

The Mental Health (Compulsory Assessment and Treatment) Act 1992

John Dawson, Senior Lecturer, Faculty of Law, University of Otago

The mental health law reform process, commenced in 1983 in the wake of the report of the Oakley Committee of Inquiry, has at last delivered new legislation governing the process of committal, to come into force on 1 November. This article reviews the major changes in the law and highlights a number of outstanding issues. The Act should be understood within a wider legislative context, against a backdrop of hospital closures and changing practice in psychiatry. The Criminal Justice Act 1985 made significant changes to the law concerning mentally disordered offenders. The Protection of Personal and Property Rights Act 1988 reworked the law concerning disabled persons' property administration and gave the Family Court new powers over the personal lives of disabled adults, including the power to appoint welfare guardians. Now this 1992 Act substantially revises the 'civil' side of mental health law. All this must be integrated with law governing the new structure of health administration and with the legislation establishing the office of the Health Commissioner.

In many ways the new Act is catching up with trends in psychiatric practice that are well established, particularly the movement from institutional care to treatment in the community, punctuated by short periods of inpatient admission. The development of the multi-disciplinary team as the treatment provider is now reflected in the law. There is evidence that the need for greater respect for psychiatric patients' rights, identified in a series of recent inquiries, has been recognised; and the Act goes some distance towards acknowledging the widespread concerns within the Maori community regarding institutional psychiatric practices. In assessing the new law one must also keep in mind the extent of the ban on civil suits for medical negligence, the problems patients face in obtaining legal advice, the chronic underfunding of mental health services and trends towards deregulation and privatisation of health care.

The new Mental Health Act's provisions

The Act is a reworking of the present law - governing compulsory admission and treatment, patients' rights, review processes, and the legal infrastructure of compulsory psychiatry. It is a compromise between competing demands - for rapid access to treatment in genuine emergencies, adherence to fairer procedures in mental health proceedings and protection of the public from 'dangerous' people. The Act incorporates a number of changes introduced in other countries. So we see the establishment of Review Tribunals, a statement of patients' rights and a beefed-up grievance mechanism, some limits on treatment without consent and the establishment of a staggered approach to committal, permitting early discharge and rapid transfer from hospital to community. All powers under the Act must be exercised with 'proper respect' for the cultural identity, personal beliefs and family ties of the patient. And the law itself is 'deinstitutionalised'. A patient may be assessed or treated at any specified place, which need not be a hospital. The administrative functions of superintendents are shifted to regional administrators and responsible clinicians, who need not be doctors. In future any hospital may treat patients under compulsory orders.

The definition of 'Mental Disorder'
The Act contains a new, two-part definition of 'mental disorder', rendering a person subject to control. 'Mental disorder' means (s.2) -

'an abnormal state of mind (whether of a continuous or an intermittent nature) characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it -

- a) poses a serious danger to the health or safety of that person or of others; or
- b) seriously diminishes the capacity of that person to take care of himself or herself.'

The definition is linked to rules in s.4, prohibiting the use of compulsory powers over a person 'by reason only of' their political, religious or cultural beliefs, sexual preferences, criminal or delinquent behaviour, substance abuse, or intellectual handicap. This last exclusion is of particular significance and raises difficult questions about the fate of intellectually handicapped minor offenders.

Doctors writing initial medical certificates and Police exercising powers of arrest need now only be satisfied that there are **reasonable grounds for believing** that the proposed patient is (or 'may be') mentally disordered, not simply 'is mentally disordered' as required under current law. This may lower the committal threshold and should go some distance to meeting the complaints of families that it is too difficult to have a patient certified at present. Certainly, initial certification will be no more difficult to obtain.

Duly authorised officers

Part III provides for the appointment by all health authorities of 'duly authorised officers', who will be experienced mental health professionals. They will perform crucial new functions as 'brokers' of compulsory psychiatric treatment, particularly in facilitating arrest and certification at the time of committal or recall to hospital, partly relieving the Police of these tasks. They will also have the duty of assisting and advising families and caregivers.

Compulsory admission and assessment

The new, time-limited steps in the compulsory admission process are set out in the table. These resemble procedures followed under s.19 of the 1969 Act. They will cover all patients admitted under compulsory powers. The patient will undergo initial examination by two doctors (one of whom should be a psychiatrist) and will then enter a period of about a month's assessment which concludes

THE NEW ADMISSION & ASSESSMENT PROCESS

Application for a patient's compulsory assessment made by any person over 18 to a Director of Area Mental Health Services (s.8)

Accompanied by one medical certificate which states 'there are reasonable grounds for believing that the patient may be mentally disordered' (s.8(3))

Arrest may be authorised by the Duly Authorised Officer, the Police, a certifying doctor, a Judge or a Registrar (ss.31, 32, 41, 109, 110, 112)

Director arranges an assessment examination, conducted by a nominated psychiatrist, if possible (s.9) who writes a Certificate of Preliminary Assessment (s.10)

5 days compulsory assessment and treatment in hospital or the community (s.11)

The nominated Responsible Clinician writes a Certificate of Further Assessment (s.12)

14 days compulsory assessment and treatment (s.13)

The Responsible Clinician writes a Certificate of Final Assessment (s.14)

Application to District Court for the making of a Compulsory Treatment Order (s.14(4)), authorising 14 more days compulsory assessment and treatment (s.13)

Court hearing within 14 days of application (33 days maximum since admission) (s.18). The hearing may be adjourned for 1 month (s.15(2))

Six-month Compulsory Treatment Order (CTO) made by Judge (ss.17-30)

Formal Clinical Review by treatment team after 3 months of CTO and every 6 months thereafter (s.76)

Right of Appeal to Review Tribunal after every formal clinical review (s.79)

Judge extends CTO for a further 6 months (s.34)

Judge makes CTO indefinite (s.34) approximately 13 months after admission

High Court powers of inquiry retained (s.84)

with a private District Court or Family Court hearing to determine whether they should be placed under a Compulsory Treatment Order (CTO). The Order has an initial life of six months but may be renewed following the patient's Clinical Review by hospital staff. CTOs are of two types - Community Treatment Orders and In-Patient Orders.

Community Treatment

The Act structures the delivery of treatment in the community through the use of outpatient assessment and Community Treatment Orders¹. At each stage of admission and assessment a priority is established in favour of treatment as an outpatient. A person could be assessed, treated and

maintained under a court order without ever being admitted to hospital, but the patient may be quickly transferred to hospital, whereupon they re-enter assessment. A limited, independent power to grant compulsory inpatients leave for up to six months is also retained (s.31).

Treatment without consent

Treatment without consent is governed exclusively by Part V. Only treatment 'for mental disorder' is expressly authorised. Three categories of psychiatric treatment are created - psychosurgery, ECT and Other (principally medication), with rules governing each. ECT may be administered without the patient's consent with the approval of a

psychiatrist appointed by the Review Tribunal (s.60). Psychosurgery requires the consent of the patient, the Review Tribunal and an appointed psychiatrist (s.61). Treatment by any form of medication may be authorised by the Responsible Clinician during the period of assessment and the first month of a CTO (ss.58, 59 (1)). Thereafter, the consent of the patient must be obtained, or the approval of a psychiatrist appointed by the Review Tribunal - providing, in effect, a right to a second opinion after two months. This requirement may be overridden in an emergency (s.62).

Patients' rights

An important inclusion in Part VI of the Bill is a specific statement of patients' rights with a grievance mechanism established through which complaints may be made: to the District Inspector or Official Visitor and thereafter to the Review Tribunal if the patient remains unsatisfied. If recommendations are made to remedy breaches those responsible 'shall.... rectify the matter' (s.75(2)). The language used here ('rights', 'every patient is entitled') suggests there may be a parallel power to enforce these rights in the general courts². The specific rights granted include entitlements to: information about the patient's treatment and legal position, respect for cultural identity, language and religious beliefs, appropriate medical treatment, visitors, mail and telephone calls and to seek legal advice. No particular mechanism is provided for legal advice to be provided.

Restricted patients

New provisions are introduced to place greater restrictions upon patients detained under Inpatient Orders who are considered to present 'special difficulties because of the danger he or she poses to others' (ss.54-55). After a hearing a District Court may declare them to be 'restricted patients', which has the legal effect of limiting the hospital's ability to grant them leave, but is also likely to delay discharge.

A Joint Venture of Waikato Area Health Board Ethics Committee and
Otago University Bioethics Research Centre

Ethical and Policy Aspects of Assisted Reproduction

4-5 February 1993

University of Waikato, Hamilton

topics to include:

*new reproductive technology, medical-legal
aspects, womens perspectives, status of the embryo
plus additional topics in medical ethics on the
second day of conference*

Programme details from:

Alastair Gunn,
Department of Philosophy
University of Waikato
Private Bag
Hamilton

or: Bioethics Research Centre,
PO Box 913,
Dunedin
Fax: (03) 474 7601

New roles for District Inspectors and Official Visitors

The Act places new responsibilities on District Inspectors, who come to resemble patients' advocates, although most of their responsibilities may be delegated to their Deputies or Official Visitors. They have numerous responsibilities in the review process; eg to decide in every case whether to appear before the Court at the hearing of a CTO application. They also retain their current roles re complaints, inquiries, inspections, patients' rights etc. This sounds like a full-time occupation. Official Visitors have similar functions. Further duties may be specified by regulations.

Special patients

The Act makes few changes to the law governing special patients who enter hospital from prison or via orders under the Criminal Justice Act. Upon admission they are to be assessed and treated as if they were placed under CTO in the usual way. Review

Tribunals will now review special patients and offer advice but the ultimate fate of many special patients is to remain in political hands, through the unchanged powers of the Attorney-General and Minister of Health over reclassification and discharge.

Some outstanding issues

Let me conclude this review of the Act by pointing to a number of issues which may give rise to controversy:

- * The duration and breadth of the authority to treat a patient without consent provided by an independent psychiatrist's second opinion
- * The independence of those giving second opinions
- * The balancing of cultural rights against compulsory treatment powers
- * The extent of family consultation required to give 'proper respect' to the importance of family ties

- * The adequacy of the resourcing of Review Tribunals
- * The appointment of non-doctors as responsible clinicians
- * The extent of the legal obligations upon health authorities to give effect to recommendations designed to uphold patients' rights.

While areas of potential dispute clearly remain and teething problems are inevitable, the new Act is, in my view, a significant advance on the Mental Health Act 1969. Having spent nine years in the pipeline, one would certainly hope it was!

¹ See J. Dawson 'Community Treatment Orders' (1991) 7 Otago LR 410

² Cf Commissioner of Police v Ombudsman [1988] 1NZLR 385