THE CIVIL COMMITTAL PROCESS

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INTRODUCTION

'Will I be for treatment tomorrow?
Janet Frame,

Civil committal is a process of social control and treatment without consent of 'mentally disordered' people, under the Mental Health Act 1969. It may cause permanent change in a person's legal and social position, as they assume **committed patient status**.

This paper attempts to describe the current operation of this process. Its focus is legal and empirical. It is based particularly upon data collected through 212 case studies, participant observation and interviews, in and around 4 North Island psychiatric hospitals in 1984. It attempts to describe who is committed, how they are committed and for how long. Its language is the language of law and of professional participants.

It does not describe the personal experiences of people who are committed, nor their particular medical treatment, nor the role of the Public Trustee. It attempts to describe the decisions made by those who wield the power of detention in psychiatric hospitals under a specific piece of legislation.

I. THE STRUCTURE OF COMMITTAL.

A. THE IDEA OF THE RULE OF LAW.

A compulsory 'clinical' relationship requires a legal basis. The Mental Health Act 1969 provides a basis for the detention and compulsory treatment of '**mentally disordered' persons**. It is the latest in a line of 'lunacy laws' permitting interference in the lives of 'mentally disordered' people, which can be traced to about fourteenth century English law. Its predecessor was the Mental Defectives Act 1911.

The legislation establishes a framework within which decisions are to be made about detention and compulsory treatment. It provides a definition of who is 'mentally disordered':

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

It provides a legal standard governing committal:

Section 24(1) '... mentally disordered and requires detention in a hospital for his own good or in the public interest.'

It sets out the **periods of time** during which legal events must occur. Powers of **arrest** are given to the Police. Specific people are required to initiate committal by launching an **application**: and two doctors must formally **certify** the patient is within the standard. Upon completion of these 'formalities' the 'patient' may be detained and treated without consent in a psychiatric hospital.

If the patient continues to be detained a **judicial hearing** must be held. The application form and medical certificates are placed before a judge or justices of the peace for scrutiny. A hospital doctor is to be consulted and the patient interviewed. The hearing may be **adjourned** with the patient detained and treated until it is resumed.

The final decision to make a **reception order**, permitting indefinite committal and treatment, is given to judicial officers. So the Act contains the principle of ***habeascorpus***-that the final decision-maker on a matter of liberty should be a court of law.

Beyond the Mental Health Act are further judge-made principles. **the rules of natural justice**, governing procedure at judicial hearings. They must be conducted 'fairly' and decisions must be 'reasonable'.

Thus a framework is apparently established in which power over personal liberty is made subject to the rule of law.

B. COMMITTAL'S LEGAL CONSEQUENCES.

The law structures committal 'in time'. This gives it a beginning, a middle, and an end: but it extends for an **indefinite** period - **until the patient is discharged.** The main legal events which accompany compulsory psychiatric hospitalisation often occur in this sequence:

1.APPLICATION 2.ARREST 3.CERTIFICATION 4. ADMISSION 5 .HEARING

5.ORDER 6.LEAVE 7.DISCHARGE

The process may be described differently by members of other professions. A doctor may describe it as follows:

1.CRISIS 2.ADMISSION 3.TREATMENT 4.DISCHARGE 5. FOLLOWUP INTERVENTION

A sociologist may view it like this:

1.IDENTIFICATION OF DEVIANCE 2.LABELLING 3.CONTROL 4.DEGRADATION 5. SECONDARY DEVIANCE

Behaviour may be seen as dangerous or symptoms of an illness; or departure from a norm, or problems in living. The **committal standard** is an attempt to define in legislation the circumstances in which 'mentally disordered' behaviour may be lawfully controlled and treated without consent.

If patients are found to fall within the standard they may be restrained and placed in a psychiatric hospital and treated with **whatever mode of treatment medical staff think fit**. This may include the administration of psychotropic drugs with numerous adverse side effects and electro-convulsive therapy (E.C.T.). Patients may be placed in **seclusion** (or solitary confinement) and **transferred** between wards and hospitals, including transfer into secure units like Oakley Hospital and Lake Alice Maximum Security Villa. **Property management** may be assumed by the Public Trustee, their **mail** may be censored, their **driver's licence** taken away.

Many of these consequences may continue after discharge if the patient leaves hospital as a **committed patient on leave**. Leave may be granted on such conditions as hospital staff think fit. The patient is usually required to **'comply with medication'** and **live where directed.** The leave may be revoked at any time and the patient 'retaken'. There is no legal standard specifically governing **revocation**, nor any certification requirement, nor any specific entitlement to a judicial hearing after redetention.

There is no legal process ensuring the regular **review** of committed patients' status by a body independent of the hospital. A further judicial hearing may be held every six months at the discretion of the Minister of Health, or by a high court judge. Patients must apply for these reviews. Few do apply and few review hearings are held. There is no appeal from the reception order.

The act requires hospital staff to review the status of committed patients at specified intervals. They have an obligation to **discharge from committal** anyone who no longer meets the standard. In practice, **the in-hospital review is the main protection against prolonged confinement.**

C. THE AVENUES OF COMMITTAL.

There are three main civil committal processes, each invoking a different section of the Act: **sections 16, 19 and 21.**

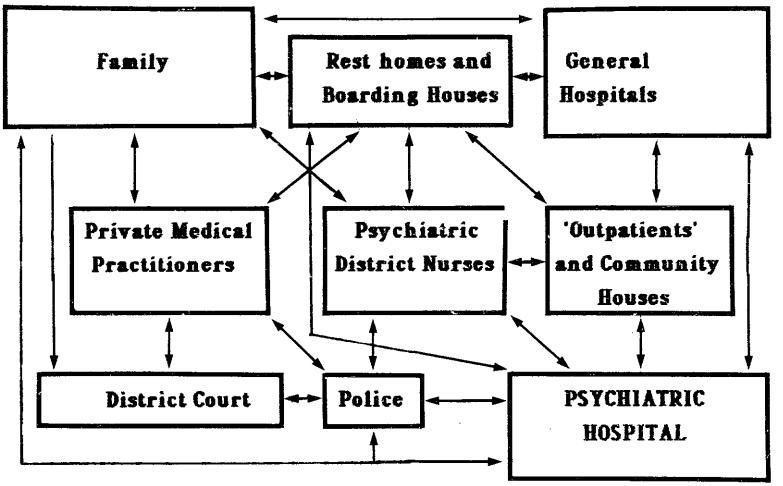
Section 16. Committal of Informal Patients	**Section 19. Committal to Hospital**	**Section 21. Committal Through the District Court**
Informal admission to psychiatric hospital	Application to Superintendent	Application to District Court Judge
↓	↓	↓
Application by doctor, authorising 'detention'	Certification	Judge reviews application and may examine applicant
↓	↓	↓
Certification	Admission to psychiatric hospital	Warrant to arrest issued
↓	↓	↓
Judicial hearing	Second certificate completed	Arrest by police
	↓	↓
	Court notified	Certification
	↓	↓
	Judicial hearing	Judicial Hearing
		↓
		Transported to psychiatric hospital

The different processes **vary in importance between hospitals**. Committal of informal patients is a frequent occurrence at Carrington. Committal through the District Court is more prevalent at Kingseat and Tokanui. In Auckland, many patients committed under section 19 are arrested or transported to the hospital by the Police. The 'emergency'

procedure is frequently used, with patients admitted on one medical certificate.

These processes operate within a **complex inter-organisational network** which regulates the flow of committed patients into and out of the hospital. This is represented by Figure I.

FIGURE I
The 'Network'

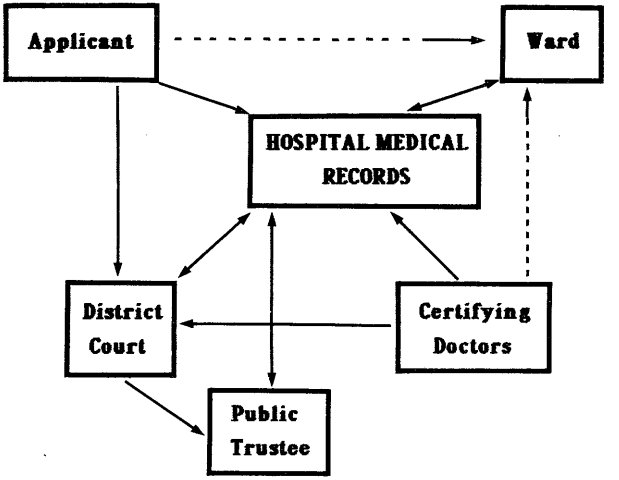


Flowing through these avenues are committal's **distinctive documents**. These are:

* The application form and any supporting affidavit of the applicant
* The warrant to arrest
* The medical certificates
* The reception order
* The order of adjournment
* The notification to the district court of an admission under section 19.

Their flow is represented by Figure II.

FIGURE II.
Document Flows



The completed documents are copied and lodged on **patients' files**. There are three files:

* The **correspondence file**, kept in the hospital's medical records
* The **clinical file**, which is kept on the ward and follows the patient within the hospital
* The **court file**, kept at the district court.

Hospital staff and the judiciary have free access to the patient's hospital files. Access to the court file is limited to court staff and the judiciary.

Other documents inform the Public Trustee of patients' committal, transfer and discharge.

No patient may be lawfully committed without proper completion of the necessary documents. **Custody and oversight of documents and files is an important administrative function.** It is performed by medical records personnel and the mental health clerk or registrar of the district court. They may acquire knowledge of the legislation which is sought out by other professionals. They administer the hearing process and are responsible for liaison. Every court and hospital has such brokers.

D. COMMITTAL'S THREE PHASES

For practical purposes it is convenient to separate the committal process into three distinct phases: social crisis management, in-patient management and control in the community.

Social Crisis Management

Social crisis management describes those aspects of committal which operate prior to the patient's admission to a psychiatric hospital. This involves the decision by some person that a social crisis exists and that its resolution requires setting in motion committal of an individual. The events which follow vary in accordance with the process chosen, but often include:

* The making of an application
* The issue of a warrant to arrest the patient
* Arrest by the Police or restraint by family members
* Detention, in police cells or at the district court
* Certification by medical practitioners
* Examination by a district court judge or two justices
* The making of a reception order
* Transportation to a psychiatric hospital.

Crisis management is characterized by the need to 'do something' and do it quickly. It is usually the culmination of a progression of events which now suggest immediate action, to prevent some harm which may befall the person to be committed or those around them. It often involves a decision by those people with whom the patient is living that 'things can't go on the way they are'. Its main actors are the patient, the patient's family, general

practitioners and the police. Its time frame is hours or days. It concludes with the patient's admission.

In-Patient Management.

In-patient management describes those aspects of committal which operate during the committed patient's admission to a psychiatric hospital. The phase is dominated by the management practices of the psychiatric institution and beats to institutional time. It includes the committal of patients admitted on an informal basis, which is often a form of crisis management within the hospital.

This phase may include:

* The hospital accepting admission of the committed patient
* The patient's assessment
* The administration of treatment, usually medication
* Seclusion
* Preventing the patient leaving the hospital
* Transfer, between wards or hospitals
* Change to informal patient status
* Recertification
* Judicial hearing at the hospital
* The making of a reception order
* Short periods of leave
* A decision as to the time and status of the patient's discharge.

Its main actors are the patient, hospital nurses, doctors and records staff, district court judges and justices of the peace. Its time frame is usually weeks or months, but may be years. It concludes with the patient's discharge from hospital.

Control in the Community

Control in the community describes those aspects of committal which operate following the patient's discharge from the psychiatric hospital, as a committed patient on leave. Leave may continue for up to two years after discharge at the discretion of hospital staff and may be further extended for successive periods by permission of the Director of Mental Health. If the patient is readmitted the two years run again from the time of redischarge.

The attitudes of staff to leave and the extent of its use vary greatly between hospitals. In part this is related to the scope of the hospitals' domiciliary or extramural services, and the phenomenon of 'transinstitutionalism', whereby patients move from psychiatric hospitals to live in other institutions such as rest homes and boarding houses. This is most common in central Auckland where patients are often visited by psychiatric district nurses or required to attend clinics at 'community houses', like Ponsonby Care Centre and Pentlands.

Patients' prospects for a full discharge will often depend upon their success in avoiding readmission; or in forming a satisfactory relationship with hospital staff or a general practitioner.

This phase may include:

* Continuing contact between the patient and hospital staff
* Acceptance by the patient of 'maintenance medication'
* The patient residing where directed
* The demand for abstinence from alcohol or drugs
* The patient's recall to hospital by revocation of leave
* Arrest by the police if the patient does not return
* Readmission.

Its main actors are the patient, the patient's family, nurses, social workers, hospital medical staff, general practitioners, rest home and boarding house proprietors and the police. Its time frame is months or years. It is concluded

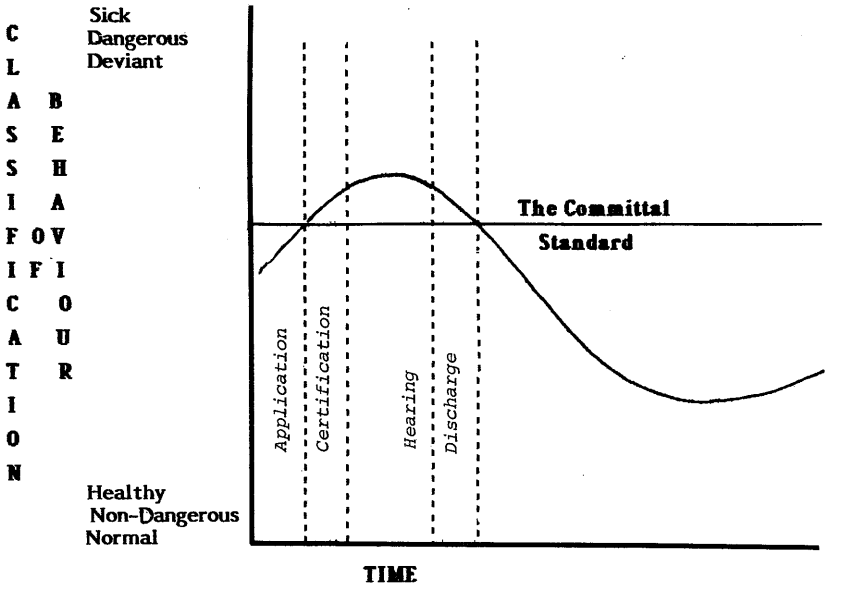
by readmission or by the patient's full discharge, often referred to as 'discharge off the Act'.

E. A MODEL OF THE COMMITTAL PROCESS.

I have constructed a model of the process by superimposing legal events upon a clinical psychologist's representation of an episode of 'mentally disordered' behaviour:

FIGURE III

The Committal Model



The model can be made dynamic by changing the positions of the variables, gaining an impression of the many decisions made.

Altering the time of the hearing, for example, may change the decision as to whether the patient <u>is</u> 'mentally disordered'. Altering the committal

standard may make patients 'committable' earlier, or not at all. Or we may redraw the curve of behaviour, to correspond with a range of 'histories'.

II. WHO GETS COMMITTED.

A. DEMOGRAPHIC AND DIAGNOSTIC DATA.

I have collected data on the demographic and diagnostic characteristics of patients who were committed in 1984. From the data a profile emerges of the committed patient population which will be familiar to those who have contact with our psychiatric services.

Compared with the general population and with all patients admitted to psychiatric care, patients committed under the Mental Health Act are significantly more likely to be **single, aged 20-39 years, male, of Maori or Pacific Island ethnic origins and be given a diagnosis of schizophrenia or affective disorder. Prior to admission, they are likely to be unemployed and living in a private residence with at least one other person. They have usually had a previous admission to a psychiatric hospital.** On many demographic criteria committed patients lie in an intermediate position between total psychiatric admissions and the New Zealand prison population.

Maori and Pacific Island people are substantially over-represented among committed patients, when compared to total admissions and to the population as a whole. The Maori percentage is more than double that expected from total population figures: the Pacific Island percentage is inflated by approximately one third. Maori patients are more likely to be committed through the district court and from prison and are greatly over-represented in secure units, as they are in prisons.

Males (56%) are more likely to be committed than females (44%), and are more likely to be committed through the district court.

Patients in the 20-29 and 30-39 year age groups are at high risk of committal. Low risk age groups are 15-19, 40-49 and 60 plus.

Patients committed are predominantly single (78%) and less than 20% are in paid employment in the month prior to admission.

Over 80% are usually resident prior to their admission in a privately owned or rented dwelling house, accompanied by at least one family member, or another person to whom they are not related.

Approximately one third of patients committed have not been previously admitted to a psychiatric hospital. Two thirds have been previously admitted, many more than once. Nearly 40% have 3 or more previous admissions, 9% 10 or more. Approximately 50% have been admitted under a legal order on a previous occasion, 25% 3 times or more.

There are significant differences in the diagnoses given committed patients compared with those given to the class of all patients admitted to psychiatric care. In particular, committed patients are more likely to be diagnosed as suffering from schizophrenia, affective psychoses, other psychoses and paranoid states. Those patients least likely to be committed are given diagnoses of neurotic depression and other depressive disorders, alcohol dependence and abuse, and stress and adjustment reactions.

Committed patients are thus less likely to be diagnosed as suffering from 'nonpsychotic psychiatric disorders'. Nevertheless, doubts may be expressed, simply on the basis of the diagnoses given, as to whether some patients committed are 'mentally disordered' within the definition in the Act. The 1% classified as having no psychiatric diagnosis are the most obvious case in point. Alcohol and drug dependence or abuse, other personality disorders and neurotic disorders are also dubious. Together these are the principal diagnoses of 15% of committed patients.

Many people, of course, do not fit the profile of the typical patient who is committed and there are many identifiable sub-populations within the class.

8% are aged 65 or over, of whom about one third have a diagnosis of senile dementia. About 20% of patients committed were said to be dangerous or seriously threatening to other people. About 15% were said to be actively dangerous to themselves. At least 12% had recent encounters with the criminal justice system.

Other identifiable sub-groups are: young patients whose committal is their first admission; patients given a diagnosis of schizophrenia who have had multiple admissions; patients given a diagnosis of affective (manic depressive) disorder who have had several short admissions; patients admitted for brief periods with 'drug-induced psychoses'; women regarded as 'victims'; long-term informal patients committed to 'legalise seclusion'; middle-aged and elderly people suffering 'severe depression'; and intellectually handicapped people whose behaviour could not be controlled elsewhere.

There is also an ill-defined group who receive diagnoses of 'substance abuse' or 'personality disorder', who live on society's margins and periodically pass through the mental health system.

B. THE EXTENT OF COMPULSION.

In 1984 there was a national total of 3081 admissions of committed patients under the Mental Health Act 1969. 21.4 per cent of the total 14381 admissions to psychiatric hospitals, psychiatric units of general hospitals and licensed institutions for the treatment of alcoholism and drug addiction. A further 662 admissions (4.6 per cent) were under the provisions of other legislation (e.g., Criminal Justice Act 1954, Alcoholism and Drug Addiction Act 1966). Thus, **a total of 26 per cent of all admissions to these institutions in 1984 involved some form of legal order.**

These figures reveal **a high degree of compulsion when compared with World Health Organisation figures for percentages of involuntary admissions in Europe** in 1982: Belgium, 7 per cent;

Denmark, 3.8 per cent; Ireland, 13.6 per cent; Italy, 14 per cent; Netherlands, 15 per cent; England, 12 per cent; Scotland, 10 per cent[1].

The proportion of compulsory admissions is far higher if we consider psychiatric hospitals only. During the twelve weeks of fieldwork at Carrington, Oakley, Kingseat and Tokanui in 1984, **45% of patients admitted to the four hospitals entered under some form of legal order**: 40% under the Mental Health Act 1969[2], 4% under the Criminal Justice Act 1954 and 1% under the Alcoholism and Drug Addiction Act 1966[3]. If we add the further group of patients who were admitted informally and committed later it is apparent that **at least half of all patients admitted to these psychiatric hospitals were detained under a legal power at some time during their admission**.

The percentage of patients entering under a legal order varied between hospitals: Carrington 47%; Oakley, 92%; Kingseat, 35%; Tokanui, 42%.

Considerable numbers of patients entering all hospitals under legal orders were committed patients readmitted from leave. At both **Carrington** and **Oakley** considerably more committed patients were readmitted from leave of longer than 2 weeks than were freshly committed under the Mental Health Act. There are no certification or judicial hearing requirements governing revocation of leave. Thus **only a minority of committed patients admitted to those hospitals are processed through the formal procedures established by the Act**.

Thirteen per cent of patients admitted under the Mental Health Act were brought before a court prior to admission.

III. HOW PEOPLE ARE COMMITTED.

A. SOCIAL CRISIS MANAGEMENT.

1. Applicants.

For every committal there is an applicant who completes the application to formally set it in motion. They may initiate committal or be sought out by another actor, such as a G.P. or the police, and asked to fill the form. Under section 19 the application (or request) is directed to the superintendent of a psychiatric hospital. Under sections 16 and 21 it is directed to the district court.

There are three main types of applicant:

* **Family members**, who have usually known the patient for many years (53%)
* **Members of the police** (14%) or **other social agencies**, who have usually never met the patient before.
* **Staff members of general or psychiatric hospitals** (26%), who apply for the committal of informal patients, whom they have usually known for a few hours or days.

In applications under sections 19 and 21 the nearest relative is required to apply unless there is some reason why not, which should be stated on the form. Many families resent having to make the application, fearing it will jeopardize future relations with the patient.

There is little space on the application form for reasons to be provided. Many contain a sentence or a few words only. Analysis of the subject-matter of application forms completed in support of 212 committals during 12 weeks of 1984 gives the following results:

TABLE I

Contents of Application Forms

	PERCENTAGE
Unusual behaviour	63
Patient's 'mental state'	54
History of 'mental disorder'	21
Dangerous to others	20
Specific diagnosis	17
Unwilling to accept treatment	17
Threatening to others	17
Poor relations with others	14
Dangerous to self	13

2. The Role and Concerns of Families.

The main role of families is to act as applicants, who make requests of professionals. When they reach the point at which 'things can't go on the way they are', and other options have failed, they approach a general practitioner, a hospital or the police and ask them to 'do something' about their 'sick' family member. Their first point of contact is usually a G.P.

It is clear many families endure great stress before this point is reached. It is usually the culmination of some weeks or months of disruptive events for which they have failed to find an alternative solution. Requesting the admission to a psychiatric hospital of one's family member is not pleasant and many families experience guilt and anxiety over it. When they do make the request, it often fails. This is frequently attributed to the reluctance of GPs 'to get involved' and to patients' ability to 'pull themselves together at the right moment'.

There is intense conflict within some families. 'Who should be committed, the patient or the family?', can be an open question. In some cases, more than one member is, or has been, a committed patient.

If 'the authorities' are prepared to act, events may proceed rapidly and beyond families' control or comprehension. They sign a strange form; then follows an information black-out. Their family member is swallowed by the mental health system and, at some uncontrollable moment in the future, which is usually 'too soon', they re-emerge. The family is expected to take them in and ensure their 'compliance with medication', with minimal contact or support from health professionals. If the patient is discharged 'on leave' they may achieve their readmission with less formality on another occasion.

In general, families have remarkably little knowledge of the committal process, the legal consequences of committal, or the treatment their relatives receive. **They are largely excluded from committal decision-making**. Often they have no idea what they have signed and no-one explains it to them. If they seek explanations they get a different one from everyone they ask.

Frequently families have sought without success to obtain the informal admission of their relative. This is declined 'until the patient deteriorates to the point they need to be committed'. This families find particularly frustrating as they believe earlier intervention could prevent committal, with its stigma and legal consequences.

Nevertheless, families often show little animosity towards mental health professionals whom they tend to view as victims of a neglected system. Certainly, **some families are satisfied** with their experiences and express admiration and gratitude to hospital staff.

Families accumulate knowledge through long experience. Others are persistent and use the telephone and eventually find their way. Educated, middle-class families fare better but can be most shocked at the conditions confronted. **Repeatedly, families complain about lack of consultation, lack of information and their sense of powerlessness in the face of immovable institutions.**

These problems are compounded for Maori and Pacific Island families, who also find psychiatric hospitals conceptualizing mental health problems with an approach, and in a language, different and alien to their own. To Pacific Island families committal is a mystery.

Although the isolated location of Kingseat and Tokanui is a problem for them, families were most dissatisfied with Carrington Hospital.

Other common family concerns are:

* Poor availability of doctors, especially on weekends
* Poor range of treatment options, particularly outside hospital
* The drastic legal consequences of committal
* The need to deal with the Public Trustee
* The need to commit the elderly
* GPs lack of expertise in psychiatric problems
* Lack of 'followup' and 'support'
* Involvement of the police
* Poor hospital conditions
* The 'doped up' condition of many patients.

3. The Role of the Police.

There is substantial police involvement in the committal process. **In more than half of all committals the police are involved immediately prior to the patient's admission.** The main police functions with regard to committed patients are:

* Arrest
* Detention at police stations
* Making applications for committal
* Ensuring certification by police surgeons
* Transporting patients to psychiatric hospitals
* Transferring patients from general to psychiatric hospitals
* Exercising their discretion not to prosecute patients who commit offences
* Rearresting patients absent without leave

* Rearresting patients whose leave has been revoked.

i. Arrest Law and Practice.

As with many powers of arrest, it is difficult to state with certainty what the law is or to specify precisely when the police are entitled to detain 'mentally disordered' people and take them to doctors and psychiatric hospitals. Actions against the police for false arrest are so rare there is little opportunity for the law to be clarified through judicial decision[4]. The section of the Police General Instructions Manual entitled 'Mental Defectives' provides only general information. Some variation between law and practice is undoubtedly explainable by the police's poor understanding of their powers. Some is also explainable by the dictates of administrative convenience.

The clearest power of arrest is conveyed by a warrant to arrest a 'mentally disordered' person, issued by a judge. Most patients committed through the district court are arrested in this way.

Further police powers are granted by **section 35** Mental Health Act. The police may apprehend any person 'found wandering at large' whom they have reasonable cause to believe:

> (a) is mentally disordered; and
> (b) is neglected or cruelly treated by any person having the care or charge of him, or is suicidal or dangerous, or acts in a manner offensive to public decency, or is not under proper oversight, care or control.

Following such an arrest the police should bring the patient before a judge, unless this:

> would expose the person concerned, or any other person, to **hardship or danger** or would deprive the person concerned of **medical treatment urgently required**[5].

Here the person may be taken directly to two doctors for certification (or one in an 'emergency') and then to the hospital. Many arrests occur under this provision in Auckland, with one certificate obtained.

Patients who informally enter psychiatric units of general hospitals and are then committed under section 19 are subject to de facto arrest at the general hospital, then transferred by ambulance, police car or hospital car to the nearest psychiatric hospital. This can be many hours drive: e.g., about 6 hours from Cook Hospital in Gisborne to Tokanui.

There is no power under the Mental Health Act to arrest a person without a warrant on private property. The police do not strictly adhere to this limitation. A Chief Inspector acknowledged this recently and said it was 'something which should be tidied up'[6].

The advantages of using the more correct section 21 procedure for obtaining a warrant are by no means clear. It places some check on police discretion, but patients may be detained for hours in cells, receive brief examinations by police surgeons under unfavourable conditions, and be fully committed on the basis of these certificates. They arrive at the hospital already under a reception order. Under the section 19 procedure the patient is transported directly to the hospital without judicial involvement in the arrest, but they may be discharged before the hearing, with no reception order made. At least there is a better opportunity for the patient to be assessed before a final decision is made.

The police may also exercise any power of arrest they possess under **other legislation**, for offences such as assault, disorderly conduct, obscene language or wilful damage. Section 41 Crimes Act also provides **a statutory protection** to any person:

> using such force as may be reasonably necessary in order to prevent the commission of suicide, or the commission of an offence which would be likely to cause immediate and serious injury to the person or property of any one.

Instead of prosecuting a person who has been lawfully arrested, the police may be authorised to institute committal, and frequently do so. A police application under section 21 may be suggested by a judge hearing a prosecution, or by the prosecutor or the defence. This occurs regularly when a psychiatric remand report favours this option.

Further powers to arrest people who have attempted **suicide** or who are elderly and unable to care for themselves are granted by sections 126 and 126A Health Act.

The police also take patients to psychiatric hospitals on an 'informal' basis. The voluntariness of the patients concerned, and the legality of this practice, is highly questionable. In one case studied a woman was brought in handcuffs from Waiheke Island and deposited at Carrington as an 'informal' patient. In another a woman, described as 'threatening and aggressive to the police', was brought 'informally' from North Auckland. Applications for their committal were then made by hospital staff. When such patients appear to urgently need treatment there is pressure on staff to accept their admission, regardless of legality.

When committed patients 'go AWOL' the police are requested to apprehend them. Carrington has a relationship with the Avondale police for this purpose. The police are frequently called on to arrest committed patients whose leave has been revoked. Both police and hospital staff prefer a nurse to be present but often they are not and considerable force may be used.

There is a widespread belief among both police and health professionals that the apprehension of 'mentally disordered' people would be better handled by 'specialists', such as trained crisis intervention teams, at least in the major centres.

ii. Police Concerns.

The most prevalent concern among the police is the time and resources it takes to process a committal application. This is energy not spent on what

they see as their main function - preventing and investigating crime. Committals through the district court are particularly time-consuming and avoided if possible. A constable said. 'We need an express committal.'

The police are conscious of their lack of expertise in dealing with 'mentally disordered' people, with the result that 'it gets a bit rough at times.' They would be happy to pass the work to another agency and avoid arresting people who 'aren't really criminals'. Younger officers rely heavily on sergeants and police surgeons.

Their other concerns are:

* Reliance on hearsay
* Lack of placements for homeless people
* Lack of time given to Mental Health Act applications by judges
* Reluctance of hospitals to accept informal admissions
* Lack of cooperation from hospital staff
* Lack of psychiatric information on the Wanganui computer
* Lack of feedback as to the outcome of committal applications
* Stress on patients' families.

iii. Concerns About the Police.

The attitudes of patients' families to the police are ambivalent and vary according to their experiences. Many families praise the police. They find them helpful and often the only body willing to 'take action'. But many are angry the police must be involved at all, to 'get help' for those who are 'sick not criminal'. Families are most angry who have seen patients arrested and detained in cells or police stations with force they regard as excessive. This is not uncommon. In one case studied 5 policemen in two cars arrived to arrest a 5 stone anorexic woman.

Hospital staff are most concerned about the way in which police deposit patients at the hospital. They frequently arrive in the middle of the night, without adequate warning. The police may not wait long to speak to staff, who may not be immediately available, so there is little information

provided about the circumstances surrounding the arrest and a poor basis for further action. This may be one reason why many patients taken to hospital by the police are quickly discharged. There is poor liaison between the police and hospitals in some areas, although in others relations have been built up over many years.

4. Certification.

Certification is **the medical powerhouse of committal**. No patient may be compulsorily admitted without completion of at least one medical certificate. Two certificates must be completed for the patient to be placed under a reception order. The medical power of certification controls the doors of compulsory admission, as the medical power of discharge controls exit. This reflects the dominant view that committal is 'a medical matter'.

Certification is a formal medico-legal process in which a registered medical practitioner certifies on a form that at a specific moment a person is **'mentally disordered and in need of detention as such'**. It is a mode of diagnosis for a specific purpose. The diagnosis is general, as the doctor certifies the person falls within one of three classes of 'mentally disordered' persons defined in the Act. It is also a social and legal decision, as the doctor decides the best available way of resolving the apparent social crisis is for the person to be detained in a psychiatric hospital under the provisions of the Mental Health Act.

Once the certificate is written a necessary condition of committal is met, but unless the doctor regularly attends the patient, they may never see or hear of them again.

i. Certification Law.

Present law governing certification dates from the Madhouse Act 1828 (U.K.)[7]. From reading the current Act as a whole one may deduce these principles:

* No person is to be compulsorily admitted without at least one (and preferably two) prior medical assessments which result in their formal certification
* Certificates are preferred from doctors who have prior knowledge of the patient
* The two certifying doctors should be independent of each other
* At least one certifying doctor should be independent of the hospital
* Initial committal on one medical certificate should occur in 'emergencies' only
* If the patient is to be placed under a reception order:
  - the certificates should be placed before the judge for scrutiny
  - the judge may regard certificates 'as evidence of' the facts in them
  - two positive certificates must be recently completed
* If the hearing is adjourned the patient should be recertified in the week before the hearing is resumed.

Formal compliance with these principles varies, and is greater in the central North Island than in Auckland. At Tokanui, for example, one certifying doctor knew the patient previously in at least 70% of cases; at Carrington, 41%. At Tokanui in about 80% of admissions under section 19 two medical certificates are completed. At Carrington the 'emergency' procedure, involving one medical certificate and completion of the 'Optional Addition', is used in nearly 50% of section 19 admissions. It is used routinely by some doctors and by police surgeons. Second certificates are written by a small pool of doctors called in by the hospital, who also recertify patients following an adjournment. There is no monitoring of the doctors' independence of each other. Kingseat appears to have difficulty obtaining certificates by outside doctors.

Of particular concern are the certification practices of police surgeons. Very rarely do they have any previous knowledge of the patient, or adequate background information. The situations in which they conduct examinations are usually inadequate, with 'patients' distressed by arrest and detained in the district court cells or police stations. There is frequent use of

the 'emergency' procedure. It is fair to add these matters concern police surgeons themselves.

ii. Contents of Certificates.

Analysis of the subject-matter of certificates written in support of 212 applications for committal during 12 weeks of 1984 gives the following results:

TABLE II

Contents of Medical Certificates.

	PERCENTAGE
Patient's 'mental state'	90
Unusual behaviour	88
Current treatment	63
History of mental disorder	61
Unwilling to accept treatment	56
Specific diagnosis	55
Denial of mental disorder	36
Poor relations with others	29
Threatening to others	29
Dangerous to Others	22
Non-psychiatric medical condition	20
Dangerous to self	17
Dangerous to property	15
Abuse of drink or drugs	15

iii. Patterns of Certification.

Certification practices vary in accordance with the committal process followed. There are four main patterns:

* Certification by general practitioners
* Certification by police surgeons
* Certification by the staff of general hospitals

* Certification at the request of psychiatric hospital staff.

Applications under section 19 involved certification by general practitioners (49%), police surgeons (14%) and the medical staff of psychiatric (16%) and general hospitals (19%). 20% were written by psychiatrists. The most common location of the examination was a hospital (36%), reflecting the number of applications which originate in the psychiatric units of general hospitals and the frequent use of the 'emergency' procedure, with the second certificate completed at the psychiatric hospital. Other common places of examination were the doctor's surgery (21%), the patient's home (19%) and police stations (12%).

Applications under section 16 at Carrington, Oakley and Tokanui involve certification by general practitioners called in to the hospital or part-time consultants. At Kingseat they are written by hospital medical staff from the wards on which patients are treated. All examinations are conducted at the psychiatric hospital.

Applications under section 21 are usually written by police surgeons (78%) or general practitioners (13%). Examinations are conducted at the district court (35%), a police station (30%) or a doctor's surgery (26%).

The great majority of examinations (87%) are reported to be of less than an hour in length. 50% take less than half an hour and 13% less than 15 minutes. Examinations at hospitals are reported to be somewhat longer than average, those at district courts or police stations somewhat shorter.

One certifying doctor had at least some prior professional knowledge of the patient in approximately half the cases. Prior knowledge is more frequent under section 19 and less frequent under sections 16 and 21.

A large number of doctors write very few certificates; a few write a large number, some 100 or more per year.

iv. Medical Concerns.

A wide range of medical concerns have been conveyed to me regarding the certification process, both by those who write certificates and by hospital staff who receive and act on them.

a. Concerns of Doctors Who Write Certificates.

The overriding concern of doctors who write certificates is the poor circumstances in which they are written and the inadequacy of the information upon which they are based. The primary factors are said to be: lack of time; lack of contact with patients' families; reliance on hearsay; frequent examinations of patients detained in cells or seclusion; and the necessity to write certificates on patients never seen before.

A further major concern is the difficulty of obtaining a second doctor willing to be involved; and the difficult position of the second doctor called in to examine a patient whom they have never seen but who has already been certified by their usual doctor at the request of the family.

Other concerns are:

* Inability of general hospitals to take committed patients
* Lack of crisis intervention services
* Reluctance of hospitals to accept informal admissions
* Lack of community treatment options
* Patients' lack of access to independent review
* The finality of the section 21 procedure, under which patients may be committed without adequate assessment
* Lack of feedback from the hospital so they do not know the outcome and cannot monitor their performance
* Confusion between different forms
* Inadequacies in the forms, particularly the lack of space and absence of a place to certify a patient is <u>not</u> mentally disordered
* Inadequate fees.

b. Concerns of Hospital Staff.

The overriding concern of hospital staff is the inadequacy of the information contained in the certificates, about which many unfavourable comments are made. Several senior doctors said the quality of certificates had declined in recent years. Perhaps the most damning comment is that large numbers of certificates are simply unreadable due to appalling handwriting. Many of the forms' spaces are left uncompleted.

In the view of staff, too many certificates are written in vague and ambiguous terms, such as 'thought disordered', 'grandiose', 'labile mood', or 'hallucinating'[8]. Overwhelmingly, **staff wish to see more factual descriptions of actual conduct, in language accessible to the lay person**. They want to know who did what to whom in what circumstances.

The poor quality of certificates was often attributed to the complete absence of training in how to complete them in medical education; and to the general disdain of doctors for legal procedure.

Other concerns are:

* Routine use of the 'emergency' procedure
* Lack of involvement of family doctors
* Inadequate physical examination of patients
* Involvement of doctors attached to hospitals in writing certificates
* Inadequate scrutiny of certificates by judges
* 'Copying' from one form to another, with repetition of hearsay
* Particularly poor certificates written by certain doctors.

The inadequacies of the certification process and the poor quality of information in certificates is of particular relevance because of their crucial role in authorising patients' detention. Under section 19 two completed certificates and an application form alone authorise the patient's compulsory admission and treatment without consent for 3 or 4 weeks.

Members of the judiciary acknowledge they rely heavily on certificates, especially when they are recently completed. One judge referred to Mental

Health Act applications as 'done on the papers'. This is confirmed by the brevity of hearings and the absence of other witnesses.

B. IN-PATIENT MANAGEMENT.

The in-patient episode of the committed patient's career is dominated by the environment and culture of the psychiatric institution. Its key features are confinement to the hospital, medication and seclusion. New Zealand's psychiatric hospitals have recently been the subject of a series of reports compiled by researchers from the Health Department[9]. For descriptions of hospital staffing, services, buildings and culture, reference should be made to these sources, which are based on data collected in 1984, the same year I conducted my field work. For a patient's view from an earlier period we may read the powerful writing of Janet Frame.[10]

1. Admission and Assessment.

Upon admission, the committed patient is placed in night clothes in a hospital ward to be observed and assessed. Initial medication is usually prescribed and many patients are placed for a time in seclusion or 'a single room'. This is usually the first point at which the patient encounters professional psychiatric staff. Key actors are psychiatric nurses and aids, who have the closest contact with patients on a day-to-day basis, and doctors. Most patients seldom see a psychiatrist as so few are employed at public psychiatric hospitals. The key decision-making unit is 'the clinical team', headed by a doctor. Many committal-related 'management decisions' are made at its weekly meetings.

Many patients are known to staff. A few others, particularly the elderly, are assessed in the home, prior to admission.

No specific written information is provided to patients about committal or its consequences. The extent to which they are informed verbally varies between wards and patients. Staff express many doubts about the ability of committed patients to take in information.

The decisions of particular relevance to committal which are made in the early stages of an admission are determinations to:

* accept the committed patient's admission
* accept the validity of 'the papers'
* complete a second medical certificate
* 'place the patient before the judge'
* seek a reception order or an adjournment
* change the patient's status to 'informal'
* discharge the patient, outright or 'on leave'.

Views as to who has most power in these decisions depends upon the profession of the person spoken to. Doctors tend to describe them as 'team decisions', strongly influenced by the demands of 'nursing management'. Other professions emphasize the role of the 'consultant' or 'team leader'. Undoubtedly the extent to which these decisions are made by 'the team' varies widely, but in cases of conflict the senior doctor prevails. Their dominant role is written into the law by section 4 Mental Health Act. Perhaps the most accurate description is provided by a doctor who said these are 'consultant decisions based on team information'.

2. Committal of Informal Patients.

Approximately one thired of the people committed during the study period were informal patients. 25% had been informally admitted to psychiatric hospitals, with an application then made under section 16. Another group were informal patients in the psychiatric units of general hospitals. They were committed under section 19 and transferred.

Forty three per cent of all committals to Carrington involved an application under section 16, many made within a few hours or days of the patient's informal admission. Many patients are transferred upon committal to Tokanui from the surrounding network of general hospital units.

The overriding reason for such committals is 'to give the hospital more control' and so facilitate patients' 'management'. Informal patients who are refusing medication, being regularly placed in seclusion, 'going AWOL', demanding to leave, or who are 'aggressive', are likely to be committed in this way, or discharged. Other reasons invoked are the need to commit a patient to employ a specific mode of treatment, such as E.C.T., to transfer patients to closed wards or units, and to prevent suicide. This is 'crisis management' within the hospital.

Patients' families may be involved in the decision if they are readily available; but this is a largely 'in-hospital' process, with decisions often made quickly or during the night. Doctors who certify these patients seldom have much previous knowledge of them.

That this mode of committal is used more at Carrington than other hospitals does not mean patients are treated much differently there. It means different policies are followed with respect to informal patients, particularly with regard to enforcing medication and seclusion without consent. Since the Oakley Inquiry Carrington nursing staff are more reluctant to coerce informal patients, with the result that more may be committed. It is clear that informal patients are regularly secluded at other hospitals. Carrington is also in the middle of the city and informal patients can easily walk out. At rural hospitals this is far more difficult.

At some hospitals an alternative policy is followed of requesting families of 'difficult' patients to take them out of hospital to have them certified by GPs under section 19.

i. Committal and Seclusion.

The linkage between committal and seclusion is particularly controversial. Many patients complain about their seclusion at committal hearings. A number of these were held in seclusion rooms. Its extensive use has been criticized by the Oakley Inquiry[11] and the Health Department[12], whose Review notes its frequent use in acute admission wards at Carrington. Many

staff agree its use is undesirable and would often be unnecessary if adequate nurses were available to provide individual attention.

One staff view is that a committal application should always be made when an informal patient is secluded without consent. This 'legalises' the practice and requires a court to be informed, and may protect the hospital from claims of abuse 'if something goes wrong'. If long-term committal is not required an adjournment may be requested or the patient discharged. At Carrington a number of long-term informal patients have recently been committed for this reason.

An alternative view is that committing patients in these circumstances is 'legal overkill'. Many informal patients need to be secluded only occasionally. To commit them to 'legalise' this, with all its consequences, is of no overall assistance to patients, but simply protects the hospital. Doctors should be entitled to exercise emergency treatment powers, as they do in accident and emergency departments, without the need to activate cumbersome committal procedures. Patients committed to authorise seclusion may be later discharged, but often they are not.

The proposal usually made for the resolution of this conflict is for hospital staff to be granted a 'short-term holding power', perhaps on the basis of one medical certificate, to restrain an informal patient for a short time, which can lapse 'when the crisis is over'.

ii. Treatment Without Consent Before the Hearing.

At some hospitals 'informal' patients are medicated without consent from the moment the application is made by a junior medical officer for their committal under section 16. 'Emergency medication' is commenced, even before the patient is certified and before a reception order is made. It is often a week before a judge comes to the hospital to determine the application. There is no statutory authority for this.

An application under section 16 authorises hospital staff 'to **detain** the person until the application is finally determined'. No power to treat without

consent is granted. The power to treat committed patients without consent comes from the reception order, or specific powers granted by sections 19(6) and 23(8). None of these apply to informal patients. Any power to treat without consent in these circumstances must be derived from doctors' common law powers to treat in 'emergencies'. The extent of these powers in the psychiatric area is unclear, but they only cover treatment required to alleviate the immediate 'emergency'.

Similarly, there is no statutory authority to treat a patient without consent following the adjournment of an application under section 16 or 21, unless this is specifically granted by the judge under section 23(8). Many judges make no reference to treatment in adjournment orders but the power to treat is assumed by hospitals.

3. Discharge.

The judgement to discharge a committed patient from hospital is said to be a 'team' decision. Often it is preceded by a 'change of status' to informal, but many patients are also discharged 'on leave'. The patient may go on 'weekend leave' or 'day leave' several times beforehand. Besides 'the patient's condition', key factors influencing discharge from hospital are the pressure on beds and the location of an alternative 'placement'.

The 'discharge off the Act' of patients on leave is largely controlled by 'the responsible doctor' and visiting staff, in particular psychiatric district nurses. Patients' families and GPs may also be consulted. The extent to which patients are 'actively discharged' from leave varies between hospitals and clinicians. In many cases the key factor is simply the passage of time. Hospitals may discharge patients on leave for a year initially, then another year. If patients survive without readmission they are likely to be discharged when the period of leave expires, although they may not be informed or aware of it.[13]

Many committed patients are soon discharged from hospital. Of those studied in 1984, 7% were discharged within a week of the application, 43% within a month and 71% within 2 months. 40% of patients admitted under section 19

were discharged or changed to informal status before the judicial hearing. Patients committed under section 19 were discharged somewhat earlier than average, those under section 16 somewhat later than average. There are also significant variations between hospitals, with stays at Tokanui and Oakley longer than those at Carrington and Kingseat.

91% of committed patients were discharged from hospital within 6 months of the application, although some were soon readmitted. 48% were fully discharged 'off the Act' at the time of leaving hospital; 43% were initially discharged on leave.

IV. THE JUDICIAL HEARING.

Fundamental to our legal system is the idea of ***habeas corpus*** - that detained people have the right to be brought before a court to have the legality of their detention determined by fair procedure. Examination of judicial hearings under the Mental Health Act is of particular interest from a legal point of view, as it reveals the extent to which this principle is a practical reality for detained psychiatric patients in New Zealand. For this reason the conduct of these hearings is discussed here at greater length.

The judicial hearing is a formal interaction between primary actors in the committal process. The judge, medical staff, the patient, and sometimes the patient's family are brought together to formally decide if the patient should be placed under a reception order, authorising detention and treatment for an indefinite period.

A. The Form of Hearings.

During 1984, with research assistants, I observed and recorded several hundred judicial hearings at 4 psychiatric hospitals and 2 district courts in the upper North Island.

Hearings are held at varying times after the launching of an application for a person's committal. They are invariably held **in private**. About 20% occur

at district courts, 80% at psychiatric hospitals. They are presided over by a district court judge or two justices of the peace. Justices frequently preside at rural hospitals and outlying courts.

District court and hospital hearings have much in common, but are different in form.

The **standard hospital hearing** involves:

* Reading of the documents
* Evidence presented by a doctor involved in the patient's treatment
* An interview with the patient and any family or friends who attend
* The decision.

Usual district court hearings are held in two parts. The first part involves:

* Reading of the application form
* An interview with the applicant
* The issue of a warrant to arrest the patient.

There is a break while the patient is located, arrested and taken to two doctors for certification. The hearing is then resumed. The second part involves:

* Reading of the medical certificates
* An interview with the patient.
* The decision.

There is no oral evidence given by a doctor but the medical certificates are freshly completed. The committed patient is led away by the police and transported to the nearest psychiatric hospital.

The hearings are highly informal. This is true of hospital hearings, in particular, which are dominated by the environment in which they are

held. Often judges sit opposite patients and doctors in cramped side rooms of hospital wards. There is a complete absence of courtroom trappings no desk, robes, registrar or stenographer. Witnesses are not sworn nor subject to rigorous questioning. Patients are presented in the order in which they are located. Doctors are seen 'on the fly'. There is sometimes so little space participants have to stand.

Hearings at the district court are usually held on the same day or the day following the application. Section 19 hearings are usually held 2 or 3 weeks after the patient's admission. Section 16 hearings are held within a few days. At Carrington they are held each Friday. Some patients who have entered hospital on an informal basis are detained, secluded and medicated without consent for up to a week without access to a court.

Usually the only participants at court hearings are the judge, the patient and sometimes the applicant. At hospitals the usual participants are the judge, the patient and a hospital doctor. For many years at Carrington judges seldom spoke to hospital doctors in person, but accepted instead a signed, standard form stating the patient was 'committable' on the day of the hearing.

Social workers were present at 4% of hearings, psychologists at 3%. Family members attended 20%, and then only at Carrington following changes made by the judiciary immediately before the study began. They very rarely attend at other hospitals. Their attendance at Carrington has again become rare since the study ceased.

Although at the hearings I observed nearly 30% of the patients committed were Maori or Pacific Islanders, other people from these ethnic groups were virtually never present and are very rarely in positions of influence in the mental health system. No interpreters were present although some patients did not speak English. They were exhibited and led away.

Hearings last an average of 20 minutes. At hospital hearings, about 5 minutes is spent by the doctor describing the patient's condition in their

absence. About 10 minutes is spent interviewing the patient. In the remaining time the documents are read and the decision made.

One of three decisions is reached. The patient is committed under a reception order; the hearing is adjourned to a later date, with detention (and sometimes treatment) authorised in the interim; or, if the medical certificates or the doctor giving evidence do not support committal, the patient is discharged. At **no hearing observed was the patient discharged by a judge or justices contrary to medical advice.**

B. Compliance with the Rules of Natural Justice.

Although personal liberty may be at stake, procedures followed at judicial hearings under the Mental Health Act bear little relationship to the rules of natural justice, which govern what is a fair hearing.

Many patients receive no notice of the impending hearing or are informed immediately before it begins. Justices give euphemistic and misleading accounts to patients of the hearing's function so that some patients do not realise it is a hearing at all. The word 'committal', for example, is never used by justices.

Two per cent of patients are legally represented. At some hospitals patients are never represented. There is no transcript taken and there is no appeal.

Patients are usually excluded from the hearing during the doctor's statement and they are not shown the application form nor the medical certificates. Thus **most patients are excluded from the entire evidence presented in favour of committal** and have no opportunity to challenge or comment on it.

Much of the evidence given is **hearsay**, often double or triple hearsay, repeated, for example, from family to nurse to doctor to judge. With rare exceptions, **no witnesses appear on patients' behalf**. Family members who attend usually favour committal.

Large parts of patient interviews do not involve questioning of patients but consist of direct judicial statements to patients of the good will of hospital staff and the need to take medication as directed.

Sometimes the judicial officers and the doctor agree on the disposition before the patient is seen. Hearing procedure is dominated by what one might call 'procedural bias' - the procedure is tailored to the assumption that patients are 'mentally disordered', although this is an issue the judge is to determine. There is a widespread assumption that 'more formal' hearings would somehow be damaging to patients, although why or how this might be so is seldom articulated.

Everywhere hearings are held in private. Many patients families do not know they are on and they are often an unknown quantity to non-medical staff who have worked in psychiatric hospitals for years.

C. Scrutiny of Evidence.

The committal process is characterised by deference to medical opinion. At hearings the evidence presented is overwhelmingly 'medical' in orientation - diagnosis, 'mental state', history of admissions, treatment regime, the patient's response and attitude to treatment. There are also descriptions given of patients' conduct which are viewed as 'disordered' or 'dangerous'. Social issues such as cultural context, housing, financial or benefit status, available social supports, employment - these matters are rarely discussed, although it is clear that social factors are often crucial in precipitating compulsory admission.

Medical certificates that are formally correct are never rejected, regardless of content. The judiciary have a higher opinion of their value than hospital staff, who believe they are often inadequate. The superintendent of one hospital has complained about their quality to the judiciary. The doctors who complete them are not called to hearings. Medical students receive no training in how to write them.

The oral evidence of the hospital doctor is usually a brief monologue, given by a medical officer, registrar or house surgeon. It is rarely questioned or probed by the judge. Few justices have the forensic skills to expose medical evidence to scrutiny.

In no case observed was a patient discharged at a hearing contrary to medical advice. **In practice, medical witnesses are the primary decision-maker.**

Judicial officers sometimes appear confused. This is partly caused by the language used, which is the language of psychiatry, and by their limited knowledge of the Mental Health Act. It is also caused by uncertainty as to the appropriate judicial role in the face of a collapse of the adversary process.

At hospital hearings, for example, only the hospital is represented, by the doctor who gives evidence, presents argument for committal and sometimes questions the patient to elicit 'disordered' thinking. There is no adversary, except the patient, who is excluded from the evidence. This could only be redressed by representation of patients, or by the judiciary adopting an inquisitorial stance, cross-examining the hospital's evidence and calling for other information and witnesses as required. This is rarely attempted. As a result, proceedings are neither adversarial nor inquisitorial and are hopelessly lopsided in favour of the hospital.

In practice, many judicial officers ensure the correct documents have been completed and formalities adhered to but do not contest the substantive decision. This is seen as a 'medical matter' and a 'hands-off' position is adopted.

There are two areas in which an independent exercise of judicial discretion is apparent. The first is in the issuing of a warrant for a patient's arrest on the application of a family member. This is of limited practical impact, however, as so few committed patients are arrested on a warrant, in comparison with numbers admitted.

The second area is the decision to adjourn a hearing. If there is one judicial maxim consistently followed at hearings, it is, 'If in doubt, adjourn'. This is seen as a compromise solution. It permits delay of the final decision. The patient's detention and treatment continue during the adjournment, and frequently the patient is discharged in the interim without a reception order being made. There is no involvement of the Public Trustee and the patient is discharged outright, not on leave. This option of adjournment without reception order has been used more frequently in recent years. It was the outcome of approximately 20% of hearings observed in 1984.

D. Total Evidence.

An analysis of the subject-matter of the total evidence presented in 89 cases in 1984 in which a reception order was made is presented in Table III. The evidence analysed is the application form, the medical certificates, any other written material, and the oral evidence presented at all parts of the hearing.

TABLE III

Contents of All Evidence Presented When Reception Order Made.

	PERCENTAGE
Unusual behaviour	98
Patient's 'mental state'	97
Specific diagnosis	87
Unwilling to accept treatment	84
History of 'mental disorder'	81
Current treatment	76
Poor relations with others	55
Denial of 'mental disorder'	52
Patient's 'response to treatment'	48
Threatening to Others	47
Patient accepts treatment	30
Abuse of drink or drugs	28
Dangerous to Others	28
Non-psychiatric medical condition	27
Threatening to self by neglect	24
Dangerous to self	19
Dangerous to property	19

E. Judicial Concerns[14].

The primary concern of Auckland judges is the physical environment in which hearings are held; e.g., in siderooms of wards at Carrington Hospital. They believe adequate judicial hearings are impossible in these circumstances. They wish to conduct them in one central room and with more formality, although the extent of formality favoured varies.

A further concern is the complexity and poor drafting of the Mental Health Act. They wish the law to be 'simplified and clarified', particularly as it is largely addressed to non-legal actors. At present they cannot ensure compliance with procedural details. They are disturbed by the quality of evidence presented - the reliance on hearsay and documents; the absence of

oral evidence by certifying doctors, family and senior hospital staff; and their own lack of skill in interviewing patients and assessing psychiatric opinions. They have mixed views on the value of legal representation for patients, but many favour a patients' advocate or duty solicitor and want a statutory power to appoint a lawyer 'in some cases'. Many favour judicial specialisation in mental health work by judges of the Family Court. They oppose the continued involvement of justices.

Other judicial concerns are:

* the desire for one medical certificate to be completed by a psychiatrist
* the vague committal standard
* the need for 'clarification' of the legal basis of compulsory community treatment
* certifying doctors' lack of knowledge of patients
* the poor circumstances in which medical examinations are conducted
* the automatic link between committal and loss of property rights
* patients' lack of access to independent review
* indefinite duration of committed patient status
* the ease with which committed patients are granted leave.

Justices have fewer concerns. In general, they find hearings adequate as they are. A number from the Te Awamutu area have conducted them at Tokanui for 10 to 20 years. They do not favour more formality. They believe this would be 'a traumatic ordeal' for patients and would 'prevent them talking'. Nor do they favour legal representation, as lawyers would 'complicate things' and pressure them to discharge patients.

Many do not view committal as 'a legal matter'. They decide 'on medical grounds' and rely on the opinion of the hospital doctor. If they disagree with that view they 'might adjourn the decision' but would not discharge the patient.

They see an important part of their function as 'giving the patient confidence in the hospital' and 'providing an outside ear to talk to'. Large parts of their interviews with patients are direct statements about the

expertise of staff and the need to accept their judgements, especially on medication. Many justices have limited knowledge of the legal consequences of a reception order and are unclear about their powers. Some have studied the Mental Health Act but, like many others, find it difficult to understand. They favour continued involvement of justices, as they contribute a 'common sense lay view' and are 'not expensive'.

Their main concerns are:

* illegible medical certificates
* use of psychiatric jargon by doctors
* lack of feedback on the outcome
* lack family input 'in some cases'
* their lack of training.

F. Application of the Committal Standard: Medication 'Legalised'.
The committal standard laid down in section 24 Mental Health Act is very rarely mentioned at hearings and is not strictly applied. Before making a reception order, the Act requires the judge to be satisfied:

> that the person **is mentally disordered and requires detention in a hospital** either for his own good or in the public interest.

This involves a judgment based on the narrow range of evidence presented and selection of **the appropriate time frame**.

Doctors tend to focus on the future, aiming to improve the patient's **prognosis**. Lawyers may focus on **behaviour in the past** which indicates a need for detention. Patients and their families are concerned about **when** they are committed, and **how long** they must stay committed and continue medication. Views may conflict when a decision is made as to **who is 'committable'**. Choices made reveal the dominant view.

One may inquire, for example, whether there is an insistence on direct evidence of recent past acts to demonstrate 'disorder' and 'need for

detention'? Are patients immediately discharged from committal who cease to demonstrate 'disordered' behaviour? Or are opinions about the patient's future readily accepted as the basis of decisions, with patients maintained on committal, even outside hospital, for long periods?

Answers to these questions are complicated by the apparently episodic nature of many forms of mental disorder; and by the need to decide upon a person's committal at a specific instant, whereas committal, once begun, is of indefinite duration.

These problems are not resolved by the Mental Health Act. Both committal and discharge standards appear to be expressed there in the present tense. A person may be committed who 'is mentally disordered and requires detention'. Any patient shall be discharged who 'is fit to be discharged', which is any patient whose 'detention as a mentally disordered person is no longer necessary either for his own good or in the public interest'.

But, in section 2, a 'mentally disordered person' is defined as a person who suffers from 'a psychiatric or other disorder, whether continuous or episodic, that substantially impairs mental health'. Thus **the legislation both demands an instantaneous decision and acknowledges that 'mental disorders' may endure through time.**

The law does not resolve the question: **is a person 'committable' whose 'mental disorder' is not immediately apparent today**? May they be committed on their history to prevent relapse in the future? This question receives many answers, depending upon the particular view of the decision-maker.

One judge, for example, said, 'I must be satisfied he needs to be detained today. I can't make an order just so you can bring him back in the future.' But the doctor requested committal 'to ensure compliance with medication', with the aim of preventing relapse and ensuring rapid readmission. The patient's mental disorder might not be apparent today but it had been in the

recent past and would be again without medication. To which the patient might add, 'It already seems like I've been here forever.'

Because decisions at hearings are based on medical evidence, to which the judiciary defer, **the longitudinal and predictive view of 'mental disorder' consistently wins out.** This reaches its logical conclusion when patient and 'illness' are identified, as often occurs at hearings when a patient is described as 'a chronic schizophrenic' or 'a manic depressive', which they will be until death. They may be required to 'comply with medication' permanently, which is enforced by maintaining them as a committed patient on leave.

In practice, the key to committal is **diagnosis**, through which behaviour is constituted as 'mental disorder', liable to control by the Mental Health Act. **'Mental disorder' becomes 'a fact' to which the law is applied**, and diagnosis a shorthand in which doctors communicate to judges that patients are 'committable'. The **'doubtful cases'** are those in which no clear diagnosis is expressed; those in which the medical evidence is ambivalent as to whether the patient suffers from a 'mental disorder' within the scope of the Act; and those in which the patient's disorder is said to be no longer apparent at the moment of the hearing.

The diagnoses of **substance abuse and personality disorder** create most uncertainty. There is little consensus among mental health professionals as to whether patients given these diagnoses are covered by the Act. Some think they are but should not be; others that they are not but should be. Some favour a 'treatability' standard; others think treatment is a waste of resources. If there is a majority view, it is that persons with these diagnoses are not 'strictly' covered but do, on occasions, need to be detained. Certainly, they are.

Very few doctors or judges refer to the definition of a 'mentally disordered' person contained in the Mental Health Act.

Patients' **'need for detention'** is also justified in most cases by reference to their requiring treatment or psychiatric assessment, which they will not accept unless compelled to do so. The form of treatment proposed is usually medication, often to be administered by injection. This is summarised as the need **'to ensure compliance.'**

Less frequently, the threat the patient poses to their safety or that of other people is specifically advanced as the reason for committal. Other patients are charged with offences and these may be dropped if they are placed under the alternative control of a reception order. A few committals observed were of informal patients of many years standing, with the order now sought to 'legalise' their regular seclusion.

Rarely is it proposed to hold the patient in 'detention' for an extended period, although a few patients are detained for long periods, some in secure conditions. It is usually suggested that in-patient treatment should continue for some weeks or months. The committed patient will then be discharged on leave on continuing medication. If the patient 'relapses' or 'goes off again' they can be immediately returned to the hospital. **Often the judge is specifically told the patient will be discharged from hospital on the day of the hearing or within a few days.**

Thus **at many hearings the issue is not the patient's admission or detention but their status on discharge**. This is particularly true of Carrington where admissions are often short and committed patients are frequently maintained on leave for long periods. In recent years there have been more than 1000 committed patients on leave from Carrington and Oakley at any one time, far more than are detained in hospital.

As one judge told me at a hearing: 'Committal does not mean **detention in** a hospital. It means **control by** the hospital.' Judge Finnigan has written[15]:

> Detention is something different from the detention normally contemplated by Judges....[B]riefly it means that the person is made

subject to the will of other persons in respect of where he lives and how he lives and about whether and, if so, by what means his condition will be treated.

Unfortunately, **this approach may conflict with the specific wording of the Mental Health Act**. Section 24(1) states with complete clarity that, to be lawfully placed under a reception order, the person must be in need of detention in a hospital. The location of detention is specified. The broader approach is widely adopted by the judiciary, however, despite the established legal principle that when personal liberty is at stake, legislative standards should be strictly applied.

Thus **two issues for the new Mental Health Act** are: first, whether this functional alteration of the statutory standard to permit compulsory community treatment should be prevented, or whether it should be legitimised in legislation through a Community Treatment Order; and second, whether medical diagnosis, prognosis and prediction of 'compliance with medication' are to continue to be the basis of most long-term committal decisions, or whether there will be a more rigorous insistence on direct evidence of dangerous acts or personal neglect, and on the provision of other evidence which places the decision within its social and cultural context.

V. OUTCOME.

Most patients committed to psychiatric hospitals are detained for a few weeks or months and are then discharged. I followed the careers of the patients subject to 212 applications for committal in 1984. The following Table IV lists the length of time between the applications and the date on which they were first discharged from hospital, either outright or on long leave. Brief holiday discharges are excluded.

TABLE IV

Time Between Application and Discharge From Hospital.

TIME	PERCENTAGE	CUMULATIVE PERCENTAGE
Within 1 week	7	7
Within 1 month	36	43
Within 2 months	28	71
Within 3 months	11	82
Within 6 months	9	91
Not discharged within 6 months	9	100%

I also determined the legal outcome 6 months from the date of the application. The results are listed in Table V:

TABLE V

Legal Outcome at 6 Months.

	PERCENTAGE
Fully Discharged	49
Committed, On Leave	35
In-Patient, Committed	11
In-Patient, Informal	2
In-Patient, Special	0.5
Dead	2

In approximately half the applications the patient remained under some form of continuing legal control six months later. The majority of these patients were discharged from hospital as committed patients on leave, required to accept medication and subject to instant recall.

A small but significant percentage continued to be detained in psychiatric hospitals, usually as committed patients. Several were detained in Oakley, one in maximum security at Lake Alice, where he remains 2 years later.

VI. Monoculturalism.

The models for our legal and psychiatric institutions were imported from Victorian England and colonial Australia. Their roots are in the Vagrancy Acts and poorhouses of the 18th century. The Mental Health Act 1969 incorporates a legal structure established by the New Zealand Lunatics Act 1868. Carrington Hospital was built in 1865. It has recently been declared an 'historic place' by the Historic Places Trust while fully occupied. There is little evidence of cultural diversity within these institutions.

With rare and isolated examples, there is no Maori or Pacific Island representation among members of the professions who have power to influence committal practices. Even where tentative moves have begun to involve members of these ethnic groups in the assessment and 'treatment' of psychiatric patients, this has yet to make an impact on the legal process.

The languages of law and psychiatry; the dominance of the scientific, 'medical' conception of 'mental illness', with its reliance on psychiatric diagnosis and medication; the premise that we can distinguish a group of 'mentally disordered' people to be detained in large and isolated hospitals; the importance of written evidence; the formidable 'professionalism' and privacy of its decision-making processes; the poverty of social and cultural analysis - **committal's institutional forms are distinctively 'western', 'European', Pakeha.**

This is illustrated most clearly by the impotence of the family in committal decision-making; and by the certification and committal at 'judicial hearings' of patients who do not speak English, when no interpreter is present. This was not mentioned as a concern by professionals interviewed about the hearing process. Our legal

system permits citizens to be deprived of fundamental liberties without the possibility of their understanding a word that is spoken.

VI. Conclusion.

This paper has sought to describe the way in which decisions are made to detain 'mentally disordered' people in New Zealand psychiatric hospitals under the Mental Health Act 1969. Its focus is on professional decision-making, with the viewpoint of patients unexplored. Its findings will be no surprise to those who have substantial contact with our compulsory psychiatric services; nor to those who have carried out similar studies in other countries, with similar results[16].

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

This paper has examined a decision-making process whose structure is established by legislation. A **premise of current law is that the liberty of individuals may be protected by establishing a balance of power between professionals.** Here I have not contested this premise, but have examined the extent to which it operates in practice. In particular, I have examined, as a symbol, a forum of professional interaction - the committal hearing.

I have sought to discover whether one profession is scrutinised by the other; or whether there is **deference** of one profession to the other when

important decisions are made. There must be a point at which deference becomes so marked that one profession does not check, but reinforces the other's decisions - when law 'legalises' decisions made by doctors, or doctors 'medicalise' the decisions of lawyers: one legitimating the other. If the courtroom is not a place of disclosure for the scrutiny of reasons and evidence, what function has it?

Judge Finnigan writes[17]:

> The judge is required by the Act to conduct an independent hearing and make an independent decision. If he merely approves decisions already made by others, he is not exercising any power given to him by the Act.

By examining the degree of deference I have sought to discover the **location of power** in the committal process. From this perspective, the most important finding is that at several hundred judicial hearings observed not a single patient was discharged contrary to medical advice. The 'medical' view dominates the process I have studied. The law channels and sustains it, by 'making it legal'.

ACKNOWLEDGEMENTS: I wish to thank Lesley De Mello, Max Abbott, Michael Stace, Warren Young, the Mental Health Foundation, the Institute of Criminology, the National Health Statistics Centre, the Auckland and Waikato Hospital Boards, and all the many people who have contributed to this study. For financial assistance, my thanks to the Mental Health Foundation, the Medical Research Council and the Legal Research Foundation.

NOTES

[1] World Health Organisation, Public Health in Europe , No.25.

[2] Excluding readmissions of informal patients on leave for less than two months; including committed patients who were admitted from leave of longer than two weeks.

[3] A survey at Tokanui in 1979 gave similar results: Fama, 'Legislation and Practice in Compulsory Admission to a Psychiatric Hospital', (1983) NZ Medical Journal 130.

[4] This problem is exacerbated by s.124 Mental Health Act, which erects a substantial barrier to patients' legal actions; see, e.g., Hastwell v Police , M. 49/83, Unreported, High Court, Nelson, Ongley J., 20 November 1984; also Towards Mental Health Law Reform, Report of the Task Force on Revision of Mental Health Legislation, Mental Health Foundation, Auckland, 1983, at 255.

[5] S. 35(2). This power was added by the Mental Health Amendment Act 1972.

[6] See the comments of Chief Inspector Shields, reported in 'Clarifying rights of the mentally ill', NZ Herald, June 21, 1986; and Hastwell supra n.4.

[7] 7 Geo. IV, C.41. See Brunton, 'Mental Health Law in New Zealand: Some Sources and Traditions', in Dawson and Abbott eds, The Future of Mental Health Services in New Zealand: Mental Health Law, Mental Health Foundation, 1985, at 49.

[8] Page and Firth reveal an identical situation in Canada, see 'Civil Commitment Practices in 1977', 24 Can. J. Psychiatry 329 (1979).

[9] See Review of Psychiatric Hospitals and Hospitals for the Intellectually Handicapped, Department of Health, Wellington,1986; Dowland and McKinlay, Curing, Caring and Controlling, Department of Health, Special

Report Series 75, Wellington,1985; also Park, Social Relationships in a Psychiatric Hospital, Department of Health, Occasional Paper No. 27, Wellington, 1985.

[10] See, Faces in the Water, The Women's Press, London, 1980; and An Angel at My Table, Hutchinson, Auckland, 1984.

[11] Report of the Committee of Inquiry Into Procedures at Oakley Hospital and Related Matters, Government Printer, Wellington, 1983.

[12] Review of Psychiatric Hospitals etc, supra n.9.

[13] For more extensive discussion of the leave process, see Dawson, 'The Development of Community Mental Health Services in New Zealand: Implications for Law Reform', 1 Community Mental Health in New Zealand, 1984, 12.

14 See also, Finnigan, 'A Judge's View of the Committal Process', in Dawson and Abbott eds, supra n.7 at 27.

[15] Ibid.

[16] See, e.g., Wexler, Scoville et al., 'The Administration of Psychiatric Justice in Arizona,' (1971) 13 Ariz. L.R. 1; Zander, 'Civil Commitment in Wisconsin: the Impact of Lessard v Schmidt', [1976] Wisc. L.R. 503; Fennell, 'The Mental Health Review Tribunal: A Question of Imbalance,' 4 Brit. J. Law and Society 186; Hiday, 'Court Decisions in Civil Commitment: Independence or Deference', 4 Int. J. Law and Psychiatry 159; Warren, The Court of Last Resort, Univ. of Chicago Press, 1982.

[17] Supra n.14 at 30.