in which to do so. This principle applies to all individuals, regardless of disability.

One aim of normalisation is to treat the mentally disordered as much like others as possible and to integrate them into the mainstream of everyday life.[52] It

44 Ibid, 1363.

45 Supra at note 40, at 19.

46 Ibid, 21.

47 In *Mitchell v Allen* [1969] NZLR 110, an action to bring civil proceedings against two doctors was granted. It was alleged the two doctors acted without reasonable care in certifying and committing the plaintiff. The writer is unaware of any similar decisions since this case.

48 Accident Rehabilitation and Compensation Insurance Act 1992, s 4.

49 Ericsson, "Discussion Paper on Normalisation" (1991) Huddersfield Conference on Developing Good Community Mental Handicap Services; discussed by du Fresne, infra at note 55.

50 Ibid.

51 Submission of the New Zealand Institute of Mental Retardation in *Guardianship for Mentally Retarded Adults: Submissions to Minister of Justice* (1982) 5-7 lists: normalisation, integration, presumption of competence, recognition of varying capacities of individuals, maximisation of self determination, and maximisation of capabilities as the principles to be applied.

52 Supra at note 40, at 102.

endeavours to maximise their potential by encouraging them to make decisions for themselves and thus obtain a greater degree of independence.[53] The principle is recognised in a preference for community based care where this is practicable.[54] It implies that strategies intended to enhance the capacity/competence of the mentally disordered individual will be developed in the overall patient management plan.[55] By emphasising this, devaluation of the disordered individual is minimised and the possibility of reintegration into society increased. If, as a society and a legal system, we are genuinely committed to maximising the integration of the mentally disordered into the community then normalisation is an essential prerequisite for such integration. It is also self evident that if mentally disordered individuals are to be encouraged to be an integral part of the community, and should be isolated only when there is a perceived threat to their or others' safety, then such integration should recognise that they have at least some capacity. The appropriate way to protect a recognition of this capacity is by statutory expression of a presumption of competence.[56] How a person is perceived by others strongly influences how that person behaves. The greater the presumption of incapacity (legal or social) the more likely the individual will act, or remain, incapacitated. It is submitted that the concept of normalisation, including a presumption of competence, is an essential feature of maximising capacity, minimising erosion of rights, and supporting integration into society.

A presumption of competence is based on the premise that every individual is capable of looking after their own affairs until the contrary is proved.[57] Such a presumption must operate alongside a clear, established code (legal or ethical) for establishing both the degree and extent of incapacity. Categorising a person as disabled (physically, mentally or intellectually) cannot on its own be used as a criterion; otherwise, once a disability is proved, a finding of incapacity would tend to follow automatically, creating a presumption of incompetence.[58]

In conclusion, a presumption of competence is an essential requirement in any modern legal system which asserts that its citizens have rights and shows regard for the protection of these rights. Such a development would be in harmony with the MI Principles.

III: THE LAW AND COMPETENCE

1. Statutory Expressions on Competence/Capacity in New Zealand

The preamble of the Protection of Personal and Property Rights Act 1988 ("the PRA") states that the Act is "to provide for the protection and promotion of the personal and property rights of persons who are not fully able to manage their own affairs." Part I of the Act deals with personal rights, Part II with the appointment of

53 Ibid.

54 Supra at note 16, Principles 3 and 7(2).

55 du Fresne, "Plea for a Measure of Normality" (1993) Forensic Psychiatry Conference, Waitangi.

56 In New Zealand such a prescription exists only in the Protection of Personal and Property Rights Act 1988; see infra at notes 59-66 and accompanying text.

57 Supra at note 40, at 103.

58 Ibid.

welfare guardians and Part III with property rights. It was clearly intended by the drafters that in determining whether a Court needs to make orders for the protection of individuals[59] or their property,[60] the starting point for the assessment should be a presumption of competence. Section 4 asserts that except as provided under the Act, or any other enactment, the rights, privileges, powers, capacities, duties and liabilities of any person subject to an order under the Act shall be the same as those of any other person for all purposes of the law of New Zealand. Therefore, rights can only be limited by an express order of the Court and all other rights remain unaffected. Under s 5 it is stated that every person shall be presumed, until the contrary is proved, to have the capacity:

(a) To *understand the nature*, and to *foresee the consequences*, of decisions in respect of matters relating to his or her personal care and welfare; and

(b) *To communicate* decisions in respect of those matters (emphasis added).

The Court only has jurisdiction under the Act if a person lacks, wholly or partly, such capacity as defined in either s 5(a) or (b).[61] The mere fact that a person has made or is intending to make a decision that a person exercising ordinary prudence would not have made is not in itself sufficient ground to establish incapacity.[62] This is consistent with the common law.[63] In addition, the person must lack capacity to make or communicate decisions for a welfare guardian to be appointed by the court. Even then, such appointment should only occur if it is the only satisfactory way to ensure appropriate decisions are made for the care and welfare of that person.[64]

In relation to property rights, there is a similar presumption of competence.[65] Again the court's jurisdiction is limited to making orders in areas where capacity has been determined to be lacking.[66]

The PRA, by giving primacy to the presumption of competence is enlightened rights legislation. An individual's rights cannot be limited by a court order without demonstration of incapacity. If incapacity is determined, rights can only be limited in a way directly related to that incapacity and then only to the extent necessary to compensate for it. The concept of "global incompetence" is clearly rejected. Further the primary objectives of the Court on exercising its jurisdiction are expressed as being:[67]

59 Section 10.
60 Sections 29 - 34.
61 Section 6(1).
62 Section 6(3).
63 Supra at note 39.
64 Section 12(2)(b).
65 Section 24.
66 Section 25.
67 Section 8.

(a) To make the least restrictive intervention possible in the life of that person in respect of whom the application is made, having regard to the degree of that person's capacity; and

(b) to enable or encourage that person to exercise and develop such capacity as he or she has to the greatest extent possible.

The PRA is in total harmony with normalisation concepts including the themes of "citizenhood" and "pupilhood," and extends to a prescription of competence. [68] Given such statutory enlightenment it could have been expected that there would be a similar approach to normalisation and competence in the MHA, passed some four years later. The Act's preamble includes the intention of both defining the rights of persons subjected to compulsory psychiatric assessment and treatment and providing better protection for these rights. Issues of autonomy and competence in relation to mentally disordered persons will most likely arise in relation to their right to refuse psychotropic medications. If a committed patient is deemed to lack capacity by a health professional, the duty to ensure informed consent is largely abrogated. The possibility of this occurring is demonstrated in the submissions of the defendant institution in *Rogers*.[69] The institution contended that a committed mental patient was incompetent to decide whether or not to receive treatment and had no constitutional right to refuse treatment.[70] They further submitted that once committed, patients were clinically deemed not only to lack the capacity to decide whether treatment was necessary, but also what treatment was necessary.[71] This fixed attitude to the relationship between mental disorder and competency has even been reflected in judicial statements. For example, it was stated by Denning LJ in *Richardson v London County Council*:[72]

> It is an unfortunate feature of mental illness that those afflicted by it do not realise *the need for their being under the care and control of others*. They resent it, much as a small child or a dumb animal resents being given medicine for its own good...

Although views have changed in the intervening thirty eight years, the above statement does define the problem. The MHA and its application to cases will be examined in an endeavour to determine whether a presumption of competence is necessary in New Zealand's mental health law.

The MHA s 2 definition of mental disorder states that:

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

68 Supra at note 49.

69 Supra at note 41.

70 Ibid, 1360.

71 Ibid, 1361.

72 [1957] 2 All ER 330, 338 (CA) (emphasis added).

(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.

Once the criteria for an abnormal state of mind have been met, the individual comes under control of the Act if he or she exhibits dangerous behaviour (limb (a)) *or* has seriously diminished capacity for self-care (limb (b)). Those individuals who come under the Act's provisions under limb (b) are by statute labelled as being of diminished capacity. It is submitted that without a statutory statement protecting other aspects of capacity, this limb of the definition lends itself to a clinical presumption of decisional incapacity. However, the Act implicitly establishes a presumption of partial capacity/competence, first, in those provisions establishing a duty for "ascertaining the patient's wishes in the matter (where that can be done)" and second, in Part V of the Act where the relationship between treatment and consent is established. These provisions will now be discussed to determine the extent to which the Act protects capacity.

(i) Section 12(8) establishes that a patient's wishes must be taken into consideration in determining whether to make a s 16 application for review.

(ii) Section 14(6) establishes a similar duty for a district inspector when considering whether to appear before the court to be heard in respect of a compulsory treatment order application.

(iii) Section 16 establishes that the court must discuss with the patient his or her views on matters relating to a proposed course of assessment and treatment.

(iv) Section 19 states that the court may excuse a patient from proceedings *if* satisfied that the patient wholly lacks the capacity to understand the nature and purpose of the proceedings.

(v) Section 20 states that where a patient appears capable of addressing the court, the court shall give the patient an opportunity to do so.

(vi) Section 27 establishes that upon application for a compulsory treatment order the court must determine whether the patient is or remains mentally disordered; such an order can only be granted if mental disorder as defined in s 2 is present. There is no obligation for the court to determine the degree and extent of incapacity of the patient. However, this would be appropriate for those patients found to have "seriously diminished capacity to care for themselves" pursuant to the second limb of the definition. Such a compulsory treatment order is a judicial determination that treatment is necessary, not that the patient lacks decisional capacity.

(vii) Section 59 states that after one month of compulsory treatment, no patient shall be required to accept any further treatment unless either consenting to it in

writing after an explanation of the treatment (including expected benefits and likely side-effects); or the treatment is considered to be in the interests of the patient by a psychiatrist appointed by the Review Tribunal. Section 59(4) requires that "wherever practicable" the responsible clinician shall attempt to obtain consent to treatment even though such treatment may be authorised under the Act without the patient's consent. The legislature has recognised the importance of a therapeutic alliance between patient and clinician but this has not been expressed in a way which acknowledges the importance of decisional capacity. The weakness of subsection (4) is the term "wherever practicable," meaning wherever this is able to be accomplished. This may impliedly mean (1) able to be accomplished because the patient has decisional capacity or (2) able to be accomplished in the absence of necessity or staffing and resourcing problems. With meaning (1), there would be an obligation to obtain informed consent from a person who has decisional capacity. With meaning (2) there could be non-patient exigencies which negate the obligation to obtain informed. In addition, under s 59, consent may validate treatment when a patient has no decisional capacity and no understanding of the treatment to which he or she is "consenting". This is the very situation when an second clinician's independent opinion is required. It is contended that s 59 should be reworked to include an obligation to assess decisional capacity. If it is present, patient consent should be sought. The current provision does little to protect a patient's right to self-determination where capacity does exist or a right to "patient interest" assessment if capacity is lacking.

(viii) Under s 60, electro-convulsive therapy (ECT) may be administered in two situations: under s 60(a) the written consent of the patient is required; or under s 60(b) the treatment must be considered "in the interests of the patient" by another psychiatrist appointed by the Review Tribunal. The criticisms are the same as for s 59 with one addition; there is no proviso equivalent to s 59(4) requiring that the patient interest test be applied only if consent has been withheld. Brookbanks has commented that "s 60(b) is a consequential provision that only comes into operation when the conditions in s 60(a) are not satisfied (that is, the patient's consent is not forthcoming)".[73] However, this writer interprets s 60 differently. The (a) and (b) provisions are alternatives. There is no equivalent of the s 59(4) duty to attempt to obtain consent prior to invoking s 60(b). Section 60 commences with the statement "[n]otwithstanding anything in section 58 or section 59 of this Act". Clearly there is an implied legislative intention that the circumstances necessary to legitimate ECT should be different from those required to legitimate medication. If this interpretation is correct why should such a distinction be created? One possible conclusion is that ECT was regarded as a more potent therapy only used in individuals who are severely mentally disordered and who are therefore less likely to have decisional capacity. On this analysis clinicians have the option proceeding directly to the para (b) provision and decide the issue on patient interest grounds. This section is closer to a presumption of incompetence than of competence. Section 60, and to a lesser extent s 59, are foundations built

73 Brookbanks, "Electro-convulsive Therapy and the Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ)" [1994] 1 J Law and Med 184, 191.

on sand when measured against the MI principles. The principles preclude a decision that a person lacks legal capacity without an independent and impartial tribunal hearing pursuant to domestic law.[74] They also require that no treatment should be given to a person without his or her consent unless urgently needed to prevent immediate or imminent harm or if an incompetent patient unreasonably withholds consent to treatment deemed to be in their best interests.[75] As structured, neither ss 59 or 60 meet these standards. Furthermore they contain a patient interests test rather than a best interests test.[76] The former implies only that on a balance of benefits and risks, a particular treatment is perceived to be beneficial.[77] The latter implies additionally that, of all available treatments, a suggested treatment is the best available. As s 60 stands, a patient with or without decisional capacity could lawfully receive ECT as long as it was perceived to be beneficial, regardless of whether there was an equally or more beneficial alternative.

(ix) Section 61 is built on a firmer foundation. For brain surgery to be performed the patient must consent in writing and the Review Tribunal must conclude that the consent was freely given and that the nature, purpose and likely effect of that surgery was understood. This is not a presumption of competence, but rather a provision that withholds treatment unless a person with capacity to understand gives informed consent.

In conclusion, the MHA does not include a presumption of competence, though neither is there a presumption of global incompetence. It does not distinguish between the competent and incompetent in constructing mechanisms which determine the lawfulness of treatment. It recognises as valid "consent" from an individual who may not have the capacity to understand that treatment. These are shortcomings of some concern. It seems anomalous for there to be a presumption of competence in the PRA, an Act to protect personal and property rights of persons "who are not fully able to manage their own affairs," without extending a similar presumption to protect the personal rights of those requiring treatment for a mental disorder. The HRA does not mention competence despite its goal of existing to "provide better protection of human rights." It is unlawful to discriminate on the basis of psychiatric disorder, pursuant to s 21(1)(h)(iii). It is possible that concerns related to the treatment provisions of the MHA discussed above amount to discrimination; for example the s 60(b) provision to permit ECT despite refusal to consent when the patient's decisional capacity had not been assessed may well be seen as discriminatory.[78] However, the ss 151 and 152 disclaimer of the HRA that the Act shall not "affect anything done by or on behalf of the Government of New Zealand" may preclude the application of such arguments to psychiatric institutions and services until after 31 December 1999.

74 Supra at note 31 and accompanying text.

75 Ibid.

76 Infra at note 32 and accompanying text.

77 Supra at note 73.

78 This hypothetical situation could also be in breach of s 11 of the BORA. See supra at note 73, and infra at notes 83, 127-129 and accompanying text.

Several rights essential to autonomy are threatened in the absence of a presumption of competence, in particular the right to informed consent, along with the associated right to refuse treatment,[79] and to a lesser extent the right to liberty of the person.[80] A presumption of competence is not only scientifically logical but legally necessary to protect human rights.

2. Case Law and Capacity/Competence

The importance of a statutory presumption of competence to the conclusions in *Rogers* has already been discussed.[81] The weight of evidence was held to have persuaded the Court that:[82]

> [A]lthough committed mental patients do suffer at least some impairment of their relationship to reality, most are able to appreciate the benefits, risks, and discomfort that may reasonably be expected from receiving psychotropic medication. This is particularly true for patients who have experienced such medication and, therefore, have some basis for assessing comparative advantages and disadvantages. Indeed, a fundamental concept for treating the mentally ill is the establishment of a therapeutic alliance between psychiatrist and patient. Implicit in such an alliance is an understanding and acceptance by the patient of a prescribed treatment program.

Would the findings of a New Zealand court on similar facts be different because of the absence of this statutory presumption?

In *Re S*,[83] a patient committed pursuant to a reception order under s 23 of the Mental Health Act 1969 had been granted leave of absence from the hospital under s 66 of the Act. S was visited regularly by hospital staff who administered medication to him, such medication being considered by the superintendent necessary for his well-being and stable behaviour. S applied under s 74 for an inquiry with a view to his discharge as he no longer wished to continue either visits or medication. The medical evidence suggested that without committal he would be unlikely to allow follow up, decline medication and it was therefore likely his mental functions would deteriorate and develop aberrant behaviour. The clinicians considered S to be incompetent to make a decision about continuing or discontinuing his medication as he did not appreciate the significance of the treatment. S argued that his enforced medication contravened s 11 of the BORA which provides that "[e]veryone has the right to refuse to undergo any medical treatment." In respect of the section, Barker J stated that: [84]

79 Infra at note 83 and accompanying text.

80 The right to liberty of the person is affirmed by s 22 of the BORA. It is contended that patients considered incompetent are more likely to be considered in need of an inpatient order for compulsory treatment.

81 Supra at notes 41-42 and accompanying text. It was held that a committed patient is presumed competent to make decisions in respect of their treatment in non-emergencies.

82 Supra at note 41, at 1361.

83 [1992] 1 NZLR 363.

84 Ibid, 373 - 374.

> [T]he wide discretion given to the superintendent under s 66 would be compromised and rendered ineffective upon reading "Everyone" in s 11 of the bill of Rights as including all mentally disordered persons who are committed patients.
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> ...
>
> "Everyone" in respect of s 11 must mean "every person who is competent to consent". Being mentally disordered and competent are not mutually exclusive, although the presence of both factors simultaneously is no doubt uncommon.

In summary, Barker J first stated (obiter) that competence is rarely present in mental disorder; and second, held that the s 11 right to refuse treatment can never be extended to an incompetent person. This sounds remarkably like a presumption of incompetence rather than competence. It is hard to reconcile such reasoning with that in *Rogers*.[85] S lived in the community successfully, managing his own home and living on an invalid benefit.[86] He had family assistance, mild success on the sharemarket, and was enrolled in a personal computing course. He stated he was happy to continue with his current medication, albeit at a lower dosage.[87] These facts implied that S enjoyed a degree of normalisation, self-determination and integration within society. He had a degree of capacity. The logical starting point should have been a presumption of competence, the onus then being on the superintendent and others to prove decisional incapacity. The expert evidence however regarding S's decisional incapacity was overwhelming. Even the psychiatrist retained by S's solicitors was of the opinion that S was incompetent to make decisions about continuing or discontinuing medication. The concern in this case was not with the result but with the process of reasoning.

Re KS[88] concerned an application for a judicial inquiry pursuant to s 84 by a patient who was subject to a compulsory treatment order under s 28 of the Act. The patient objected to his responsible clinician's decision that he required ECT. Temm J held that s 60 provided that if the responsible clinician considered that ECT would be "beneficial" to the patient and the patient does not consent, Parliament has empowered its administration subject to the s 60(b) "safeguard" of a second opinion by a psychiatrist appointed by the Review Tribunal. This procedure having been followed, and the second opinion confirming the responsible clinician's view, the Court was unwilling to exercise the s 84 powers simply because the patient objected. It has been suggested by Brookbanks that: [89]

> [T]he decision appears to represent, at some level, a return to the presumption of "global incompetence" in that it appears to imply that if a patient has been detained for treatment, then any treatment that may seem to clinicians to be desirable may be administered irrespective of the wishes of the patient or his or her family .... [T]he determination that the clinician's decision, made in accordance with the terms of s 60, is effectively inviolable, raises an important question about patient autonomy and competence .... [D]oes the decision mean that a refusal of consent even by a competent patient is ineffectual where the clinical decision to treat has been taken?

85 Supra at note 41 and accompanying text.

86 Supra at note 83, at 365.

87 Ibid, 366.

88 [1993] NZFLR 845; (1993) 11 FRNZ 15.

89 Supra at note 73, at 190 and accompanying text.

Brookbanks contends that where clinicians are empowered to overrule patient consent in this way, the treatment should be considered "necessary" in order to be in the patient's interest.[90] This would limit the possibility of a competent patient exercising a purported right to refuse treatment under s 11 of the BORA yet being denied such right because under s 4 of the BORA the s 60(b) power prevails. Such threats to issues of autonomy and self-determination occur in part because of the lack of a presumption of competence. If decisional capacity was a mandatory consideration, it would necessitate consideration of a patient's view that alternative treatments which were less intrusive and perhaps equally effective were available. Under such circumstances a more likely result would be that of *Re S* (shock therapy)[91] where Twaddle DCJ held (in approving the treatment) that relevant considerations included the risk to the patient's health if shock therapy was not authorised; the painful intervention in his life; and the availability of alternate interventions.

3. Other Legal Concepts Impacting on Competence

Three further issues need considerations in any rethinking about competence.

(a) Best interests v substituted judgment

Two conceptually different tests have been developed for making decisions on behalf of mentally incapacitated adults. The "best interests" standard is the more paternalistic approach,[92] derived primarily from child care law. The decision-maker takes the decision they believe is best for the interests of the incapacitated individual. In contrast, a decision made for an incapacitated person under the "substituted judgment" standard represents the choice which that particular person would have made had she or he been competent to do so. Substituted judgment is the more "integrating" standard on normalisation principles. It also reflects the usual situation that capacity fluctuates in mental disorder and that during periods of understanding and lucid communication there should be opportunities to assess a patient's views on therapeutic matters. Substituted judgment encourages communication with the patient about potential therapeutic considerations during periods of insight and capacity; an integrating activity.

The substitutes judgment standard has been found to be appropriate for the execution of a statutory will. In *Re D(J)*, Megarry V-C said: [93]

90 Ibid, 191.

91 [1992] NZFLR 208.

92 Supra at note 40, at 105.

93 [1982] Ch 237, 243 - 4.

> [I]t is the actual patient who has to be considered and not a hypothetical patient .... I do not think the Court should give effect to antipathies or affections of the patient which are beyond reason. But subject to all due allowances, I think that the Court must seek to make the will which the actual patient, acting reasonably, would have made if notionally restored to full mental capacity, memory and foresight.

> This holding fits comfortably with substituted judgment in regard to treatment decisions, although it has been suggested that introducing an element of reasonableness detracts from the purpose behind adopting the standard and as a consequence may make little difference in the majority of cases than if a best interests test had been adopted.[94] However, "thinking oneself into the shoes of the person concerned and recognising the value we all place on personal preference ... is a mark of respect for human individuality which may have a value greater than its personal effect."[95] This value upholds maximising self-determination and a degree of normalisation.

However, there is undoubtedly a place for a best interests standard. In *Re F*[96] Lord Brandon stated that:

> [T]reatment will be in the best interests of such patients if, but only if, it is carried out in order either to save their lives, or to ensure improvement or prevent deterioration in their physical or mental health.

Though the decision itself has been the subject of criticism much of this has been related to the sterilisation issue.[97] The best interests test as enunciated by Lord Brandon could be considered a "necessity" test. This would be a preferential interpretation of "in the interests of the patient" as expressed in ss 59 to 61 of the MHA.[98]

(b) Advance directives

Advance directives enable a competent person to give instructions about their wishes or who their substitute decision-maker should be if they are later assessed as incompetent. They are a useful component of the autonomy armamentarium; the individual can appoint a representative in whose substitute decision-making he or she would have confidence. However, in practice they are limited; first, by the reality that many do not wish to acknowledge their potential incapacity, second, by the fact not all contingencies will be foreseeable and third, by the difficulty in determining the degree of incapacity that will trigger an advance directive. This third problem is best accommodated by the "springing power of attorney" which

94 Supra at note 40, at 108.
95 Ibid.
96 *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 55.
97 Grubb and Pearl, "Sterilisation - Courts and Doctors as Decision-makers" [1989] CLJ 380.
98 See text, supra at p11-13.
99 Law Reform Commission of British Columbia, *Report on the Enduring Power of Attorney, Fine Tuning the Concept*. (1990).

requires a specific contingency to "spring" it, such as the principal's incapacity.[99]

(c) The parens patriae jurisdiction

In *T v T*[100] Wood J concluded that the parens patriae jurisdiction no longer existed in the United Kingdom after the Mental Health Act 1959 transferred the power previously exercised under the doctrine to the patient's guardians. It was accepted by the Court of Appeal in *F v West Berkshire Health Authority* that this jurisdiction no longer existed in England in relation to persons of "unsound mind".[101] In *Pallin v Department of Social Welfare* Cooke J stated:[102]

> I think too that a High Court Judge has a residual jurisdiction, derived from the right and duty of the Crown as parens patriae to take care of those who are not able to care for themselves ... and that our law as to the prerogative jurisdiction over infants is not complicated by the procedural distinctions in England ...

In *Re X*[103] Hillyer J relied on the parens patriae jurisdiction to authorise a hysterectomy on a severely mentally retarded fifteen year old girl who lacked the capacity to understand, and therefore consent to, the procedure.[104]

The original form of the Mental Health Compulsory Assessment and Treatment bill would have repealed s 17 of the Judicature Act 1908 which recognised of the High Court's inherent "jurisdiction and control over the persons and estates of idiots, mentally disordered persons, and persons of unsound mind".[105] However, the proposed clause repealing s 17 was not enacted. The legislators presumably determined that the parens patriae jurisdiction was still necessary in New Zealand law.

Parens patriae is inherently paternalistic. The alternative procedure is to seek a declaration from the Court that a proposed course of action is not unlawful. With the abrogation of parens patriae in England, such a declaration was sought in *Re F.*[106] Allowing the court to make such a declaration is less invasive to autonomy. In *Auckland Area Health Board v Attorney-General*[107] doctors and the Board sought a declaration clarifying whether they would be guilty of culpable homicide for withdrawing life support from an individual with an extreme case of Guillain Barré Syndrome, the result of which was to leave the brain, though still living, entirely disengaged from the body. There was no capacity to communicate nor understand. The Court held it had jurisdiction to make a declaratory order and that such jurisdiction should be exercised sparingly.[108] The withdrawal of life-support was found not to be unlawful after a best interests argument. It is unfortunate that a substituted judgment argument was not discussed by the Court, and indeed

100 [1988] 1 All ER 613, 618 (DC).
101 [1989] 2 All ER 545.
102 [1983] NZLR 266, 272.
103 [1991] 2 NZLR 365.
104 Ibid, 371.
105 Collins, *Medical Law in New Zealand* (1992) para 3.6.13.
106 Supra at note 96.
107 [1993] 1 NZLR 235.
108 Ibid, 243 - 4.

criticism has been proffered for not doing so.[109] A declaratory judgment following a substituted judgment argument would demonstrate the Court's recognition of the importance of autonomy.

IV: TESTING CAPACITY AND COMPETENCE

1. An Emphasis on Expert Evidence?

One criticism of *Re F* is that the doctrine of necessity appears to leave the task of deciding whether a person is incapacitated to the individual doctor.[110] The Law Commission (UK) speculated that there *may* be a temptation to decide that the patient is incapacitated even though he or she is capable of understanding the broad terms explanation required by the common law.[111] In New Zealand, s 67 of the MHA requires that "[e]very patient is entitled to receive an explanation of the expected effects of any treatment offered to the patient, including the expected benefits and the likely side-effects, before the treatment is commenced." It does not require that the capacity to understand be tested; nor is there any requirement in ss 59 and 60 that capacity to understand be assessed before consent is obtained.[112] The pressure of workload and resource availability could exacerbate the tendency for a clinical presumption of incapacity. This is possible even though most decisions are taken by "highly responsible professionals without a personal and financial interest in the outcome."[113]

Similarly, where there is a judicial review of an intended treatment plan, theoretically the best chance a clinician has of that plan not being overruled is to "prove" that patient is incapacitated. Although the finding in *Re S* that S lacked decisional capacity could not be objectively challenged on the basis of a case report, it does demonstrate the subjectiveness of clinical opinion as to incapacity.[114] While the history of S's illness cannot be used to determine current capacity, it is helpful to trace the arguments which purportedly established incapacity. Dr M expressed the view that S's current state and past history indicated the need for committal to continue indefinitely otherwise S would be unlikely to allow medical followup and would decline to take medication which would result in the deterioration of his mental functions.[115] This is not a test of capacity; rather, it is a best interests argument that disregards issues of capacity. It is the very problem identified as being encouraged by ss 59 to 61 and 67 of the MHA, passed since the S case.[116] Dr F [117] found S quiet, polite and reserved but

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109 Tobin, "The Incompetent Patient's Right to Die: Time for Legislation Allowing Advance Directives?" (1993) NZ Recent Law 103, 104.

110 Supra at note 40, at 43.

111 Ibid.

112 For an explanation of the problems associated with this see text, supra at p 11 - 13.

113 Supra at note 40, at 43.

114 Supra at note 83, at 374.

115 Ibid, 366.

116 See supra at note 73 and accompanying text.

117 Supra at note 83, at 366.

with little emotional modulation of the voice. He considered S harboured persistent paranoid delusions, and that if not committed, he would refuse the injections which he insisted he did not need. It was considered that, without medication, it was likely that hospitalisation would be needed. Again this is a best interests argument. Dr F also considered S incompetent to make the decision about continuing or discontinuing his medication and that it was therefore in his interests for him to remain committed. No criteria were reported that could objectively establish incompetence (although that it may well have been present). Linking the comments about decisional incapacity with S's interests by the word "therefore" suggests the reasoning was: S has decisional incapacity, therefore it is in his best interests to remain committed. This is not the test in law. There is no evidence reported as to how decisional capacity was established; that S was incompetent. Yet Barker J held that:[118]

> [I]n the opinion of all the mental health professionals who have seen S and in the opinion of the psychiatrist, specifically retained by S's solicitors, S is incompetent to make the decision about continuing and discontinuing medication. He does not appreciate the significance of the treatment.

While this may have been so, it is not clear which clinical and legal tests upon which this conclusion was based. This is judicial deference to expert opinion. This result is almost inevitable in an Act where the following three factors interact:

(i) if s 5(b) is satisfied, the statutory definition of mental disorder establishes that there is some degree of incapacity;
(ii) there is no presumption of competence and therefore no incentive to identify objective criteria to establish incompetence; and
(iii) in the absence of consent, there is quick resort to a patient interests test in considering treatment options.

These three factors were the same under the 1969 Act in force at the time of *Re S*, and the 1992 Act.

2. Medical and Psychological Tests of Capacity

Research in the United States suggests that doctors' decisions in relation to capacity are influenced by two major extraneous factors, their "attitude to client group" and a "treatment bias."[119] The attitude hypothesis maintains that doctors' own images of mentally disordered people influence their assessments of capacity and the threshold determining incapacity. The treatment bias theory maintains that clinicians are inherently predisposed to decide to treat a patient. They are therefore more likely to find patients who consent to treatment to be competent than those

118 Ibid, 374.
119 Roth, Meisel, Lidz, "Tests of Competency to Consent to Treatment" (1977) 134:3 Am J Psych 279, 283.

who are less cooperative. The authors identified five separate tests of competence: evidencing a choice; "reasonable" outcome of choice; based on "rational" reasons; ability to understand; and actual understanding.[120] In a review of clinical approaches to capacity, an integration of these tests was proposed in an attempt to overcome their limitations.[121] It was suggested that to be found competent in respect of any particular decision a patient must reach a certain standard in each of the following categories:

(i) communicating choices and maintaining a stable choice long enough for it to be implemented. Questions about a proposed procedure are repeated after several minutes;
(ii) understanding relevant information. Can the patient remember, repeat, and paraphrase information provided?;
(iii) appreciating the situation and grasping what it signifies for them. This includes acknowledging illness which is present, evaluating its significance and that of treatment options including risks and benefits; and
(iv) manipulating information rationally by reaching conclusions which are consistent with the starting premises.

However, what these criteria do not establish is the threshold of capacity. Insistence on a high degree of comprehension could result in many people of average intelligence and no disorder being adjudged incompetent. The tests therefore are highly subjective.

Another approach has relied upon psychological analyses of the decision-making process with a quantitative definition consisting of two parts; first, the presence of decision-making abilities, and second, the absence of decision-making disabilities.[122] The abilities include understanding relevant information, deliberating about it, and deciding to accept or reject it. The inabilities are phenomena which prevent development of, or cause loss of the abilities, such as delusional systems, organic (cerebral) damage or profound depression.

The search for a single test of capacity has been likened to a search for the Holy Grail.[123] It has been acknowledged that "[i]n practice judgments of competency go beyond semantics or straightforward applications of legal rules; such judgments reflect social considerations and societal biases as much as they reflect matters of law and medicine."[124] However, if tests of capacity introduce some common concepts and prevent arbitrary determinations of incompetence then they should not lose credibility because of persisting subjectivity. As Millet puts it, in mental illness, "there are no pathological indexes or proofs, only behaviour ... [B]ehaviour

120 Ibid.

121 Applebaum, Grisso, "Assessing Patients' Capacities to Consent to Treatment" (1988) 319 N Eng J Med, 1635.

122 Tepper, Elwork, "Competence to Consent to Treatment as a Psychological Construct" (1984) 8 Law and Human Behav 205.

123 Supra at note 119.

124 Ibid.

is not physically objective, [rather it] is a matter of observation and interpretation."[125] Furthermore Gostin asserts that: [126]

> There is no scientific basis for assuming that mentally ill people cannot perform as well as others. In each case the question must be asked - is the person capable of functioning responsibly in the specific area of concern? A right or privilege should be limited only when an independent Court or tribunal decides, on the basis of *demonstrable evidence*, that the person is incapable of exercising it. Mentally ill people, like others, have varied and unique skills and limitations. A mentally ill person is seldom incompetent all of the time and in relation to all activities.

Although there is little that is definitive in regard to tests of capacity, it can be concluded that:

(i) when considering capacity, clinicians, lawyers and judges alike must apply themselves practically to identify, analyse and document components of capacity;
(ii) understanding is the essential prerequisite to capacity; and
(iii) the legal system should require a relatively low threshold for capacity in order to recognise the importance of autonomy and self-determination.

V: THE BILL OF RIGHTS MENTAL HEALTH LAW AND THE PRESUMPTION OF COMPETENCE

1. Interaction between the Bill of Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992

The rights of the BORA are not absolute. Pursuant to s 5 they are subject to "reasonable limits". If a right is restricted and this restriction fails the s 5 test, this could be considered an infringement of the BORA.[127] The test has two parts; first, determining whether the limits on the right are "prescribed by law" and second, whether they are "reasonable". As Rishworth points out, the ordinary statute status of our BORA means that when limits on rights are prescribed by a clear unambiguous statute, there can only be two possible outcomes, both producing the same result:[128]

125 Millet, "Legal Rights and the Mental Health System" (1992) 17 Queens Law J 215, 218-9.

126 Gostin, "Human Rights in Mental Health: A Proposal for Five International Standards Based on the Japanese Experience" (1987) 10 Int J Law & Psychiatry 353, 365 (emphasis added).

127 Rishworth "The New Zealand Bill of Rights Act 1990: The First Fifteen Months" in *Essays on the New Zealand Bill of Rights Act* (1992) 7, 19.

128 Ibid, 21.

(i) either the limits prescribed are reasonable in which case the statute is consistent with the BORA and the bill cannot be invoked to influence its interpretation under s 6 which applies when there is an inconsistent meaning available;

(ii) or, the limits are unreasonable, but the statute must receive its clear unambiguous meaning because s 4 indicates that inconsistent statutes prevail over the BORA.

The situation is similar where a statute is ambiguous; the inconsistent meaning either is a reasonable limit, or if unreasonable, it may still be held to be a necessary meaning that the statute must bear and should therefore prevail due to s 4.[129]

Therefore, under the MHA, clear and unambiguous statements which purport to limit BORA rights will be found either to limit those rights because such limitations are reasonable in a free and democratic society or, despite being unreasonable, prevail by virtue of s 4.

In *Re S*[130] the s 11 right to refuse medical treatment was invoked, as was s 22, the right not to be arbitrarily detained. Barker J applied ss 4 and 6 to conclude that s 11 of the BORA should be read down so as to mean only that "everyone who is competent to consent had the right to refuse treatment." Rishworth however has suggested that "everyone" in s 11 should literally mean everyone, because it is unlikely that ss 4 and 6 were intended to read down the BORA itself.[131] Even so, overriding the right of committed patients to refuse medication could be a reasonable limit on that right. The superintendent would have to argue that in a free and democratic society, it is reasonable for a law allowing committal for compulsory treatment to override the right to refuse that treatment, notwithstanding that the patient may be competent to consent. Failing that, if the provisions for compulsory treatment were clear and unambiguous they would prevail under s 4.

It is apparent that while the BORA asserts rights, it can do little to prevent their limitation. Provisions in the MHA limiting BORA rights will prevail.

2. Does the Bill of Rights Assert a Presumption of Competence?

Section 28 of the BORA states that:

> An existing right or freedom shall not be held to be abrogated or restricted by reason only that the right or freedom is not included in this bill of Rights or is included only in part.

There is a common law presumption that a person is competent until proved

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129 Ibid.

130 Supra at note 83, at 374.

131 Supra at note 127, at 28 - 9.

132 Supra at note 40, at 19.

otherwise.[132] The Law Commission (UK) stated that "there is a common law test of capacity, to the effect that the person concerned must at the relevant time understand in broad terms what he is doing and the likely effects of his actions." [133] The test does not include an assessment of the wisdom of a decision.[134] However, the existence in New Zealand of such a common law presumption is uncertain. *Re S* and the MHA would suggest that it is at best moribund. There is no guarantee that s 28 of the BORA could be used to resuscitate it. A presumption of competence therefore requires statutory expression.

3. Situating and Applying a Statutory Presumption of Competence.

The PRA already contains a presumption of competence, similar provisions could be placed either in the BORA or the MHA. Given the importance of a right to self-determination and autonomy it is appealing to suggest amending the BORA to include such a presumption. However, the arguments already advanced indicate that this would not protect the presumption from limitation by other Acts, especially the MHA. There is pragmatic appeal to placing the presumption in the MHA, the statute to which it would most frequently apply. Before deciding between these alternatives it is important to identify what the practical aims of a presumption of competence should be.

The MHA was intended to "redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment." The circumstances in which the Act declares compulsory assessment and treatment lawful are contained within the s 2 definition of mental disorder. During the process of assessment, up to and including judicial granting of a compulsory treatment order, the patient must exhibit mental disorder 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.

The definition indicates how a presumption of competence may apply, the circumstances where capacity should be tested, and where treatment could be compulsory despite presumed competence. First, if the assessment/treatment process has been commenced because the mental disorder is such that limb (b) is satisfied, a presumption of competence is essential. If this limb is satisfied the patient is by that very definition partially incapacitated. A presumption of competence would require individual capacity to be assessed, identifying those areas where capacity is compromised as well as those where it remains. An individual patient may have lost the capacity to look after personal nutrition and hygiene because of their mental disorder, yet be able to understand the advantages and disadvantages of treatment. Such an individual has diminished practical

133 Ibid.

134 Ibid.

capacity but retains decisional capacity. Recognition of a survival of decisional capacity should, in this writer's view, lead to a different process in respect of ss 59 and 60 (concerning medical or ECT therapy while subject to a compulsory treatment order). Second, if the mental disorder is such that the limb (a) criterion is satisfied the issue is one of individual and public safety. Under considerations of public safety, detention for compulsory treatment is not arbitrary [135] and it is not unreasonable to treat whether or not decisional capacity is present.

VI: CONCLUSION

In summary, there is a need for a presumption of competence in New Zealand mental health law, together with specific rules as to when it applies and when it can be overridden. This would not necessarily lead to different outcomes insofar as which patients are subjected to what treatments. However, this is not an outcomes argument, it is a process argument. The process should be one where respect for autonomy, self-determination, recognition of capacity (partial or otherwise), integration, and normalisation are maximised. That the outcome may be unchanged for most does not negate the need for a process which maximises self-respect and respect for the process, because by so doing the patient-clinician therapeutic alliance is furthered.[136]

A recent New Zealand text on individual rights and freedoms does not include a discussion of a presumption of competence as a basic human right.[137] It is submitted that it is time for it to be recognised as such and that the presumption of competence is of such fundamental importance that it should be specifically recognised by amendment to the BORA. This would allow for limitations of that right pursuant to law provided such limitations are reasonable in a free and democratic society. Those limitations could be clearly and unambiguously spelled out by minor but important amendments to the MHA.

There is no special feature of mental illness such that those who are unfortunate enough to be afflicted by it should be seen as less deserving of a legal presumption of competence than those of us who may be more fortunate and not so afflicted.

135 *Re M* [1992] 1 NZLR 29, 38 per Gallen J. The quality of behaviour necessary to come within the category against which the public requires to be protected must be no less than a potential to commit serious physical violence.

136 Supra at note 41, at 1361.

137 Huscroft and Rishworth (eds) *Rights and Freedoms* (1995).