COMMUNITY TREATMENT ORDERS

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I INTRODUCTION

In the last two decades compulsory psychiatric treatment in New Zealand has shifted into the community. But there has been no corresponding change in the legislative base. This growing gap between psychiatric practices and the Mental Health Act 1969[1] has become a major factor in the current reform of our mental health legislation.

Proposals in the Mental Health Bill[2] would establish Community Treatment Orders (CTOs) providing mental health professionals with a revised form of authority to enforce psychiatric treatment outside hospitals, at any specified place. A person under a CTO would be obliged to accept treatment as an out-patient. The order would grant a power of entry into their residence to mental health professionals, who would seek to perform therapeutic functions and monitor the patient's condition. If the patient failed to comply with the order, or their condition was considered to have deteriorated, their out-patient status could be revoked. They could be apprehended and hospitalised.

With these proposals likely to be enacted, this is an appropriate time to review the suggested CTO regime. This paper considers the reasons why we should adopt a new legal structure governing compulsory community treatment, the form this regime should take, and who should be its subjects.

The Hopes for CTOs

We live in the era of closure of large psychiatric hospitals. This is often called the era of "deinstitutionalisation", but it is doubtful that that word describes the phenomena. Many patients move from one institution to another (eg, from a public hospital to a private rest home) and many "mentally disordered" people are not "institutionalised" at all. Psychiatric services are increasingly based on a community treatment model with provision made for patients to undergo short periods of in-patient treatment in critical periods. Treatment in the community is not merely a supplement to in-patient care; it is increasingly the norm, with hospital care the exception.

But why the need for compulsion? Why should people for whom continuing out-patient care is recommended be compelled to receive it? Is a

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1 All statutory references in this article are to the Mental Health Act 1969 unless indicated.

2 The Bill was introduced as the Mental Health Bill 1987 and referred to the Social Services Committee which heard public submissions. It was referred back to the House in amended form in November 1989 as the Mental Health (Compulsory Assessment and Treatment) Bill. On the defeat of the Labour Government in October 1990 the Bill was held over to the new Parliament. The Bill is discussed in this article in its amended, 1989 form, but is referred to as the Mental Health Bill for convenience.

patient who is fit to be discharged from hospital not also fit to be free of involuntary treatment and control? Should they not be entitled to decide for themselves on the out-patient regime? It is true that many discharged psychiatric patients do not remain in continuing care. For many reasons, including disagreement with the view that they are mentally disordered, distaste for medication, or the absence of services, many drop out of contact with professionals and discontinue treatment. In some cases their behaviour may deteriorate, causing concern to those around them. Some may again be hospitalised, perhaps via re-committal. These are the patients who pass through "the revolving door"; and these are the patients whom many view as "the casualties of deinstitutionalisation", as evidence of a major failing of the contemporary mental health system, lack of continuity of care.

Compulsory community treatment is seen as a way to break this cycle. It is seen as a means to provide continuing psychiatric treatment to a class of long-term mentally ill people, to prevent their health and behaviour deteriorating to the point where they become "dangerous" to themselves or others and again require hospital care. Because of its preventive focus, and because it permits patients to live outside hospitals, compulsory community care is seen as a "less restrictive alternative" to involuntary in-patient treatment. Its primary aims are to reduce the frequency of patients' "relapse" through continuing medication, to reduce "dangerousness", and to prevent committal to in-patient care. If it can achieve those aims, by providing treatment to those who will not receive it without "structure", it may involve less interference with liberty than the restrictions entailed in periodic in-patient care. In particular, placing a patient under a CTO may often be less restrictive than the sanctions applied if the patient falls foul of the criminal law.[3] It may also be true that some patients are "more free" with medication than without.

At its best, then, compulsory community treatment would be more respectful of some psychiatric patients' health *and* liberty, while also protecting society from *some* violent acts. Geller, an important commentator on out-patient commitment in the United States, writes[4]: "Involuntary out-patient treatment represents an effort to provide more suitable care and treatment for patients who, in the structure and workings of the present system, are either overconfined or undertreated."

Expanding the legal options will provide mental health professionals with a more flexible range of treatment alternatives and may assist them to develop a therapeutic alliance with an important group of patients with whom they would otherwise lack contact. CTOs could provide professionals with a clear legal framework within which they could carry out their work without any fear of legal action where the patient's consent is unclear. Such orders may also provide relief for patients' families. This may be of par-

3 Though no sentence under the Criminal Justice Act 1985 may authorise psychiatric treatment without the convicted person's consent: see ss 56, 148 of that Act.

4 J Geller, "Clinical guidelines for the use of involuntary out-patient commitment" (1990) 41 Hospital and Community Psychiatry 749, 754.

ticular assistance to women caring for aggressive men. Finally, there are hopes that the use of CTOs may reduce or prevent homelessness; and, not least, that the prevention of hospitalisation will reduce health care costs, when the price of psychiatric care is running at around $NZ100,000 per in-patient year.[5]

The Doubts

Beside these hopes must be set the risks, that CTOs will be ineffective or misused or will infringe other important values. The primary danger is that the introduction of CTOs will institutionalise the social control and monitoring in the community of that broad range of people who can plausibly be considered "mentally disordered", without the hoped-for therapeutic benefits ever being realised. They may not be realised because the services and social supports that could make the promise of community treatment a reality may simply not exist – due to cuts in health expenditure, due to failure to divert savings from hospital closures to the community and due to a lack of specific funding for this class of patients who are difficult and expensive to treat. Community mental health staff may also be resistant to accepting involuntary patients. They may be reluctant due to doubts about the efficacy of compulsory treatment and distaste for coercion of medication. They may be concerned that the judiciary will determine their caseloads without providing resources. Other factors are fear of these patients and fear of potential liability for their violence. A further difficulty is the inability to fit potential out-patients within the ruling "dangerousness" committal criteria[6]: how many patients will both meet this standard and be suitable candidates for community care? Other patients may be inappropriate candidates for the order in that they will not benefit from involuntary medication, which will be the primary, if not the exclusive, form of treatment offered.

In sum, there may be a striking gap between theory and practice. The outcome may be that CTOs are not employed as genuine alternatives to in-patient committal but as an additional system of control. The class of persons who may be subject to compulsory powers may be expanded. Outpatient treatment may be ordered as a compromise disposition where a person does not clearly meet the committal standard but is considered "too dangerous" or "too sick" to be granted an outright discharge. A process similar to plea bargaining may occur, with negotiation taking place between judges, families and hospital staff as to the place, duration and nature of community treatment, but without the involvement in the negotiations of the community mental health professionals who will be expected to pro-

5 This figure was quoted to the seminar, "Community Care Works", at Dunedin Hospital, November 1990, by Dr P McGeorge, Director of Psychiatric Services, Auckland Area Health Board.

6 The current draft of the Bill would permit an adult to be compulsory treated who suffers from "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": cl 2.

vide that treatment. Placement under a CTO may involve entry into a quasi-criminal status, permitting a person to be placed under surveillance and control, without the need to comply with the procedural and substantive safeguards of the criminal law, and with few therapeutic benefits for the individuals concerned.[7]

A further objection concerns the means of enforcement. It may be found that some patients will comply with the requirements of a CTO even without the threat of sanctions; but, in practice, the primary means of monitoring compliance with involuntary medication is the use of compulsory long-acting injections and mandatory blood tests. Other means of scrutinising aspects of the patient's life, such as their drinking behaviour and social contacts, may be adopted. This may so violate the privacy of the patient that the additional liberty supposedly associated with out-patient status will be illusory. Alternatively, if such intrusive means of enforcement are not adopted, there may be no way of knowing whether the patient is complying or not. It may therefore be no more effective than voluntary treatment and may as well be abandoned. In other words, monitoring compliance would be either overly intrusive or ineffective.

Another concern is the progressive privatisation of accommodation for discharged patients and the inadequate means available to monitor and enforce the quality of care. Under the implicit threat of transfer to in-patient status, involuntary patients may feel compelled to reside where directed. Lack of adequate alternative facilities is a further constraint on choice. A situation could develop in which patients under legal orders are effectively imprisoned in inadequate and largely unmonitored private sector environments.[8]

There is also the fear that the use of CTOs will perpetuate the aura of compulsion surrounding psychiatric services. This will extend to out-patient treatment. Abolition of compulsory community care, on the other hand, may help break down consumer distrust and encourage voluntary treatment. In the long run this may be more effective, and is certainly less coercive, than reliance on compulsion.

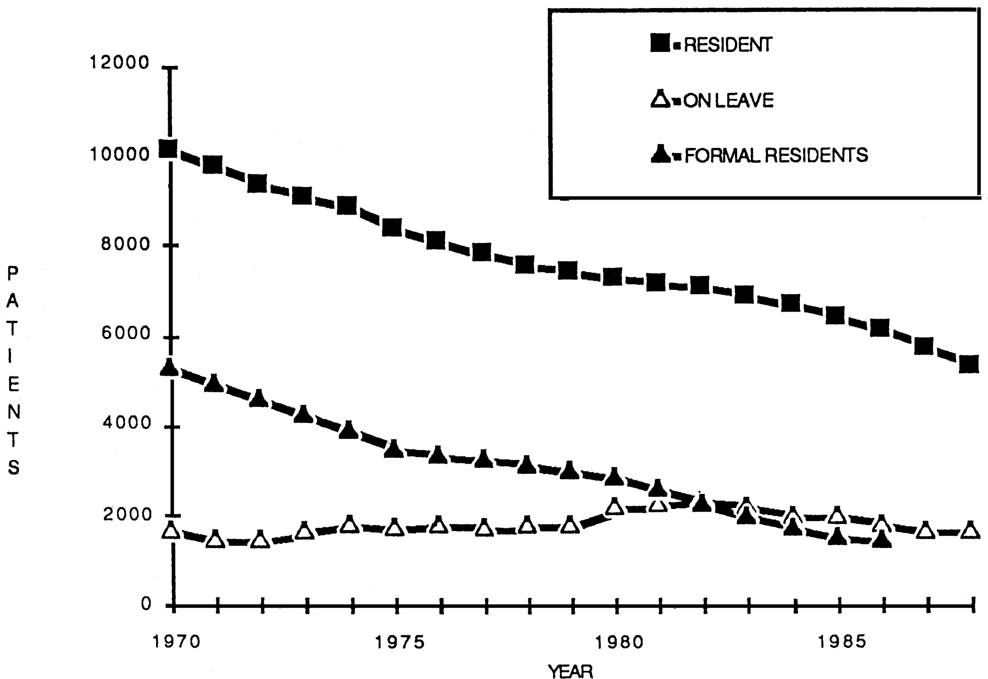
It is in a context of deregulation, privatisation and cuts to health budgets that we must assess these dangers in New Zealand.

7 Consider, by analogy, the use of Community Care Orders under the Criminal Justice Act 1985. These were hailed upon introduction as a humane alternative to imprisonment which would reduce inmate numbers. We now find prison musters hitting record levels and, in addition, nearly a thousand people a year placed under the sentence of community care. For this reason the Minister of Justice recently called the Act "a failure": "Act a failure, says Graham," *Otago Daily Times,* Dunedin, 23 February 1991.

8 Some monitoring procedures are established by law; see Health Act 1956, s120A, and Old People's Homes Regulations 1987; Disabled Persons Community Welfare Act 1975, Part II; Local Government Act 1974, s 639, Fifteenth Schedule. The value of these regimes as a means of preventing exploitation of the mentally disabled is questioned by J Kendrick, "The chronically disabled and the private sector" (1985) 2 Community Mental Health in New Zealand 57.

II *COMMUNITY CARE AND LAW REFORM*

One impetus for the reform of our mental health legislation is the desire to bring the law into line with psychiatric practice. The practice of community psychiatry bears increasingly little relation to the statute, which is unsatisfactory for both patients and professionals. The increasing significance of compulsory community care is illustrated by the following figure:[9]



The plotting of the data begins in 1970, the commencement date of the 1969 Act. In the subsequent two decades the number of residents in our psychiatric and intellectual handicap hospitals has roughly halved. The

9 The data are derived from the publications of the National Health Statistics Centre: ie, the annual publication *Mental Health Data* and the five-yearly census of hospital residents. The sets of data are not exactly comparable: *Mental Health Data* presents annually the average numbers of residents and patients on leave; the census presents every five years the legal status of those patients actually resident on a particular day. In some cases I have had to "fill in the dots" between census years, and the data is not up to date. Nevertheless, I believe the data presented is accurate enough to indicate clearly the increasing significance of compulsory community treatment to our psychiatric services and mental health law. On recent trends in psychiatric institutionalisation see New Zealand Planning Council, *Care and Control: the Role of Institutions in New Zealand* (1987), Wellington.

proportion of formal residents detained under some form of legal authority has declined even further. But the number of patients on leave (ie, committed and special patients granted conditional leave of absence but subject to recall) has remained relatively stable. It even increased for a while during the 1980s as the "deinstitutionalisation" process gathered momentum. At some moment in the mid-1980s the number of patients on leave came to exceed the number of formal patients detained in hospital. In simple numerical terms compulsory community treatment has now become the major function of the Mental Health Act. But that Act, based on an institutional model, provides a poor basis for compulsion in the community. Committed patients are ordered to be "detained" in "gazetted" psychiatric hospitals or licensed institutions, under "reception orders". Cadres of officials are appointed to monitor institutional conditions. Legal powers over patients repose in the superintendent of the institution or in hospital doctors. While services are increasingly provided in settings outside psychiatric hospitals the legislation is wedded to this institutional form.

So it is not surprising that the Act provides no adequate framework to govern community treatment. What it does provide, in section 66,[10] is a power to grant committed patients leave of absence from the hospital and a power to revoke that leave. This power has been creatively used, particularly in Auckland, in an attempt to adapt the existing legal regime to the new delivery of services. At present, there are about 1700 patients throughout the country in this position on any particular day. The main aims of leave in practice are to ensure that the patient continues to take medication outside hospital and to facilitate rapid readmission. Few procedural protections are guaranteed persons treated in this way. Leave may be granted on such conditions as hospital staff think fit. It may be granted for up to two years initially, then extended. The leave may be cancelled and the patient recalled (ie, redetained in hospital) at any time during the period of leave. If the patient fails to return they are deemed absent without leave and may be apprehended by any person and taken to any psychiatric hospital. The section does not require a formal hearing to be held as to the conditions of leave, nor concerning a patient's rehospitalisation. No criteria governing the recall decision are stated in the Act. The full pressure of a developing compulsory community treatment system must now be carried by this minimal and discretionary legal structure. It is not a pressure that section 66 was ever fitted to bear.

An Example of the Inadequacies of the Current Law: Leave vs Discharge

The difficulties in operating a compulsory community treatment system on the slim basis of section 66 become apparent when one examines the important issue of the committed patient's right to a full discharge "off the Act". The problem lies in the apparent contradiction in the Mental Health Act between the power of hospital staff to grant a committed patient leave from the hospital and their concurrent duty to discharge any such patient who is no longer in need of "detention". Section 66 permits

10 S 66 is closely modelled on the equivalent provision in the previous legislation: see the Mental Defectives Act 1911, s 80.

committed patients to be granted leave; but, in addition, sections 73(1) and (13) require that a committed patient on leave *shall be discharged* when the superintendent is of the opinion that "his *detention* as a mentally disordered person *is no longer necessary* either for his own good or in the public interest" (emphasis added). There is thus a mandatory duty to discharge in those circumstances. So, when can a committed patient be granted leave? When should they be fully discharged instead? When a decision is made, for example, that a committed patient is fit to be granted leave, has not a decision also been made, in effect, that their "detention" is no longer necessary? If their detention *was* necessary why would they be granted leave? At the very moment the patient departs on leave they should be discharged instead. But what room would remain for use of the leave provisions? To make room for them we have to take a broader view of what may constitute a need for detention.

We could read the phrase "in need of detention" to mean "requiring compulsory psychiatric treatment", *at whatever location.* Detention as a mentally disordered person would then be something different from "normal" detention. It would not mean only incarceration or confinement in a hospital or at some controlled location, but *could encompass any form of restraint on personal liberty necessary to administer psychiatric treatment without consent.* A person who would be likely to require in-patient treatment if they discontinued medication, and who would refuse it without legal compulsion, could be maintained indefinitely as a committed patient on leave. The institutional model could be abandoned and committal used as a form of compulsory community treatment order. It was along these lines that "detention" was defined operationally in Auckland in the mid-1980s. Judge Finnigan of the Auckland District Court, who frequently conducted committal hearings at Carrington Hospital during this period, wrote:[11]

> Detention is something different from the detention normally contemplated by Judges . . . broadly, 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.

Judge Finnigan expressed similar views in the reports of two inquiries he conducted under section 73. Discussing the justification for continued committal, the judge referred, in one case, to the need for "compulsory drug therapy and the related loss of liberty",[12] and in the other to "the necessity for the good of the patient that she be subject to continued compulsory medication".[13]

But there are several good legal reasons why this broad approach is un-

11 D Finnigan, "A judge's view of the civil committal process", in M Abbott and J Dawson eds, *The Future of Mental Health Services in New Zealand: Mental Health Law* (1985) Mental Health Foundation, Auckland, 27.

12 *In the Matter of an Inquiry under the Mental Health Act 1969* (1984) 2 DCR 303, 308. The judge also made some observations on the standard of proof required in committal proceedings, at 307; cf *In re JPS* (1984) 2 DCR 32.

13 *In the Matter of an Inquiry under the Mental Health Act 1969* (1984) 2 DCR 348, 352.

tenable. First, giving this wide meaning to the word "detention" is contrary to the accepted principle that we should give a narrow reading to all legislation affecting personal liberty.[14] That principle is now codified in section 6 of the New Zealand Bill of Rights Act 1990.[15] Second, the broad reading violates the plain meaning of the word "detention", which surely entails some form of physical constraint in a defined space, akin to imprisonment, incarceration or confinement. It would not ordinarily include the situation of a person living in their own home or in a place of their choice, free to move about the community, subject only to the requirement that they accept medication regardless of consent. A narrower reading of the word "detention" is also supported elsewhere in the statute where the word is often used in the phrase "detention *in a hospital*".[16]

There may be legitimate ways around this: eg, we may accept a *periodic* need for detention as an adequate justification for the maintenance of committed patient status, reasoning by analogue from the way in which "mental disorder" is defined in the Act, to include a disorder which is "continuous *or episodic*".[17] So the use of leave may be permissible where the patient has performed recent "dangerous" acts, suggesting a potential need for rapid recall to hospital; or where the patient has been detained in hospital for a long period, suggesting a need for a graduated form of discharge. But there is certainly no clear indication in the Act that the leave provisions may be adapted to use as a community treatment order in situations where in-patient hospitalisation is neither necessary nor imminent. Here, I suggest, the duty to discharge patients no longer in need of detention is the overriding consideration.

Nevertheless, there is little doubt that the broader approach has often been followed in practice.[18] To point this out is not to suggest that psychia-

14 As Woodhouse J said of our previous mental health legislation in *Mitchell* v *Allen* [1969] NZLR 110, 113: ". . . the statute itself contains the clearest evidence of an intention to ensure that there will be no peremptory or indiscriminate interference with personal freedom. Obviously it is of fundamental importance that whenever the Mental Health Act is invoked to detain a man against his will, a high degree of care must be exercised to see that the facts of the case are within the strict boundaries which the Act defines."

15 This states: "Wherever an enactment can be given a meaning that is consistent with the rights and freedoms contained in this Bill of Rights, that meaning shall be preferred to any other meaning." Relevant rights and freedoms include the right to refuse to undergo medical treatment (s 11), to freedom of movement and association (ss 17 and 18), to be secure against unreasonable seizure of the person (s 21), and the right not to be arbitrarily arrested or detained (s 22). Construing the Mental Health Act consistently with these rights would seem to require that the word "detention" be given a narrow construction and the duty to discharge a strong reading.

16 As in the definition of a "committed patient" in s 2, and in the criteria governing the making of a reception order in s 24. The word "hospital" is also defined narrowly to mean "a psychiatric hospital or licensed institution" only: s 2. Detention in a private house is itself the subject of the "single patient" provisions and it is reasonable to assume that where long-term detention in a home is contemplated these provisions should be employed: ss 38 and 39 and Second Schedule.

17 S 2 (emphasis added).

18 See eg, J Dawson, *The Process of Committal* (1987) Mental Health Foundation, Aucklavnd, 4, 125, 141-2, 149-150; and the comments of Dr Fraser McDonald quoted in J Dawson, "The development of community mental health services in New Zealand: implications for law reform" (1984) 1 Community Mental Health in New Zealand 12, 16-18.

trists are acting in bad faith, nor to deny that compulsory community treatment may be considered good clinical practice. But accepted practices followed in good faith may be unlawful when they are not within the scope of the authority provided by statute. Very similar issues were litigated in England in *R* v *Hallstrom*,[19] where two long-term psychiatric patients obtained a declaration that their compulsory community treatment was unlawful under a legal standard framed in terms of the need for patients to be "detained" to "receive medical treatment in a hospital". This was held to require a present need for in-patient treatment. Following this decision calls were made by both psychiatrists and legal commentators for the English legislation to be amended to permit this form of treatment.[20]

III CTOs and the Mental Health Bill

What, then, is required of an adequate legal structure for compulsory community psychiatric treatment? Primarily, the law must establish entry and exit criteria, fair procedures and an administrative infrastructure, with sufficient particularity to prevent arbitrary decisions.[21] The law must set the criteria for the selection of the CTO's subjects, by establishing the requisite degree of "mental disorder" and "dangerousness" or self-neglect necessary to justify intervention. It must specify the circumstances in which out-patient care is the appropriate option. It must also specify the decision-makers who have the authority to apply these criteria and declare the procedures to be followed. These would usually provide for compulsory assessment and medical certification; for the filing of reports; and for judicial or tribunal hearings to be held which respect the principles of natural justice. The consequences of the CTO for the patient and the powers granted to the professionals must be spelled out. The bodies responsible for providing patients with services must be designated. There must be procedures for transferring CTO patients to in-patient care. The means for orders to be renewed or reviewed should be provided. Finally, the law must specify the time periods within which all these forms of authority must be exercised or the patient discharged.

The provisions in the Mental Health Bill meet these basic requirements. The Bill structures the delivery of compulsory community treatment through the use of out-patient assessment[22] and Community Treatment

19 [1986] 2 All ER 306, QBD, McCullough J. An earlier round of this litigation resolved an important issue concerning committed patients' access to the courts. In *Ex parte Waldron* [1986] 1 QB 824 the Court of Appeal decided that the statutory limit on the right to bring "civil proceedings" concerning "any act purporting to be done in pursuance of" the Mental Health Act (which exists in substantially similar terms in the English and New Zealand legislation) does not cover an application for judicial review. There was therefore no need to apply to the High Court for permission to bring the application: cf Mental Health Act 1969, s 124.

20 See eg, D Brahams, "Treatment of uncooperative psychiatric patients in the community: Mental Health Act in need of reform" [1986] The Lancet 863.

21 The New Zealand Bill of Rights Act 1990, s 21, provides: "Everyone has the right not to be arbitrarily arrested or detained."

22 See, for example, cl 8.

Orders.[23] At each stage of a patient's assessment and treatment a priority is established in favour of out-patient status. A person could be assessed, compulsorily treated and maintained under a court order without ever being admitted to a hospital. But if out-patient status becomes untenable, the patient may be transferred to hospital without undue formality.[24] A more comprehensive legal structure is established than governs the current leave process.

In addition, however, the legal authority to grant leave from hospital remains.[25] This was not included in the original Bill but was reintroduced by the Social Services Committee. The duration of leave is to be limited to a maximum of six months; but otherwise the leave provision is re-enacted in more or less its present form with all its attendant problems. As a result, use of leave rather than a CTO is likely to be the preferred option for effecting a patient's conditional discharge for up to six months, if this provision remains. Parallel systems of compulsory community care could operate, under different forms of legal authority, one relatively structured, the other discretionary, with hospital staff being in a position to choose between the two. In my view, this situation should be reversed and the leave provisions again struck out.

Compulsory Admission and Assessment

The process of compulsory treatment under the Bill is divided into two stages: a period of assessment and treatment which lasts about a month; and longer-term treatment under a court order, which will have an initial life of six months.[26] At no point need a person be admitted as an in-patient. The Compulsory Assessment Interview, for example, may be conducted at any specified place, which could be the patient's home. The initial five days' treatment should only be in a hospital if it is considered that the patient cannot be dealt with as an out-patient. If the responsible doctor considers the patient can be adequately assessed and treated as an out-patient they should be transferred. This process may also be reversed. While the patient is undergoing out-patient assessment the responsible doctor may direct their admission to a specified hospital. In other words, once the initial criteria and the procedures governing compulsory treatment have been met, medical staff have the power to decide where it shall take place. This need not be in a hospital. When, at the end of the initial assessment period, a Compulsory Treatment Order is made by a District Court Judge, there is a choice between an In-patient Order and a Community Treatment Order. But medical staff may also later convert one type of order into the other. So a compulsory in-patient may be discharged into out-patient status for the remaining duration of the order (or they may be discharged on leave, which may be an easier option). Community status may also be revoked. If so, the order does not simply continue to run, but the

23 Cls 25 and 26.
24 See cls 8(4), 11(3), 26(3).
25 Cls 27A and 27B.
26 Cls 28 and 29.

patient re-enters the assessment process as an in-patient, as if they had just passed "Go".

The Criteria to be Met

There are a number of sequential criteria to be met before a CTO can be made. The Court must initially find that the patient is "mentally disordered".[27] It must then find, "having regard to all the circumstances of the case, it is *necessary* to make a compulsory treatment order".[28] It must next determine which type of order to make. Before deciding upon a CTO, the Court must satisfy itself on two further grounds, that the public health authority "provides through the institution or service named in the order care and treatment on an out-patient basis that is *appropriate* to the needs of the patient",[29] and that "the social circumstances of the patient are adequate for his or her care within the community".[30] If these criteria are met, the Court "*shall* make a community treatment order *unless* the Court considers that the patient cannot be treated adequately as an out-patient."[31] Further, the Court cannot make an in-patient order if the patient is, at the time, an out-patient. It can only order their re-assessment.[32]

It is notable that a clear priority is established in favour of community treatment, *if* the conditions are met. This is a big "if". Difficulties in meeting these conditions in fact may severely restrict the number of CTOs made; firstly, because of the poverty of out-patient and after-care services available in many parts of the country (the Bill is not a funding statute and will not ensure that one extra dollar is channelled to community mental health services); and secondly, because even if out-patient treatment and accommodation are available, they may not be "appropriate" or "adequate" for patients who must meet the criteria of dangerousness or self-neglect necessary to be subject to compulsory powers at all. Many, perhaps most, patients who meet those criteria would not be considered suitable candidates for community care. So, despite their apparent priority, CTOs may still be ordered in relatively few cases. It is also notable, in the present draft, that it is the public health authority that must provide the designated out-patient treatment. Perhaps it may provide this *through* a contract with a private sector provider, but this requirement appears to provide some limit on the total privatisation of compulsory community care. But the use of compulsory powers is no longer related to the institution of the psychiatric hospital. The concept of the gazetted hospital is abolished. In future compulsory patients may be assessed and treated at any specified place. The powers of the superintendent are to be assumed by regional health adminis-

27 Cl 24(1).
28 Cl 24(3), emphasis added.
29 Cl 25(4)(a), emphasis added. There is no further limitation in the Bill on the range of possible service providers: cf Mental Health Act 1990 (NSW), s 114, providing for service providers in this area to be gazetted as "health care agencies" as a means of controlling the quality of services offered. These services must be provided on the basis of a documented treatment plan.
30 Cl 25(4)(b).
31 Cl 25(2), emphasis added.
32 Cl 25(3).

trators. The jurisdiction of District Inspectors and Official Visitors will extend to compulsory patients wherever they are.

There is one other important criterion that probably should be met before a CTO is made that is not included in the Bill. There is no specific demand for clinical pre-assessment of the patient by the nominated programme's staff. This may result in patients being rapidly discharged or transferred back to in-patient care. As a result of such experiences, most out-patient commitment statutes in other jurisdictions require acceptance by the programme as a pre-condition of an order.[33] Some even require the filing in court of a written treatment plan. This kind of evidence should also be demanded by judges in New Zealand, whether or not it is specifically required by statute.

The Effects of a Community Treatment Order

The primary effects of a CTO are to require the patient to attend for and accept out-patient treatment and to receive visits from mental health professionals.[34] If patients refuse, they may be arrested and transported to clinics or hospitals. The powers conveyed to treat and visit are not unlimited. They are restricted in time by the duration of the order. They are also restricted in scope. The treatment must be provided and visits made by the employees of a specified institution or service. The visits must be "at reasonable times" and "for the purpose of treating the patient".[35]

Treatment provided without consent is further limited by Part IV of the Bill, which applies to all patients under orders. A patient may be treated with medication during the month of assessment and during the first month of a compulsory treatment order. Thereafter, if the patient does not consent, and an emergency does not exist, a second opinion approving the continued treatment must be obtained from another psychiatrist appointed by a Review Tribunal. This will occur approximately two months after the patient enters assessment. The use of electro-convulsive therapy (E.C.T.) without consent is also subject to a second opinion[36] and special limits are placed on psychosurgery.[37] These limitations will not satisfy those opposed to all forms of involuntary psychiatry. They do provide some restrictions on the long-term use of psychotropic drugs and other intrusive forms of treatment, and some check on idiosyncratic practice.

Any person who exercises *any power* under the Bill is required by clause 4A to do so:

> (a) With proper respect for the patient's cultural and ethnic identity, language, and religious or ethical beliefs; and
> (b) With proper recognition of the importance and significance to the patient of the patient's ties with his or her family, whanau, hapu, iwi, and family group, and the contribution those ties make to the patient's well-being.

33 Cf the Criminal Justice Act 1985, ss 52 and 54, requiring the consent of the offender, the agreement of the designated agency and the filing of a report before a convicted person can be sentenced to a programme of community care.

34 Cl 26.

35 Cl 26(2).

36 Cl 43.

37 Cl 43A.

This overriding requirement could also act to limit the effect of CTOs or to prevent their use entirely on patients from some ethnic groups. For example, the requirement that medical staff respect Maori spiritual beliefs could act as a further limit on treatment without consent; and consultation with a patient's whanau or family may, in future, be legally required in many situations.

Powers of Arrest

The Bill establishes two forms of authority for the arrest and rehospitalisation of a patient who is refusing to attend for treatment in accordance with a CTO. If the patient fails to attend, a warrant may be issued to the police for their arrest and transportation to the place of treatment.[38] A much simpler power is granted to a new cadre of statutory officials to be known as "duly authorised officers". They are to be appointed by all regional health authorities. Their primary functions will be to assist and liaise with patients' families and others involved in community care. They are granted specific powers in relation to patients who refuse to attend for compulsory assessment or treatment. In those circumstances they "may take all reasonable steps to take the patient to the place where the patient is required to attend for assessment or treatment, or . . . to return the patient to the hospital".[39] They may call to their assistance members of the Police who may enter any premises, by force if necessary, to detain the patient.[40]

Transfer to In-patient Treatment

If at any time during the currency of a CTO the responsible clinician considers that the patient *"cannot continue to be treated adequately as an out-patient"*,[41] the patient may be directed to re-enter the assessment process. If they fail to present themselves at the hospital they may be arrested. This puts considerable discretion in the hands of the treating clinician, who must decide when this transfer should occur. A revocation standard[42] is stated, which focuses on adequate treatment; but it is phrased in broad terms and provides little guidance as to the degree of deterioration in mental health a patient must exhibit before out-patient status may be revoked.

What if the issue is not really treatment at all? What if the patient has consistently complied with treatment but is nevertheless considered to now present an unacceptable risk to others? Would that be sufficient grounds

38 Cl 89(2).
39 Cl 31D.
40 Cl 31E.
41 Cl 26(3), emphasis added.
42 On the revocation to leave see *X* v *UK* (1981) 4 EHRR 188, where the recall to Broadmoor special hospital in England of a "restricted" patient was compared with the requirements of the European Convention on Human Rights. The New Zealand Bill of Rights Act 1990 now prohibits arbitrary detention (s 22), declares that all detained persons have rights to reasons, information and legal advice (s 23), and guarantees the right to be dealt with in accordance with the principles of natural justice. All these rights should now apply to the situation of a committed or special patient detained in hospital via revocation of leave, though they should not be applied so as to render the leave process "ineffective" (s 4).

for revocation on the basis that "dangerous" patients require closer observation than out-patient status permits? Or what if the opposite is the case – that the patient has never complied with treatment but has not yet suffered a deterioration in mental health? These are the difficult decisions clinicians face.

The Duration of Orders

A CTO will usually be made at the conclusion of the assessment period and will have an initial life of six months. Following a District Court hearing it may be extended for a further six months and the court may then make the order indefinite.[43] In addition, all patients under orders will have a right of appeal to Review Tribunals after three months of an order and thereafter at six monthly intervals. The High Court's powers of inquiry and discharge are also retained.[44] The responsible doctor is under an overriding obligation to discharge at any time a patient who is considered "fit to be released from compulsory status".[45] This means medical staff will not be bound by the duration of a court order. Patients whose condition changes or who are not considered suitable candidates for a CTO could be instantly discharged.

IV THE SUBJECTS OF COMMUNITY TREATMENT ORDERS

In recent years, compulsory community psychiatric treatment programmes have been introduced by statute in many other jurisdictions. For example, CTO regimes have recently been enacted in Victoria[46] and New South Wales.[47] In particular, the United States acts as a vast legal laboratory for the testing of this type of regime, known there as involuntary out-patient commitment. More than half the states provide for it, though the statutes vary. Three states in particular have acted as pioneers in the field – North Carolina, Arizona and Hawaii. In the last decade a literature has emerged which goes beyond legal analysis of CTO statutes[48] to identify the clinical indicators for its use in individual cases and to assess its outcome in comparison with other forms of disposition such as out-

43 Cl 29.

44 Cl 62. A patient on leave has also successfully challenged the lawfulness of her detention by writ of habeas corpus: see *R* v *Board of Control, ex p Rutty* [1956] 2 QB 109. On the scope of review by habeas corpus in mental health proceedings see R Sharpe, *The Law of Habeas Corpus* (2nd ed 1989) Ch 6; and B Hoggett, *Mental Health Law* (2nd ed 1984) 241-244. The right of all detained persons to challenge the validity of their detention by way of habeas corpus is now codified in the New Zealand Bill of Rights Act 1990, s 23(1)(c).

45 Cl 30(1).

46 Mental Health Act 1986 (Vic), s 14.

47 Mental Health Act 1990 (NSW), ss 114, 118-143. This Act also makes provision for Community Counselling Orders.

48 For such an analysis see I Keilitz and T Hall, "State statutes governing involuntary outpatient commitment" (1985) 9 Mental and Physical Disability Law Reporter 378.

right discharge.[49] If New Zealand is to adopt a similar legal regime we should try to learn from this experience.

The literature clearly indicates that the major barrier to CTO use is lack of funding for community services in an era of budgetary cuts and staff shortages. It also indicates that a CTO regime cannot work unless it can select those clientele for whom this form of treatment is clinically indicated. It is *not* suitable for patients who will not benefit from medication (or who are not refusing it in any case), for those who do not have enough social support, housing or money to survive safely outside hospital, nor for those who are actively "dangerous". It is not even a partial solution to the problem of homelessness as homeless people do not have the minimal social stability necessary to succeed in out-patient programmes.

This form of treatment is considered most appropriate for severely mentally ill individuals with a history of multiple admissions followed by failure to comply with voluntary out-patient treatment, who have a clearly identifiable disorder that responds well to medication. In a recent review of the literature Geller[50] develops sequential guidelines to help identify suitable subjects. The patients must be interested in living in the community but have previously failed in an attempt to do so. They must have the degree of competency necessary to understand the treatment proposed and the capacity to comply with it. The treatment must have demonstrated efficacy when used properly by this type of patient. The patient must not be "dangerous" when complying with the ordered treatment. Further, the out-patient system must be willing and able to deliver, monitor and enforce the treatment; and the in-patient and out-patient services must support each other, eg, by accepting the patient's readmission to hospital when necessary. When such criteria are met and community programmes are adequately funded and organised it is claimed that out-patient commitment can be successfully implemented in a significant proportion of cases.[51] The New South Wales Mental Health Act 1990 has more or less adopted the above clinical indicators as the actual legal criteria.[52] Section 133(2) of that Act requires, as conditions precedent to the making of a CTO, that the affected person has previously refused to accept appropriate treatment; that there has been a subsequent relapse into "an active phase of mental illness"; that this resulted in involuntary admission to hospital; and that the care and treatment there provided was beneficial on a previous occasion. The wisdom of writing such detailed clinical criteria into the legislation

49 See Geller, supra n 4; P Appelbaum, "Out-patient commitment: the problems and the promise" (1986) 143 American Journal of Psychiatry 1270; E Mulvey, J Geller and L Roth, "The promise and the peril of involuntary out-patient commitment" [1987] American Psychologist 571; R Wilk, "Involuntary out-patient commitment of the mentally ill" [1988] Social Work 133.

50 Supra n 4.

51 See J Geller, "Rights, wrongs and the dilemma of coerced community treatment" (1986) 143 American Journal of Psychiatry 259; V Hiday and T Scheid-Cook, "The North Carolina experience with out-patient commitment: a critical appraisal" (1987) 10 Int J Law and Psychiatry 215; R Van Putten, J Santiago and M Berren, "Involuntary out-patient commitment in Arizona: a retrospective study" (1988) 39 Hospital and Community Psychiatry 953.

52 See also *Report of Mental Health Steering Committee* (1988) Sydney.

may be debated. But even where the CTO provisions are drawn in more general language, as in our Bill, judges and other decision-makers may properly demand this kind of evidence in order to be satisfied that an order is "necessary" or "appropriate" to the needs of the particular patient.

V CONCLUSION

The movement in New Zealand over the last two decades from an institutional to a community treatment model in the delivery of compulsory psychiatric services has overrun its legislative base. The drafters of the Mental Health Bill have now chosen to bring the law into line with the practice of clinicians who consider compulsory out-patient treatment appropriate, via specific provision for Community Treatment Orders. This will establish a more adequate legal structure than exists in the current leave process.

But should we legitimise compulsory community psychiatric treatment at all? To be acceptable it must fulfil its promise of therapeutic benefits to patients without unnecessary erosion of their rights in the community. But what chance is there of community mental health services delivering in their current situation of congestion and underfunding? If there are no significant therapeutic benefits, we are simply left with coercion.

Compulsory community treatment may be extended to new classes of patients. It may be seized by judges as a "way out" in hard cases. It may become enmeshed in cultural conflict, be progressively privatised and periodically abused. It is certain to be distrusted by patients. Would it be wiser to establish a voluntary out-patient system to direct our limited treatment resources to those patients who are willing and most likely to benefit?

It seems probable, however, despite these doubts, that Community Treatment Orders will be provided for in the new legislation. In my view, this development should be viewed with more caution than enthusiasm. The use of CTOs should be limited to those few individuals for whom it is clearly clinically indicated and to those situations in which a quality community service will be provided.

We may well seek to address the real problems of social neglect and poverty facing psychiatric patients. It is unlikely that the answers will be found in compulsion alone. Court orders will not squeeze cash or compassion from a community that does not care.