'FUNDAMENTAL RIGHTS' AND THE MENTALLY DISABLED

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In 1985 a draft Bill of Rights was published in *A Bill of Rights for New Zealand: A White Paper*[1] and presented to the New Zealand Parliament by its chief proponent, the Minister of Justice, Mr Geoffrey Palmer. It was referred to the Justice and Law Reform Committee of the House for the hearing of public submissions. These commenced in Auckland in February 1986. It has received a mixed, often negative reaction, reflecting in part doubts about extending the power of a judiciary drawn from one culture,[2] one sex[3] and one profession.[4]

According to the preamble, the draft Bill's purpose is "to affirm, protect and promote human rights and fundamental freedoms in New Zealand, and to recognise and affirm the Treaty of Waitangi". It would be entrenched as "supreme law". The Treaty of Waitangi is incorporated in it. A range of civil and political rights is affirmed.

The Bill's guarantees are enforceable through judicial process. The courts may declare inconsistent laws to be "of no effect"[5] and grant such remedies as they consider "appropriate and just in the circumstances".[6] Its provisions may only be altered by a special majority of the House of Representatives (75 percent) or a simple majority at a referendum.[7]

The Bill's guarantees are not absolute. They are made subject, through Article 3, "to such reasonable limits prescribed by law as can be demonstrably justified in a democratic society".

Mr Palmer's stated purpose in publishing the draft is "to engender debate and provide a focus for the issues".[8] Most debate has proceeded at the "macro" level – of institutional design; the role and mana of the Treaty; the implications of extended judicial power; and the scope of "justified limitations".

This article has a more modest purpose – to advance debate by reference to a specific reform agenda. Using the Bill's language of rights I will compare its guarantees with law and State practice towards the mentally

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1 See, generally, Elkind and Shaw, *A Standard for Justice* (1986).
2 See Kelsey, "Decolonisation in the 'First World' – Indigenous Peoples' Struggles for Justice and Self-Determination" (to be published).
3 See Joychild, Kapua and Mathieson, "MPs or Judges?", *Broadsheet,* November 1985 at 348.
4 See "Palmer Jumps to Bill of Rights Defence", *The Dominion,* 25 March 1986.
5 Article 1.
6 Article 25.
7 Article 28.
8 *Bill of Rights for New Zealand: A White Paper* (1985) at 6.

disabled.[9] This approach is adopted in agreement with the view of Laurence Tribe that we should be:[10]

> seeking to achieve such ends as human freedom not through any *one* characteristic structure of choice but through that *combination* of structures that seems best suited to those ends *in a particular context.*

Comparison of New Zealand mental health law with human rights' principles is timely in any case. The obligations imposed upon us by the ratification in 1978 of the International Covenant on Civil and Political Rights demand that we review our mental health laws in line with these principles, whether we have a Bill of Rights or not.

I THE SOCIAL AND LEGAL CONTEXT

Our mental health system is characterized by institutions, compulsion and neglect. A recent report to the Minister of Health concludes, "It could be said of the country's psychiatric hospitals: It is a cruel paradox that the least is provided where the need is greatest."[11] Scores of deficiencies are listed. Few hospitals have stated philosophies, goals or objectives. Patients remain in hospital who could be more appropriately cared for in other environments. There is insufficient emphasis on community resources and lack of recognition of cultural needs in many aspects of patient care. The range of treatment options is inadequate with an "undue reliance on drug therapy and various forms of custodial care"[12] including seclusion (or solitary confinement).

The list is battering: idiosyncratic prescribing; poor drug recording; "Dickensian" facilities for seclusion and restraint; "time-out" boxes; lack of reviews; lack of enthusiasm for the multi-disciplinary team; major shortages of professional staff.[13] The entire service is under-financed and tied to a funding formula that ensures that this situation continues. Twenty percent of hospital board funds are spent on a service providing more than 40 percent of patient bed days. As a result, "Staff frequently have to use inappropriate interventions and are able to provide only basic care".[14] None of this is news. The report is only the most recent in a procession of inquiries

9 No opinion is expressed on other issues raised by the Bill such as the incorporation of the Treaty of Waitangi and the inclusion of a wider range of social and economic rights.

10 *American Constitutional Law* (1977) at 1137.

11 Department of Health, *Review of Psychiatric Hospitals and Hospitals for the Intellectually Handicapped* (1986) at 20.

12 Ibid at 7.

13 Ibid.

14 Ibid at 20.

that have examined psychiatric services.[15] Their recommendations are frequently ignored.

Services at Oakley Hospital were examined by the Hutchinson Commission in 1971, by the Ombudsman in 1982, and by the Oakley Committee of Inquiry in the same year. This last report states:[16]

> It is most disturbing to us that we consider a substantial number of deficiencies to which attention was drawn in the Hutchinson report still exist with little apparent improvement. In many cases these deficiencies could have been remedied at least to some extent if those responsible had had the will to attempt to remedy them and in some cases if funds had been made available for this purpose. In re-reading the report of the Hutchinson Commission this Committee has a strong sense of deja vu. We note that many of the matters which we consider unacceptable were referred to as unsatisfactory in that report.

Throughout New Zealand psychiatric patients continue to be detained in conditions that would be unacceptable in general hospitals.

It is not surprising that an aura of compulsion surrounds this system. The proportion of patients admitted under some form of compulsion is high by international standards. Twenty-six percent of all patients admitted during 1984 to our psychiatric hospitals, general hospital psychiatric units and alcoholism and drug addiction institutions entered under some form of legal order.[17] The World Health Organisation provides the following figures for percentages of involuntary admissions in Europe in 1982:[18] Belgium, 7 percent; England, 12 percent; Ireland, 14 percent; Italy, 14 percent; Netherlands, 15 percent, Scotland, 10 percent.

The figures are even less flattering if one considers admissions to psychiatric hospitals only.[19] A three month study of admissions to four North Island psychiatric hospitals in 1984 found 43 percent of patients admitted under some form of compulsion:[20] 38 percent under the Mental Health Act 1969,[21] 4 percent under the Criminal Justice Act 1954 and 1 percent under the Alcoholism and Drug Addiction Act 1966. A further

15 See, eg, *Report of the Commission of Inquiry into Psychiatric Services at Oakley Hospital* (1971) (The Hutchinson Report); *Summary of a Report Compiled upon an Investigation into a Complaint against the Department of Health and the Department of Social Welfare* (1977, Office of the Ombudsman); *Report of the Commission of Inquiry into the case of a Niuean Boy* (1977); *Report on the Complaint of Ms J Schaverien Against the Auckland Hospital Board Concerning Oakley Hospital* (1982, Office of the Ombudsman); *Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters* (1983).

16 *Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters* at para 2.5.1.

17 Unpublished figures supplied by the National Health Statistics Centre.

18 World Health Organisation, *Public Health in Europe,* No 25, "Mental Health Services in Europe: 10 years on" at 52-53.

19 In 1984 the psychiatric units of general hospitals admitted informal patients only.

20 See Dawson, *The Process of Committal* (forthcoming).

21 Including patients returned to hospital upon revocation of their leave: see Mental Health Act 1969, s 66.

group of patients were admitted informally but committed later.[22] A survey of Tokanui Hospital in 1979 gave similar results.[23]

The legislation under which patients are detained also compares poorly with that in force in other western democracies.[24]

Detained patients do not have adequate access to courts under present law, for many reasons. They do not have adequate access to legal advice and representation and they are seldom represented in practice, even at committal hearings.[25] Patients' civil actions are blocked by the procedural hurdles of section 124 of the Mental Health Act.[26] Actions for medical malpractice causing personal injuries are blocked by the Accident Compensation Act 1982. The judiciary has no jurisdiction to examine institutional conditions or practices, such as the use of seclusion. Patients have no right of access to their own medical records.[27] Their complaints are directed to Official Visitors and District Inspectors who have no powers to make changes. And current legislation provides poor access to independent review of detention decisions.[28]

As a result, although there are nearly 4000 compulsory admissions to psychiatric hospitals or licensed institutions each year, there is limited judicial oversight of this mode of confinement, under which citizens are deprived of fundamental rights.

The primary modes of public scrutiny of psychiatric services in New Zealand are, in fact, commissions of inquiry and Ombudsman's reports. These are discretionary, ad hoc mechanisms, and although they provide needed publicity they cannot provide legal remedies or enforce changes.

The mentally disabled are one of the poorest and most powerless groups in the country. Their influence on the political process is negligible. They have gained very little from it. Here, then, is a specific context of human rights' concern. That these concerns are real is surely revealed by the description of Oakley Hospital and the circumstances surrounding the death of Michael Watene provided in the Oakley Report.[29] Is this not a fair test for a Bill of Rights?

22 See Mental Health Act 1969, s 16.

23 Fama, "Legislation and Practice in Compulsory Admission to a Psychiatric Hospital", (1983) NZ Medical Journal 130.

24 See *Towards Mental Health Law Reform,* Report of the Task Force on Revision of Mental Health Legislation (1983) (hereafter *TMHLR*).

25 See Dawson, "Civil Committal Study: Preliminary Data", in Dawson and Abbott eds., *The Future of Mental Health Services in New Zealand* (1985) at 37; and Dawson, supra n 20.

26 See *Greatbatch* v *Attorney-General and Auckland Hospital Board* unreported, High Court, Auckland, 22 May 1985; *Hastwell* v *Commissioner of Police* unreported, High Court, Nelson, 20 November 1984. In *Hastwell* leave to proceed was granted but the decision has been appealed. I know of no case in which a patient-initiated legal action has been sustained against a member of staff of a New Zealand psychiatric hospital.

27 See Hospitals Act 1957, s 62. Patients may be able to request access to their records as "personal information" if the Official Information Act 1982 is extended to cover Hospital Boards.

28 See Mental Health Act 1969, ss 73 and 74, and *TMHLR,* supra n 24 at chapter 19.

29 Supra n 16.

II THE PROTECTION OF FUNDAMENTAL RIGHTS

An affirmative statement of the rights of disabled people generally, and of detained psychiatric patients in particular, has never been included in New Zealand law. Yet daily they suffer restrictions of fundamental rights – to control personal liberty, to refuse unwanted treatment, simply to be left alone. A major aim of a Bill of Rights is surely the adequate protection of such rights and the setting of standards and procedures governing the manner in which they may be restricted.

Mental health law is an area in which it can be argued that current New Zealand law does not comply with the draft Bill. It thus presents a case study of the legal restructuring that will be necessary if the Bill is enacted.

There is a long history of separate legislation and practice with regard to the mentally disabled and many restrictions may be held to be "justified limitations". The courts will hesitate to take action in areas they view as the primary concern of other institutions. Nevertheless, New Zealand mental health law and practice may face many challenges under the Bill which may succeed if current legislation and practice are not amended.

This section of this article compares New Zealand's mental health laws against the Bill's guarantees, on the basis of a review of mental health litigation under the United States Bill of Rights and the European Convention on Human Rights. The discussion is general and speculative. In part this reflects our inability to predict the full impact of a Bill of Rights, in particular the interpretation of Article 3, permitting "justified limitations" of declared rights. It also reflects the poor development of mental health law in New Zealand. At present we have little more than bare statutes and an agenda searching for a forum.

Most affected by the Bill will be the substance and procedure of laws governing the arrest, detention and compulsory treatment of "mentally disordered persons". It is useful to list at the outset those rights which may be curtailed when a person becomes a committed patient, subject to a reception order under the Mental Health Act 1969:

> The right to control personal liberty and to freedom of movement.
> The right to consent to treatment, both while in hospital and while living outside hospital on leave.
> The right to manage property.
> The right to drive.
> The right to receive mail free of censorship.
> The right to freedom of association.

Challenges to restrictions on such rights may be initiated under numerous articles of the draft Bill. Many are closely inter-dependent and a law or practice may often be challenged on several grounds. The process of arrest of mentally disordered persons provides a good example. Laws governing this process may be measured against Articles 15, 16, 19 and 21, governing liberty of the person, rights on arrest, seizure of the person and observance of the principles of natural justice, respectively. A legal challenge would measure current law and practice against the guarantees provided by *all these clauses read together as a whole.* By knitting rights together in this way the most effective protection may be provided.

1 Arrest and detention of the mentally disabled

The Mental Health Act 1969 permits "mentally disordered persons" to be arrested and committed to psychiatric hospitals for an indefinite period until discharge.[30] Numerous aspects of this process could be challenged.

Rights guaranteed to "detained" persons by Article 15, governing liberty of the person, would surely be extended to those detained under the Mental Health Act and all other legislation which permits institutionalisation, including detention under the Alcoholism and Drug Addiction Act 1966, the Tuberculosis Act 1948 and the Children and Young Persons Act 1974. These may also extend to disabled persons placed in institutions by the substituted consent of guardians.

The standards and procedures followed in committal proceedings could be litigated. The requirement in Article 15(1) that persons shall not be "arbitrarily" detained suggests the "void for vagueness" doctrine may be incorporated into New Zealand law on the basis that excessively vague standards permit "arbitrary" detention. Committal and discharge standards under the Mental Health Act could be challenged. They are phrased in the broadest terms, without reference to specific behaviour. Section 19(1) refers to persons who "should be placed under care and treatment in a hospital either (a) in the interests of the welfare of that person; or (b) in the public interest", and section 22(4) uses the words "mentally disordered and requires detention as such".

Standards governing powers of arrest under the Mental Health Act could face similar scrutiny. Section 35 permits the Police and Medical Officers of Health to arrest a "mentally disordered person", when this "appears expedient for that person's good or in the public interest", and he or she 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.

Persons arrested under this section would be covered by Article 15(2), providing specific rights to be informed of the reason for an arrest, to consult a lawyer and to be informed of that right.

At present, the vast majority of committed psychiatric patients have no access to legal advice and are not represented, even at committal hearings where they are formally deprived of fundamental rights. Legal representation at such hearings may be guaranteed under the Bill as a requirement of the rules of natural justice.

Persons arrested under the Mental Health Act are often held in cells at police stations or district courts following their arrest. They may then be handcuffed and transported in police cars or vans to hospitals which may be hundreds of miles from the place of arrest. Acutely ill persons are sometimes detained for weekends in police cells without medication. Security measures may be adopted which are based on the incorrect assumption

30 This process has been the subject of recent empirical research by the author: see Dawson, supra n 25. A similar committal process operates under the Alcoholism and Drug Addiction Act 1966: see *TMHLR,* supra n 24.

that all mentally disordered persons are "dangerous". All such practices may be compared against Article 15(3), declaring that detained persons "shall be treated with humanity and with respect for the inherent dignity of the human person".

Other modes of detention in psychiatric hospitals may be reviewed, including revocation of leave; the admission of children by the substituted consent of their parents or guardians;[31] prison to hospital transfers;[32] and procedures under section 16 of the Mental Health Act for the detention and committal of persons who enter psychiatric hospitals as informal patients.

Article 21 would require decision-makers in these processes to adhere to the principles of natural justice, which may be enforced through judicial review. No statute could abrogate these requirements. This could have profound implications for decision-making in the mental health area, where these rules are frequently ignored, despite the restrictions upon fundamental rights which may be imposed. The procedures followed at judicial hearings at which patients are formally committed could be examined[33] and the demand for compliance with the rules may extend beyond such formal hearings to govern other important decision-makers: for example, politicians deciding upon the discharge of special patients; and persons accepting the admission of child patients.

At committal hearings at present the rules of natural justice are routinely ignored. Besides being unrepresented, many patients are given inadequate notice of the hearing. They do not have access to the medical certificates and other documents presented. Medical evidence is given in their absence. There is no opportunity to challenge this or to seek an independent clinical examination. No transcript is made and often no reasons are given for the decision.

Interpreters are not present at committal hearings when patients who are committed do not speak English. The right to information in one's own language may be required as an element of the rules of natural justice, or by Article 13, governing the rights of minorities to use their language.

The administration of tranquilising or sedative drugs prior to a hearing could be reviewed. Their use may prevent effective communication between a patient and a lawyer or court, denying a fair hearing and breaching Article 7, guaranteeing freedom of expression.[34]

The Bill's provisions may also found a right for all detained patients to seek periodic review of their status before a court or tribunal. Detention based on the existence of continuing mental disorder or dangerousness is

31 See *Bartley* v *Kremens* 402 F Supp 1039 (1975); *Re Roger S* 569 P 2d 1286 (1977); *Parham* v *JR* 442 US 584 (1979); *Secretary of Public Welfare* v *Institutionalized Juveniles* 442 US 640 (1979).

32 See *Vitek* v *Jones* 445 US 480 (1980).

33 *Lessard* v *Schmidt* 349 F Supp 1078 (1972); *Lynch* v *Baxley* 386 F Supp 378 (1974); *O'Connor* v *Donaldson* 442 US 503 (1975); *Addington* v *Texas* 441 US 418 (1979); *Wintwerp* v *The Netherlands* 2 EHRR 387 (1979).

34 See *Bell* v *Wayne County General Hospital* 384 F Supp 1085 (1974).

not justified solely by proof that a person committed specific past acts, as under the criminal law. It should be periodically demonstrated that the person continues to fall within the committal standard.[35]

Article 15(2)(c) specifically affirms the right of all detained persons to challenge their detention by way of habeas corpus. In theory, the writ is available to psychiatric patients at present but is rarely, if ever, invoked in practice. Sections 73 and 74 of the Mental Health Act, governing committed patients' rights of appeal, place the decisions as to whether a judicial hearing will be held within the discretion of the Minister of Health or a judge of the High Court. A hearing may be declined by the Minister.[36] High Court judges can and do delegate their powers of inquiry to the District Inspector or some other person, usually a barrister.[37]

In practice, the power to discharge committed patients rests with the medical staff of psychiatric hospitals. The power to discharge special patients (who enter psychiatric hospitals via involvement with the criminal justice system) lies with the Minister of Health and the Attorney-General.[38] Unlike the United Kingdom, where Mental Health Review Tribunals have operated since 1961,[39] committed patients have no direct right of access to review of their status before an independent tribunal.

This right of review before a Mental Health Review Tribunal possessing the power of discharge has recently been extended in the United Kingdom to cover those patients under hospital orders, equivalent to our special patients. The previous discharge process, which placed the decision as in New Zealand within the discretion of politicians, was found to violate the European Convention in *X* v *UK*.[40]

Proposals for changes to our Mental Health Act do include the establishment of regional review tribunals to review the status of all detained patients.[41] Whether the final power to discharge special patients will remain with politicians, with tribunals having the power to make recommendations only, is an open question.

The extent to which review procedures may be litigated under a Bill of Rights will depend here, as in other areas, on the final form of the new legislation.

2 *The rights of in-patients*

Article 15(1) declares:

> Everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

35 See *Specht* v *Paterson* 386 US 605 (1967); *Fasulo* v *Arafeh* 378 A 2d 553 (1977); *State* v *Fields* 390 A 2d 574 (1978); *Wintwerp* v *The Netherlands* 2 EHRR 387 (1979); *X* v *UK* 4 EHRR 188 (1981).

36 S 73(5).

37 S 74(1).

38 Criminal Justice Act 1985, Part VII. See *TMHLR,* supra n 24, ch 12.

39 See Peay, "Mental Health Review Tribunals and the Mental Health (Amendment) Act" [1982] Crim LR 794; and *TMHLR,* supra n 24, ch 19.

40 Supra n 35; see Gostin, "Human Rights, Judicial Review and the Mentally Disordered Offender" [1982] Crim LR 779.

41 *Review of the Mental Health Act 1969: Discussion Papers* (1984).

Article 20(1) declares:

> Everyone has the right not to be subjected to torture or to cruel, degrading or disproportionately severe treatment or punishment.

Passage of the Bill will permit these guarantees to be measured against the conditions in which people are detained in prisons, psychiatric hospitals, social welfare institutions and other places of confinement. The courts will have jurisdiction to monitor and enforce minimum conditions. This will permit the facts of institutional life to be examined in individual cases in a public forum open to the press.

Confinement in a psychiatric hospital and the legal consequences of committed patient status also involve restrictions upon many of the fundamental rights affirmed in the Bill. Freedom of movement and association, for example, are plainly implicated.

The traditional mode of monitoring institutional conditions in New Zealand has been to grant powers of inspection to statutory officials such as Official Visitors and District Inspectors.[42] I do not wish to disparage the valuable (and usually unpaid) work of such persons, but their inquiries usually occur in private and they have the power to make recommendations only, which may be ignored. They are no substitute for scrutiny by a court empowered to grant legal remedies such as injunctions and damages when minimum conditions are infringed.

All aspects of institutional life could be scrutinised. The inappropriate or excessive use of seclusion, restraints, solitary confinement and "time out" as part of behaviour modification programmes could be litigated and criteria governing their use laid down. The Report of the Oakley Committee of Inquiry details the seclusion practices followed at Oakley Hospital. Patients were routinely placed in seclusion upon admission. Michael Watene was kept in seclusion for over a week with no explanation to him as to why he was kept in that position.[43] There have been frequent challenges to such practices in other countries.[44]

Over-crowded conditions could also be examined.[45] The 1983 Oakley Report stated: "We believe that there should be a drastic reduction in patient numbers in both Wards M3 and M7 as soon as possible . . .".[46]

The performance by psychiatric patients of non-therapeutic labour without adequate pay could be contested and compensation sought.[47]

The guarantee in Article 15 of freedom of association could lead to judicial review of patients' visiting rights and the powers which exist under the Mental Health Act to transfer detained patients to any hospital in New Zealand (section 69) and to remove patients to other countries (section

42 *TMHLR,* supra n 24, ch 17.

43 See 1983 Oakley Report, supra n 16 at para 4.4.

44 Eg *Greenholtz* v *Nebraska Prison Inmates* 442 US 1 (1979); *Rogers* v *Okin* 478 F Supp 1342 (1979); *A* v *UK* (1980) 3 EHRR 131; *Bell* v *Wolfish* 441 US 520 (1980); *Youngberg* v *Romeo* 457 US 307 (1982). See *TMHLR,* supra n 24 at 257-259; and *Seclusion and Restraint: The Psychiatric Uses,* Report of the American Psychiatric Association Task Force (1984).

45 See *Hilton* v *UK* (1978) 3 EHRR 104; *Bell* v *Wolfish* 441 US 520 (1980).

46 Supra n 16 at para 11.6.

47 See *Souder* v *Brennan* 367 F Supp 808 (1973); *TMHLR,* supra n 24 at 259-261.

72). Transferring patients denies freedom of association with friends and family.

The use of seclusion and confinement to a locked ward infringes freedom of association and movement within a hospital. Provisions establishing offences involving sexual intercourse with a "mentally disordered female" (section 113) may face challenges; as may section 20D of the Transport Act 1962, providing for the automatic suspension of detained patients' driver's licences.[48]

Sections 62 and 63 of the Mental Health Act permit the censorship of committed and special patients' mail. These may be challenged as unnecessary or overbroad, in contravention of the guarantee of freedom of expression in Article 7.[49] Rules governing access to telephones could be examined. Article 19's prohibition of unreasonable seizure of correspondence might also be invoked to prevent interference with patients' right to communicate.

Section 42 of the Electoral Act 1956 disqualifies from voting some committed patients, special patients and convicted prisoners. These prohibitions may be tested against Article 5(1) which guarantees voting rights to "Every New Zealand citizen who is of or over the age of 18 years". The current bar to the election of "mentally disordered persons" as Members of Parliament could face a similar challenge under Article 5(2).[50]

Some actions against the Crown by psychiatric patients may currently be blocked by the procedural barriers set up by section 124 of the Mental Health Act and similar provisions.[51] Section 124 requires patients to obtain the permission of the High Court before they can even launch civil or criminal proceedings based on acts done "in pursuance or intended pursuance" of the Mental Health Act. It also sets a special six months limitation period during which actions must be brought, although the limitation period is usually six years.

The procedural barriers established by section 124 may be challenged on the basis that they deny patients the right to bring civil proceedings against the Crown "in the same way as civil proceedings between individuals" (Article 21(3)). The Department of Justice has supported repeal of section 124 in its submission on the Mental Health Act, noting that prison officers have no similar protection and have never felt the need for it.

3 Treatment rights

Passage of the draft Bill would raise numerous issues regarding treatment rights of committed patients and detained persons generally. These include the right of detained persons to receive treatment, the right of all

48 See *TMHLR*, supra n 24 at 254-255.

49 See *TMHLR*, supra n 24 at 251-254. The correspondence rights of prisoners have recently been litigated before the European Court and Commission of Human Rights: *Golder* v *UK* (1975) 1 EHRR 524; *Silver* v *UK* (1980) 3 EHRR 475.

50 See *TMHLR*, supra n 24 at 262.

51 See *TMHLR*, supra n 24 at 255-256, and *Hastwell* and *Greatbatch*, supra n 26. S 129 of the Health Act 1956 is a similar provision.

persons to give informed consent to treatment and rights of access to independent medical examination.

The guarantee in Article 15(3) of humane conditions for detained persons could found a right to minimally adequate treatment for committed psychiatric patients and prisoners. The right to treatment for detained patients has long been recognised as required by the United States Constitution.[52] In *Wyatt* v *Stickney* the court wrote:[53]

> To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.

A right to education or "habilitation" for the intellectually handicapped has also been recognised.[54]

These rights are not based on any general entitlement of citizens to State-funded health care, but on the more limited demand that when the State incarcerates for treatment purposes, some minimal services must be provided in return to meet the requirements of due process.

Similar arguments could be advanced under Article 15(1), which prohibits "arbitrary" detention, on the basis that detention for treatment without treatment being provided is indeed "arbitrary". On the same basis arguments may be advanced that a "treatability" criterion should be included in committal standards to prevent the detention of persons who suffer no "treatable" disorder.[55]

A right of access to independent medical examination may be established under the rules of natural justice as an aspect of the general right to present all relevant evidence to decision-making bodies.[56] In the criminal context, the right to adequate facilities to prepare a defence is expressly provided by Article 18(b), (f) and (h).

All uses of compulsory therapy could be tested against Article 20(3) which provides "Everyone has the right to refuse to undergo any medical treatment".

Who can doubt that the right to control one's bodily integrity is as fundamental as other rights protected? It could be argued this right is an element of humane treatment of detained persons as guaranteed by Article 15(3), but it is preferable for it to be specifically stated. This also makes it clear the right applies to persons who are not detained, and so may be applied to compulsory treatment in the community, which is an increasing phenomenon.

The right to consent to treatment is the most controversial issue in law and psychiatry.[57] It is the subject of continuing constitutional litigation in the United States. A qualified right to refuse treatment has been recog-

52 See *TMHLR,* supra n 24 at ch 14.
53 325 F Supp 781 at 785 (1971).
54 *Youngberg* v *Romeo* 457 US 307 (1982).
55 See *TMHLR,* supra n 24 at ch 10.
56 See *Campbell and Fell* v *UK* (1982) 5 EHRR 207; and *Ake* v *Oklahoma* 84 L Ed 2d 53 (1985).
57 For an extensive discussion see *TMHLR,* supra n 24, ch 15.

nised there and procedures established for judging patients' competence to give consent and for obtaining consent from substitute decision-makers when patients are found incompetent.[58]

The compulsory treatment of detained psychiatric patients in the United Kingdom has been made subject to new provisions giving some patients a right to a second opinion, under the Mental Health Act 1983 (UK). Psychosurgery and electro-convulsive therapy are there subject to special provisions.

Other international human rights instruments do not include a specific statement of this right. There are strong reasons, however, why it is required in New Zealand. Here the Accident Compensation Act has effectively prevented litigation in the area and stifled development of the law.[59] Persons who suffer personal injuries as a result of "medical misadventure" may claim compensation from the Accident Compensation Corporation but cannot sue a negligent doctor personally in a public forum. It is largely through malpractice actions that the law of informed consent has developed in other jurisdictions.

It is possible that a New Zealand doctor who treats a patient without consent could be sued for damages in trespass, but the bounds of this remedy are far from clear.[60]

The absence of domestic law means we must look to developments in the United Kingdom. The House of Lords, for example, has recently decided cases on informed consent[61] and the competence of children to consent.[62] But importing English law is an unsatisfactory process. Patients' rights to receive information and give consent should be decided in the light of New Zealand law and cultural context. Our law of torts has developed independently in recent years and is highly influenced in this area by the unique provisions of the Accident Compensation Act. The cultural context is influenced, for example, by Maori views of medical treatment, which should be respected.

The right to refuse treatment established by Article 20(3) would certainly not be absolute, but would be subject to "justified limitations". These would include situations in which patients are found incompetent to exercise the right due to youth, or mental disorder or unconsciousness. Doctors would be permitted to treat patients without consent in genuine emergencies. But Article 20(3) would permit the development of the boundaries of these exceptions. Rules would be formulated by the courts governing competence, substitute decision-making and psychiatric or other emergencies. All legislative provisions permitting compulsory treatment could be measured

58 See *Re Guardianship of Roe* 421 NE 2d 40 (1981); *Mills* v *Rogers* 457 US 291 (1982); *Project Release* v *Prevost* 551 F Supp 1298 (1982); *Rennie* v *Klein* 720 F 2d 266 (1983).

59 See Mahoney, "Informed Consent and Breach of the Medical Contract to Achieve a Particular Result" (1985) 6 Otago LR 103.

60 See *TMHLR*, supra n 24 at 241 n 30; Mahoney, supra n 59; and cf *Reibl* v *Hughes* (1981) 114 DLR (3d) 1 and *Chatterton* v *Gerson* [1981] QB 432.

61 *Sidaway* v *Bethlem Royal Hospital* [1985] AC 871.

62 *Gillick* v *West Norfolk Area Health Authority* [1986] AC 112.

against these common guidelines.[63] Guardians' rights to consent could also be scrutinised.

As to the exact wording of Article 20(3), it is difficult to foresee the effect of phrasing it in terms of a right to "refuse", rather than a right to "consent". Is one simply the mirror image of the other, or will this distinction have a real impact on the outcome of cases? A right to refuse is best understood in relation to a general right to give informed consent to procedures which would otherwise be an unlawful assault on the person. The main impact of framing the right in terms of refusal may be suppression of the notion that the decision should be "informed". The word "consent" is preferred in Article 20(2), governing medical or scientific experimentation. There are advantages in consistency. I suggest Article 20(3) should be reworded so that it provides "Everyone has the right to give informed consent to medical treatment". This would focus debate about exceptions to the rule upon those situations in which patients cannot be informed, as is appropriate.

Other clauses of the Bill could be invoked in the treatment context. Article 20(2), governing experimentation on humans, could be raised in relation to some treatments such as psychosurgery or hormone implantation, which may be viewed as experimental.

Article 6, governing freedom of thought, conscience and religion, may be invoked by groups whose beliefs include views on permissible forms of treatment: for example, the implications of Maori spiritual beliefs in relation to the head and brain must be considered, particularly in relation to the use of electro-convulsive therapy.

When a person dies as a result of psychiatric or other medical malpractice, a remedy may be claimed under the right to life clause (Article 14). Damages could be awarded, even for personal injuries, as Article 25 permits courts to grant such remedies as they consider appropriate for breach of protected rights. This could be interpreted to override the provisions of the Accident Compensation Act; or that Act's limitations of victim's rights to recover damages for personal injuries may be viewed as "justified limitations" upon the remedies available. The facts surrounding the death of Michael Watene at Oakley Hospital should be reviewed in this light.[64]

4 Property rights

The right to be free of unreasonable seizure of property (Article 19) could provoke challenges to all procedures (especially those followed in emergencies) for obtaining management of disabled persons' property. For example, the proposals under the draft Incapacitated Persons Property Bill (circulated by the Justice Department in 1984) for management to be effected in some cases on the basis of medical certificates, without a court

63 There are numerous provisions in force which could be subject to such scrutiny: Mental Health Act 1969, ss 19(6), 25, 49(1), 55A(1); Alcoholism and Drug Addiction Act 1966, ss 8 and 9; Children and Young Persons Act 1974, ss 42A(6) and 49A(2); Criminal Justice Act 1985, ss 121(9); Tuberculosis Act 1948, ss 10 and 16; Penal Institutions Act 1954, ss 36A and 36B; Health Act 1956, ss 88, 90, 108, 125, 126, 126A, 126B.

64 See 1983 Oakley Report, supra n 16, sections 3-9.

order, could be tested.[65] The extent to which New Zealand law in this area could be challenged will depend on the eventual form of this new legislation.

5 *Mentally disabled offenders*

Law governing the trial and disposition of mentally disabled offenders would attract special scrutiny following passage of the Bill. The detailed laws of criminal procedure governing pleas of disability and not guilty by reason of insanity could be compared against the general guarantee of a fair hearing in Article 17(1)(a) and the detailed rights of persons charged, enumerated in Article 18. The right to silence (Article 18(j)) may be raised in attempts to prevent compulsory psychiatric examination. The right to counsel may include the presence of counsel at such examinations.

Other issues, such as rights to review and independent examination, have been mentioned. Standards and procedures followed in psychiatric remands and prison to hospital transfers could be scrutinised.

III CONCLUSION

This review indicates the broad range of human rights' concerns in the mental health area. New Zealand law should take account of these concerns and refer to cases in which mental health laws have been challenged under Bills of Rights in other jurisdictions.

But many doubts will remain about the value of submitting this agenda to judicial process. How will it respond to class actions on behalf of indigent, incompetent applicants on legal aid? Will it simply defer to "medical judgement" and "political solutions"? What remedies would it grant and how would it enforce them? Will it draft seclusion protocols, appoint human rights' committees, threaten to bankrupt hospital systems?[66]

What is the role of the judiciary when there is no will to make the changes? Judges cannot levy taxes. The distinction between "civil" and "social" rights is not tenable: representation, reviews, humane conditions — we get what we pay for. Where are the lawyers who will press these cases? These are the real doubts, not points of doctrine.

At worst, litigation will waste resources, driving staff from the public health system, promoting an illusion of reform while diverting pressure from other avenues. For meaningful change we need a wholly altered mental health system.

It could be adequately staffed and resourced. The locus of treatment could be small, humane units integrated with housing of the general population. All decision-making could be open and inter-disciplinary, involving patients, their families and wider communities. Through patients' unions

65 See *TMHLR*, supra n 24, ch 18.

66 See, eg, the implementation procedure established in *Wyatt* v *Stickney*, supra n 53. Here Judge Johnson in Alabama set minimum standards governing conditions and treatment in a large State hospital for the mentally ill and intellectually handicapped. He established detailed procedures for implementation, appointing human rights' committees which included residents and ordered the State to submit a compliance report on implementation of the order within six months.

and councils consumers could have input into decisions, access to information and support from their peers. There could be a broad range of treatment options, educational programmes, patient work co-operatives; for those who cannot work, a minimum wage permitting life with dignity. The work of the police could be replaced here by crisis intervention services.

We cannot foresee the extent to which altering the law may stimulate these changes. We are bound to assess the Bill in accordance with our view of current judicial process.