# MADNESS AND THE LAW

*This thought-provoking article points to New Zealand's double standards of natural justice when dealing on the one hand with persons suspected of being mentally sick, and on the other, merely with convicted criminals.*

There must be something the matter with him
because he would not be acting as he does
unless there was
therefore he is acting as he is
because there is something the matter with him

He does not think there is anything the matter with him
because
one of the things that is
the matter with him
is that he does not think that there is anything
the matter with him
therefore
we have to help him realize that
the fact that he does not think there is anything
the matter with him
is one of the things that is
the matter with him

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## INTRODUCTION:

The law confronts deviance in two ways. Some deviants are characterised as criminal: others as insane.

We assume that the two processes are quite different. A person described as a criminal has committed an overt act which has been specifically prohibited. He is held responsible for his actions: he is morally culpable. Punishment for the transgression is seen as just and appropriate.

An insane person, however, is recognized in a different way. We cannot point to an overt act; rather we must form judgments about his state of mind by considering his behaviour. These judgments are difficult to make, so we need experts to make them. Hence doctors are involved in this legal process. The person is not held morally responsible, since his behaviour is regarded as the manifestation of sickness. This sickness is taken as sufficient justification for removing him from the community. Incarceration is described as "hospitalization", for the purpose of "care and treatment". The two processes appear quite different. The law affixes blame and punishment in the criminal process but appears concerned with sickness and cure in the insane process.

The effect of each process, however, is the same. The person is deprived of his liberty. His wishes and opinions become largely irrelevant, that is, the process is coercive. As we shall see, the law relating to the committment of the insane may be even more coercive than the criminal law: the mental patient relinquishes more legal rights and the period of incarceration is not certain.

One of the basic concerns of the English legal system is the protection of individual liberty. Hence, the necessity for procedures to minimize the chances of error in the situations where the law deliberately deprives a person of his liberty, has long been recognized. The elements of such a procedure have been elevated to philosophical expression as the principles of natural justice. Much statute and case law has sought to give them practical effect.

If the process whereby a person is found insane involves coercion and deprivation of liberty, despite the language of mental "illness" and "treatment", then the principles of natural justice should be given practical effect, as in the criminal law.

The questions to be explored, therefore, are:

(a) whether it is meaningful to talk of mental "illness". That is: how valid are the basic premises of the process, as expressed in the Mental Health Act 1969?

(b) if the Act amounts to a coercive process whereby people are deprived of their liberty, are there safeguards to ensure that this is not done in disregard of generally accepted jurisprudential principles? That is: does the Act comply with the requirements of natural justice? This will be determined partly by comparing the Act with certain safeguards built into the criminal law.

The law provides the mechanisms for social control, but to some extent, seeks to limit their use. This paper primarily seeks to illustrate that the "insane" process is such a form of social control, despite the metaphor in which it is couched. If this analysis of the functions of the process is correct, then no fundamental alteration of its structure can realistically be expected. However, we may be able to suggest some legal means to regulate its use.

## PART ONE: Premises of the Mental Health Act.

The basic premises of the Mental Health Act are:

(1) that a distinction can be made between sanity and insanity, and

(2) that insanity is an "illness". The Act assumes that states of mind can be assessed within a medical framework.

There is, however, considerable evidence available which suggests that these premises may not be valid. This part of the paper attempts to gather some of the evidence and arguments from the disciples of sociology and psychology, and explore their implications within the context of the Act.

(1) *The basic premise of the Act is that a distinction can be made between sanity and insanity.* This premise has been challenged by experiments which reveal that there is little agreement among psychiatrists as to when the condition of insanity exists.[1] The reliability, and meaning, of the psychiatric labels have become the subject of a great deal of controversy. The law can no longer assume that substantive meaning can be given to the vague definitions of "mental disorder" in the Mental Health Act. Rather, the evidence suggests that doctors would disagree among themselves about whether the person was insane, and about the precise nature of his ailment. An experiment which illustrated this was carried out by Ash, described in "The Reliability of Psychiatric Diagnosis" reported in The Journal of Abnormal and Social Psychology 1949 vol. 44.

52 males were the subjects for the study
35 were examined by 3 psychiatrists (in a group)
17 were examined by 2 psychiatrists (in a pair)

Ash measured their agreement in diagnoses, in respect of three categories of diagnoses: specific, major categories, and character of disorder. The results were as follows:

(a) *specific diagnosis:*

the groups of 3 psychiatrists were in total agreement in only 20% of cases
the groups of 3 psychiatrists were in total disagreement in only 31.4% of cases
the groups of 2 psychiatrists agreed between 31.4% - 43.5% of cases

(b) agreements with respect to *major categories:*

the groups of 2 agreed between 57.9% and 67.4% of cases.

Ash noted that there were extreme disagreements found within this category. In one pair, the following diagnoses were made about the same person:

One psychiatrist said he was psychopathic, of the "organic unstable type", while the other said he was neurotic, of the type "adjusted to low economic level".

In one-third of the groups involving 3 psychiatrists:

One found the person to have a serious disorder (psychosis, psychopathy or neurosis). Two found the same person within the normal range.

(c) *character of disorder*

the researchers created this very broad category to allow the diagnoses to be distinguished on a freer basis than the formal

1. For an analysis and summary of these disputes, see Zubin, G. in Annual Review of Psychology 1967, Vol. 18, Phillips and Dragnus in the same journal 1971 Vol. 22.

> categorization. However, even in these terms, the groups of 3 agreed in less than half the cases and no pair agreed in more than two-thirds of the cases.

These findings illustrate that the psychiatric labels are not applied with any degree of certainty.

The study has been followed by others: Mellman, B. and Scmidt, A. and Fondon, C. reported in the same journal: 1952 (47) and 1956 (52) respectively. These studies also illustrate that psychiatric categorization is not a reliable process.

The premise that a distinction between sanity and insanity can be made scientifically, by means of "experts" diagnosing a "condition" can thus be challenged. When and how the label of insanity is applied is not a matter of certainty. This can be further illustrated by challenging one of the basic assumptions involved in such psychological categorization: that the individual manifests certain symptoms which indicate his insanity. An experiment carried out by Professor D. L. Rosenhan, Professor Psychology and Law at Stanford University showed that such an assumption is invalid.[2]

Rosenhan argues that if sanity and insanity are indeed characteristics of the individual, which can be recognized without reference to the environment of the individual, then a sane person will always be distinguished from an insane context.

To test this assumption, and to challenge the notion that a distinction can be made between mental "health" and "illness" Rosenhan and seven other people gained secret admission to twelve different hospitals. As Rosenhan says . . . "if the sanity of the pseudo-patients were always detected, there would be prima facie evidence "that the distinction could be made. If they were not recognized as sane "serious difficulties would arise for those who support traditional modes of psychiatric diagnosis."[3]

To gain admission, the pseudo-patients stated that they had been hearing voices telling them that their lives were empty and hollow.[4] Apart from alleging these symptoms and falsifying names and occupations, no alterations were made in behaviour or personal histories.

Once admitted, the pseudo-patient behaved "normally". He engaged other patients in conversation, promptly obeyed requests and instructions, and responded to questions about his health with assurances that he felt fine and that the symptoms had completely disappeared. Each patient publicly took detailed notes about the other patients, the staff and the hospital.

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2. Described in "On Being Sane in an Insane Place", Science, (1971) 179.
3. Ibid, 251.
4. These symptoms were chosen for their apparent similarity to existential symptoms, since there is a complete absence of reports of existential psychoses.

None of the pseudo-patients were detected. They were discharged with the diagnosis "schizophrenia in remission" which indicates that once the psychiatric label is applied, it remains. "If the pseudo-patient was to be discharged, he must be in remission, but he was not sane, nor in the institution's view, had he ever been sane". There was no indication that the status of the pseudo-patient was ever suspect. The only "detection" of sanity was by the patients, and this was a frequent occurrence in all the hospitals.

Rosenhan attempts to explain why they were not recognized as sane. There was sufficient length of time, and the patients were behaving normally. He sees two main reasons: bias in diagnosis, and the "stickiness" of the psychiatric label.

The bias is towards what statisticians describe as the Type 2 error: that is, the physician is more inclined to call a healthy person sick than he is to call a sick person healthy. This caution may be acceptable in medical illness, but psychiatric diagnoses involve a great deal of personal, legal and social stigma. To see whether this tendency could be reversed, Rosenhan arranged another experiment. A research and teaching hospital which knew of the earlier experiment doubted that such errors could occur within its confines. The staff were accordingly informed that at some time over the next three months, one or more pseudo-patients would try to gain admission. All staff who had contact with or responsibility for the patient were asked to make judgments.

The results:

41 patients were alleged pseudo-patients by at least one staff member
23 were considered suspect by at least one psychiatrist
19 were suspected by at least one psychiatrist and one other staff member
No pseudo-patient had been presented.

The bias towards the type 2 error can thus be reversed when the stakes are high, but what of the 19 people suspected by at least one psychiatrist and one other staff member. Were they really sane or was it that the staff, in consciously avoiding the bias made more errors of the opposite sort by calling insane people sane? There will be no way of knowing, Rosenhan concludes . . . "The one thing that is certain: any diagnostic process that lends itself so readily to massive errors of this sort cannot be a very reliable one."[7]

These experiments, and others, illustrate the uncertainty in psychiatric diagnosis. We cannot assume that a doctor can make a diagnosis of insanity with any degree of certainty or meaning.

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5. Note 2, 252.
6. More thoroughly described in Scheff, *Being Mentally Ill*, Aldine Pub. Co. (1966) Ch. 4.
7. Note 2, 252.

To explore the implications of this conclusion within the process of the Mental Health Act it is necessary to consider:

(a) the shortcomings of psychiatric decision-making in this context

(b) the weight given to the medical decision within the legal process

(c) the "stickiness" of the label of insanity

(a) *The shortcomings of psychiatric decision-making* have already been noted: it can be doubted that the specific psychiatric labels have substantive meaning, and there is a great deal of uncertainty in their application. Further criticism can be made:

(1) the "type 2 error" is an undesirable bias in this area of decision-making.

Thomas Scheff, in his book *Being Mentally Ill*[8], discusses the Type 2 error. He notes that in law and medicine, practitioners are required to make decisions in areas of uncertainty. Norms develop for handling these decisions, based on the assumption that some errors are better avoided than others. These norms become "taken for granted".

The rule in law is that the error to be avoided is wrongful conviction. The norm is "if in doubt, acquit". It is implicit in the legal presumption of innocence, which is part of the whole institution of Law. The reason for this norm is that great, irreparable harm will be done to the individual if he is wrongfully convicted.

The rule in medicine is the opposite: it is better for a doctor to suspect sickness than to judge a sick person healthy. The norm is expressed and approved in countless ways: it is better for a doctor to "err on the side of caution". Such a bias is sensible in medicine, since no harm is done to the reputation or social status of the client.

This assumption cannot be made about one area of medical decision-making, psychiatry. A diagnosis of mental "illness" has profound and enduring effects on the status and whole life of the person concerned. The stigma is more comparable with that of a criminal than to medical patient. As Scheff says . . . "in making a medical diagnosis, the psychiatrist comes very close to making a legal decision, with its ensuing consequences for the person's reputation".[9]

Yet, as we have seen, the doctor will be biased towards presuming sickness: the very bias which is considered undesirable in the legal context. This decision, with its great legal consequences, is reached in the very opposite manner from that sanctioned in the practice of law.

Scheff gathered information which indicated that the decisions are made in the way he suggested. He took a sample of 116 judicial hearings for insanity. The psychiatrists questioned the person before the court, to determine whether he was insane. In 86 hearings, the

8. Note 6.
9. Note 6, 114.

psychiatrist failed to establish that the patients were mentally ill (by the criteria stated by the Judges in interviews). Indeed, 48 patients were quite unexceptional. Despite this, there was not one recommendation for release.

Mechanic, in "Some Factors in Identifying and Defining Mental Illness"[10] notes the same process. In the two mental hospitals studied over a period of three months, the investigator never observed a case where the patient was advised that he did not need treatment. All persons who appeared were absorbed into the patient population, regardless of their ability to function adequately outside the hospital. This suggests the medical "playing safe" rule predominates in psychiatric decision-making, even in a legal situation.

(2) Another criticism which can be levelled at psychiatric decision-making is that it frequently disregards context.

"Symptoms are considered to be psychological manifestations, regardless of the context in which they appear. In themselves, however, symptoms are neither normal nor abnormal; they derive significance only in the context in which they appear".[11]

Laing and Esterson[12] have illustrated that the so-called "psychotic" symptoms of schizophrenics are perfectly rational when interpreted in their family contexts. The symptoms are elements of rebellion against tyrannical or bizarre parents, that is: they are rational responses to crazy situations. Lemert[13] has documented the importance of small group organizations in the production of "symptoms". Psychological symptoms may, therefore, make sense in a social context. The medical model, however, "is based on a concept of physical rather than social events. This fractures the relationship between behaviour and social context, leading almost inevitably to a bias of seeing behaviour as meaningless".[14]

The conclusions we can draw about psychiatric decision-making are that the symptoms will be frequently interpreted as meaningless, since they are made within a medical context; and they will be taken as evidence of sickness, to be on the "safe side".

(b) *These conclusions are significant when one remembers the weight given to the medical opinion within the legal process.*

Under the Mental Health Act, the decision as to whether the person is sane or insane is effectively made by two doctors. The legal decision of insanity is based on the evidence provided by the doctors: it amounts to acceptance of their advice, and a sanction that certain further action can be taken.

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10. In *Mental Hygiene* 48, Jan. 1962, 66.
11. Coleman J. V., in an unpublished paper, quoted by Scheff n.6, 172.
12. In *Sanity, Madness and the Family*.
13. Lemert, E. M., "Paranoia and the Dynamics of Exclusion" in Sociometry, 1962.
14. Note 6, 174.

Research into court hearings in the U.S.A. indicate that they amount to speedy confirmations of the medical diagnosis. The following results were obtained by Wilde, Miller and Schwartz, and Wenger and Fletcher:[15].

Wilde found that 95.2% were committed
Millar and Schwartz that 68.0% were committed
Wenger and Fletcher that 80.3% were committed

Scheff found that in the rural court hearings, serious investigation and assessment were undertaken and that a greater attempt was made to allow the person before the court to rebut the accusation. The crucial factor in the rural setting seemed to be the greater amount of time available to the courts, and this factor may operate in most New Zealand courts to a greater extent than in the U.S.A.

However, we may conclude that the medical diagnosis is the most important element in the court hearings, and that once this has been provided, the legal decision will generally confirm it.

(c) *The "stickiness" of the psychiatric label:*

As we have seen, the medical adviser is more likely to confirm the notion that the person is sick than he is to refute it. The court is more likely to accept the medical diagnosis than to reject it. The mental hospitals, according to Rosenhan, do not challenge it. It appears that once a person has been defined as "mentally ill", all his subsequent behaviour is interpreted *as if* he is indeed insane. Rosenhan describes some of the ways in which this is done.

The personal histories of the pseudo-patients were generally unexceptional, yet were frequently distorted by the psychiatrist to achieve consistency with the theory of the dynamic of the disease.

The staff made the assumption that, since the patient was in the hospital, he must be "disturbed". Accordingly, all behaviour was interpreted as manifestations of the "illness". Behaviour was always related to the aberration within the individual and never to the social context: the staff never considered that their own behaviour or the structure of the hospital affected the patient.

The "catch 22" element is: patient can only get out of the hospital by convincing staff that he is sane, yet his behaviour will constantly be interpreted *as if* he is insane. Even if a patient is discharged, the

15. As described in Gove, W. "Societal Reaction as an Explanation of Mental Illness: an Evaluation" in American Sociological Review 1963 31. The studies were:
Wilde, W., "Decision making in a Psychiatric Screening Agency" and
Wenger and Fletcher, "The Effect of Legal Counsel on Admissions to a State Mental Hospital: a Confrontation of Professions". Both in Journal of Health and Social Behaviour, 1957, September.
Miller and Schwartz, "County Lunacy Hearings: Some Observations on committments to a State mental hospital" in Social Problems, Vol. 14, p.26.

expectation is that he will be insane again. Hence the pseudo-patients' discharge as schizophrenics *in remission.*

We have seen that the validity of the first basic premise is dubious. We can now explore the second premise:

**(2) that insanity is an "illness".**

To decide this, it is necessary to consider what the notion of "sickness" involves. We can then test the notion against the conclusions we have already reached.

"Illness" suggests the existence of some disease entity, located within the individual. It implies some impairment, a malfunctioning of the system traceable to a biological, chemical or physiological "cause", which can be cured. The malfunctioning can be detected by doctors, and hospitalization is required.

This description is undoubtedly true of some forms of brain disease and brain damage, which can be traced to neuro-physiological sources. However, it is not an adequate explanation of all the disorders we call mental illnesses. To justify this assertion, four factors will be considered:

(a) It has already been illustrated that any explanation which seeks to locate insanity entirely within the individual is inadequate; yet this is exactly what the medical model does.

(b) If the disorder were indeed traceable to some scientifically verifiable "cause", then the process of diagnosis would not be as open to error as we have seen it to be.

(c) If there was such an impairment, then the disorders could be "cured" by medical means. The evidence suggests that psychiatric "treatment" effects no long lasting changes in behaviour. The "disorder" may be ameliorated, or its symptoms modified, but it cannot be "cured". The research on the effects of psycho-surgery, drugs, cerebral electro-shock, and psychotherapy is exhaustively reviewed in a book edited by H. J. Eysenck, Professor of Psychiatry at the University of London.[16] We can briefly examine some of the conclusions.

Willet,[17] studying the effects of psycho-surgery concluded that the treatment had been based on a set of observations of dubious validity and on a tenuous rationale; that the best and most responsible studies have not established that specific procedures have resulted in clinical improvement. He describes the techniques as "inadequate".

Campbell,[18] after reviewing the available research on electro-shock, noted that there is still no adequate explanation

16. Eysenck, H. J. (ed), *Handbook of Abnormal Psychology.*
17. Willet, R., *The Effects of Psychosurgical Procedures on Behaviour.*
18. Campbell, D., *The Psychological Effects of Cerebral Electroshock.*

of its action. There are no reliable studies to demonstrate that it induces changes in personality. Campbell states . . . "it is, in fact, alarming for the reviewer to find the results so often quoted fading into insubstantiality".[19]

Trouton and Eysenck similarly found no evidence of a causal relationship between drug use and personality change — "few findings have achieved the status of facts".[20] The writers referred to a recent experiment in which two different drugs, and a "dummy" treatment were administered to 142 chronic psychotic in-patients. There were no significant differences between the three treatments.

Eysenck's conclusion on the effects of psychotherapy[21] was that when untreated neurotic control groups are compared with experimental groups of neurotic patients treated by means of psychotherapy, both groups recovered to approximately the same extent.

There is, therefore, no "cure" for mental "illness". There is no evidence that anything described as "psychiatric treatment" has a lasting beneficial effect.

(d) If mental disorder were solely a medical phenomenon, its detection would be an objective, scientific process. There is, however, much evidence to suggest that this is not so.

The history of insane asylums shows that to be mad in the eighteenth, and nineteenth centuries, it was sufficient to be poor, diseased or abandoned. This is illustrated by the regulations governing admission to the two Parisian asylums: the Bicetre, and the Salpietre, the "poor inhabitants of Paris, the lazy, those who used their parents badly, prostitutes, the blind, cripples, epileptics, paralytics and all incurables". Asylums have always been society's "dumping ground".

If incarceration still fulfills this function of social control, then we would expect the "mental health" process to be used primarily against the lower classes, and those who violate social and legal norms. If, however, it is a "medical" matter, no such bias will be apparent.

The relationship between incarceration and social class has been well documented. The "classic" study appears to be that carried out by Hollingshead and Redlich, in their book *Social Class and Mental Illness*. Their study was carried out in New Haven, U.S.A.

The researchers differentiated five classes on the basis of wealth, residence, occupation and education. They ranged from the business and professional elite of Class 1, to the unskilled and unemployed of Class 5, whose existence is largely a struggle for survival.

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19. Ibid., 623.
20. Trouton, D. and Eysenck H., *The Effects of Drugs on Behaviour*, p.683.
21. Eysenck, H., *The Effects of Psychotherapy*.

The following four factors were then considered:

(a) how the person came to the attention of a psychiatrist:

The study revealed that this is largely determined by class status. Members of Classes 1 and 2 were induced to see psychiatrists in gentle and "insightful" ways. Class 4 and especially Class 5 people were subjected to "direct, authoritative, compulsory and, at times, coercively brutal methods".[22] The Police, courts and other non-medical agencies were much more frequently used in this group.

(b) incidence of mental illness:

The incidence rate per 100,000 population, was by class:

| | |
|---|---|
| Class 1 and 2 | 97 |
| Class 3 | 114 |
| Class 4 | 89 |
| Class 5 | 139 |

The rates for Class 5 were also higher for re-entry and continuous treatment.

(c) type of mental illness:

In Classes 1 and 2, 65% were diagnosed as neurotic

In Class 5, 90% were diagnosed as psychotic

The lower classes, therefore, are seen as suffering the more severe and dangerous mental disorders.

(d) type of treatment:

If the person belonged to a higher class, he or she was more likely to receive private care. The Class 4 and 5 people were mostly in state asylums. The lower classes were more likely to receive shock treatment, lobotomies, and drug treatment than individual psychotherapy. These treatments are unpleasant for the recipient, and as we have seen, they have little effect.

Mental illness is, therefore, "discovered" more frequently in the lower classes. It appears that asylums remain the preserve of the powerless. This is further illustrated by the over-representation of women in mental hospitals.[23]

Historical and contemporary evidence suggests the process is one of social control. The diagnosis of insanity is a statement about the person's social performance, rather than about his biochemical or physiological functioning. Commitment is a political act requiring power and coercion. It functions to remove "undesirables" from society, not to cure illness.

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22. At p.192.
23. Well documented by Levine, S. V., Kamin, L. E. and Levine, E. L. "Sexism and Psychiatry", American Journal of Orthopsychiatry, 1974, Vol. 44.

**Conclusion to Part One:**

By considering some of the evidence available in psychology and sociology, we can see that the premises of the Mental Health Act are of dubious validity.

The notion of an objective medical process is impossible to sustain. It is only by recognizing the process as one of social control that it makes sense. The Mental Health Act, is an efficient means of protecting the existing social and political order.

## PART TWO: The Act and Natural Justice

We have seen that the "therapeutic" process is as much a form of social control as the "criminal" process. The law, therefore, should provide safeguards in both processes, to prevent wrongful deprivation of liberty.

By comparing various provisions of the Mental Health Act with the safeguards built into the criminal law, it can be seen that the Act barely fulfils requirements of natural justice.

The following aspects of the Mental Health Act will be considered:

(1) the definitions; what is it to be mentally ill?
(2) the mechanisms for beginning the legal process
(3) the rationale for incarceration
(4) the Court hearing
(5) appeal provisions
(6) conditions relating to hospitalization.

### (1) Definitions:

The basic task of the Court is to determine whether the person before it, is mentally disordered. This is defined in s.2: "mentally disordered . . . means suffering from a psychiatric or other disorder, whether continuous or episodic, that substantially impairs mental health, so that the person belongs to one of the following classes . . .

(a) mentally ill — that is, requiring care and treatment for a mental illness
(b) mentally infirm — that is, requiring care and treatment by reason of mental infirmity arising from age or deterioration of or injury to the brain
(c) mentally subnormal — that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of mind.

What kind of a decision can be made within this framework? Being mentally disordered amounts to having substantially impaired mental health. There is (and can be) no description of mental health.

We cannot say what it is but we treat people for not having it. The disorder can be psychiatric "or other", and may occur all the time or hardly ever. On this basis the Magistrate proceeds to decide what kind of disorder the person before him is suffering: illness, infirmity or subnormality.

These definitions are tautologies, since they seek to define the condition — by reference only to that condition. They can be given substantive meaning only by "experts", who are presumed to know what this condition is, and to be able to recognize it. Doctors provide the substance of telling the Court when to apply the definition.

The definitions by themselves convey no information about the inherent properties and characteristics of mental illness, but they do tell us what is going to be done about it: a mental illness is a condition requiring "care and treatment". Thus, when a Magistrate finds that the person before him is "mentally disordered", he is confirming that a certain course of action can be taken.

This can be contrasted with the codified definitions of criminal offences. These definitions do contain information about the offence, they do not need to be given substance by "experts", nor do they merely indicate the course of action which is to be taken. Rather, they seek carefully to describe the physical and mental components of the crime: to state in precise terms what the crime is, and how it can be recognised. Thus, the prosecutor must establish that the defendant committed each physical element of the crime (that is, the actus reus), with the legally culpable state of mind (that is: mens rea). Actus reus is empirically verifiable, and mens rea is usually a matter of clear inference therefrom.

The only element of certainty in a finding of insanity is that a coercive course of action will follow. The state of mind of insanity is not clearly verifiable.

### (2) The mechanism for initiating the process

Section 19 allows anyone over the age of 21 to request that the person alleged to be mentally disordered be "received" into a mental hospital.

The superintendent has very wide discretion. He can request a "reception order" in respect of a voluntary patient and detain him against his wishes while the application is being considered. Powers of apprehension are conferred on the superintendent and on medical officers of health and every member of the police in certain circumstances (ss.16-35).

Section 19 deals with ordinary admissions. The superintendent can "receive" the person into the hospital, and hold him there while the "reception order" is being considered by the Court. The superintendent has the further discretion of being able to give the person "care

and treatment" during this period. Thus the person may be subjected to electric shock treatment or given drugs, against his will, before he has had a chance to convince the court that he has no need or desire for such "treatment". Such treatment would seriously lessen his ability to present a coherent case to the court: electroshock leaves the patient confused and forgetful, and sedative drugs hardly facilitate the kind of logical thought required in a court context. This is in direct conflict with the principle that a person is innocent until he is proven guilty. If a person can be hospitalized and treated against his wishes, then the assumption of insanity has clearly been made, and the evidence indicates that all subsequent behaviour will be interpreted as if this is true. The person is put in a "no win" situation. The criminal law is quite clear on this point: when remand is seen as necessary it can only be used to further the inquiry: it cannot be for the purpose of indirect punishment.

The minimal legal safeguard here would be to give the patient the option of refusing treatment in this period.

Part IV of the Act deals with "special patients". Section 42 refers to the following:

(a) a person detained in a prison "pursuant to any sentence, conviction or order of committal or detention"

(b) a person detained in an institution "within the meaning of the Alcoholism and Drug Addiction Act"

(c) a person detained in a mental hospital after criminal conviction and pending sentence

Once more: wide discretion is conferred on the administrative heads of these institutions. The superintendent can apply for a reception order in respect of any of the above persons. If a person is in a penal institution pending trial, a temporary reception order may be requested. (Such an order does not prevent his being brought before the court for criminal trial).

Under the Criminal Justice Act, a person before the court on a criminal charge can be channelled into the "mental health" process in three ways.

(a) the court can order that a person acquitted of a criminal charge shall be detained as a security patient, or it may make a regular committal order. Such arbitary power seems contrary to the legal notions of rule by law.

(b) the court may order the accused "remanded for observation". This usually occurs before conviction, frequently when the accused is not represented by a lawyer, and without medical evidence being presented to the court. This remand can be for a longer period than the ordinary criminal remand.

(c) those who are found unfit to plead may be held as security patients.

The important points to be noted about these provisions are:

(a) they provide a coercive machinery in which the wishes, values and opinions of the person undergoing the process are quite irrelevant

(b) considerable discretion is conferred on the superintendent before the person even comes before a court. The effects of treatment may reduce the court hearing to a mere formality

(c) the provisions facilitating the transfer of people from the criminal process to the "mental health" process clearly indicate the "mad-bad" link. Such a link is explicable if both are recognized as forms of social control.

These provisions are characterized by coercion and discretion. Considering the importance of the decision in the lives of those concerned, these are not desirable features.

(3) **The rationale for incarceration.**

Section 19 allows a person to be "received" into a mental hospital before a reception order has been approved by the court. The circumstances in which such action is appropriate are . . . "where it is expedient" . . . in the "interests of the welfare of that person or . . . in the public interest".

It is doubtful whether there is any difference between the criteria. The person concerned is not consulted. His "welfare" is determined by reference to what everyone else thinks is best for him (and them). Thus, the former is determined by the latter. The criterion "in the interests of the welfare of that person" reflects medical paternalism. It is not any legal guarantee that the person will be meaningfully consulted.

Section 22 illustrates the basic assumption that being mad is, *in itself*, enough to justify incarceration. The medical practictioners must be of the opinion that the person is mentally disordered, "and requires detention as such". This entirely ignores the possibility of community care.

Section 35 deals with "special powers in certain cases". It enables every medical officer of health, and every member of the police to apprehend the person, if he has reasonable cause to believe that:

(a) the person is mentally disordered, and

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

He then may, if it appears expedient, for the person's good or in the public interest . . . make application for reception.

The same power is conferred on the superintendent of mental

hospitals. Two of the justifications are concerned with the way the person is being treated. Such reasons do not necessarily justify incarceration: if they did, we would have a bizarre notion of social welfare. Anyone not being "well treated" would be locked up. The criterion "acts in a manner offensive to public decency" substantiates the accusation that "mentally disordered" behaviour is frequently no more than socially unacceptable behaviour. The remaining test "is suicidal or dangerous", seems the only valid justification. It should be noted, however, that the proportion of dangerous mental patients is lower than in the population generally, despite the popular conception of "maniacs". It is also doubtful that incarceration would alleviate the gloom of the potential suicide; it would merely reduce his opportunities.

It is useful to consider the appeal provisions in this context, to determine whether similar reasons are used to consider whether further detention is required.

Under s.73 the task of the Magistrate is simply to determine whether the person is "fit to be discharged". By s.74, a Judge of the Supreme Court can, in determining whether the state of mind of the person required further detention, consider the fact that a friend or relative of the person is willing to take care of him. That is: the state of mind of the person is determined by reference to the entirely pragmatic matter of whether someone is willing to look after him. Presumably if there is no such person, the patient's "state of mind" requires further hospitalization.

### (4) The Court hearing

Basically this involves a Magistrate and two medical practitioners. The Magistrate can summon such witnesses as he thinks fit to give evidence "touching the mental condition of the said person". If, after receiving two medical certificates to the effect that the person is mentally disordered and hearing the evidence he considers to be relevant, the Magistrate is satisfied that the person is mentally disordered, he can authorize his detention.

The shortcomings of this procedure:

(a) the only clear formulation of the reason why the person is before the court is contained in the medical certificates. Section 31 requires the doctor to state any facts indicating mental disorder which he has observed or which have been communicated to him.

However, the doctor will rarely observe the patient in his normal social context over any length of time. Any strange behaviour will accordingly be interpreted as evidence of insanity. The doctor will have to rely to a great extent on the observations made by the family, yet, as Laing has demonstrated, the family is frequently the source of the trouble.

As we have seen, any attempt to assess behaviour entirely in medical terms is inadequate. The diagnostic process is open to massive error. A doctor tends to find sickness rather than health.

For these reasons it is undesirable that the only evidence presented to the court is in medical certificates. The social context of behaviour should be considered — perhaps provision should be made for evidence to be given by friends and fellow workers.

(b) it is possible, under ss.22 and 23, for the Magistrate to adjourn the case if one medical practitioner is not of the opinion that the person is mentally disordered.

The person can be detained for an aggregate of two months, then a different doctor can provide the required diagnosis of mental disorder. The Magistrate may authorize "treatment" during this period of adjournment, against the will of the person concerned. Both possibilities are legally appalling: protection for the person accused of insanity is virtually non-existent.

(c) the person will hardly be capable of rationally presenting his case to a court. This fact presumably renders skilled assistance necessary, yet there is no provision to ensure that he receives such help. A more desirable arrangement would be to include the right to legal representation in the Act, and extend the Duty Solicitor scheme to cover these cases.

(d) the person has no right to call his own witnesses and challenge the evidence against him. There are no procedural opportunities for the potential patient to rebut the diagnosis.

The procedure does not comply with the principles of natural justice: the right to answer one's accusers is a basic legal right. The Act should protect such a right and allow the person to call his own medical and social evidence.

This can be contrasted with the procedural safeguards provided by the Summary Proceedings Act 1957. This Act deals with the way in which a criminal accusation is made and resolved. Trial for an indictable offence proceeds as follows:

— in the preliminary hearing for an indictable offence, the accused must be present, the charge must be read to him, and he has a chance to call witnesses and challenge evidence against him. If the evidence is insufficient to put him on trial, he must be released.

— if the accused is put on trial, he is again informed of the charge against him, and can call witnesses and give evidence to support his case. The onus is on the prosecution to prove "beyond reasonable doubt", that the accused committed the criminal offence. Only when this burden of proof has been discharged, is the accused considered guilty. Various rules of evidence provide further safeguards.

### (5) Appeal Provisions:

The relevant provisions are ss.73 and 74.

Section 73 provides a complicated procedure whereby the appeal is made to the Minister of Health for the holding of an appeal by a Magistrate. Since the Minister makes his decision on the basis of advice from the superintendent, prompt administrative support for the appeal is unlikely.

By s.74 appeals may be conducted by a Judge. Access to the Supreme Court is not hampered as it is in s.73. The Judge can consider whether the patient is mentally disordered, or whether he no longer requires detention, as can the Magistrate. However, the Judge can also consider the possibility of illegal detention. In determining whether the patient is mentally disordered, he can take practical living arrangements into account.

These appeal procedures are complicated, involving different criteria and different personnel to make the same decision. There is no guarantee that the patient will be told of these rights, for what they are worth. There are further anomalies in the appeal procedures for those "patients" channelled through from the Criminal Justice System.[24]

These provisions can be contrasted with the relatively straight forward appeal provisions in the Crimes Act. The superintendent of a penal institution certainly plays no role in the proceedings comparable with his counterpart in a mental hospital. By providing the "information" upon which the Minister makes his decision, the superintendent largely determines whether there will be an appeal. Since, in a sense he is a party involved in the appeal, it seems contrary to the notion of impartiality to allow him such power. The grounds for appeal are not clearly formulated, as in the criminal process, and the onus essentially remains upon the "patient" to prove that he is sane.

### (6) Conditions of Hospitalization

Sections 62 and 63 allow the superintendent to open in-going and out-going mail. Various nonsensical reasons are given to justify this invasion of privacy. The illusion of "fair play" is maintained by s.63 (1) which states that every letter addressed to a member of Parliament or to a Judge of the Supreme Court, or to the Ombudsman or to the Director of the Division of Mental Health or to an inspector or official visitor shall be immediately forwarded unopened. One can note that a patient would probably see privacy of personal communications as more important than legal guarantees of privacy in his

24. A person acquitted of the criminal charge and detained as a special patient has no right of review. A person found unfit to plead is subject to the judge review procedure but not the Magistrate/Minister procedure. The person remanded for observation has the opposite choice.

communications with officials. The provisions are rather useless in so far as they presuppose a political sophistication and sense of efficacy on the part of the patient which is unlikely in the circumstances. The irony is that if he is politically realistic he will know that such a letter to an official would do him little good.

The provisions concerning the "cost of maintenance in psychiatric hospitals" ensure that the patient will never be in a financial position to view leaving the security of the hospital with equanimity. Any likely source of income is made available to the Director. He can determine an amount payable in "partial defrayment of the cost of care, treatment and maintenance" of the patient. If the patient has no income, the cost is a debt due to the Crown for which the following people are jointly and severally liable: the patient, the spouse of the patient, the parents if the patient is under 21 years old. There is no comparable provision for prison inmates. The patient loses the right to vote, to marry, to drive a car and to administer his own property. The prison inmate only loses the first of these rights. There are other aspects of hospitalization which are personally degrading and which make the patient less able to cope with the real world again. The Act, while purportedly concerned with cure, allows the basic sense of privacy and of financial security of the patient to be assaulted.

## PART THREE: Conclusions

Part two attempts to highlight the anomalies and undesirable features of the Mental Health Act, and to indicate where safeguards are necessary.

In recent years in the U.S.A. there has been considerable attention paid to mental health law.[25] "Class actions" on behalf of the mentally disordered have been most effective in bringing about improvements in the physical facilities and treatment services of institutions.

The debilitative effects of long term institutionalization have been recognized, and statutory changes have sought to provide for shorter hospital stays, community alternatives to institutionalization, and legal protection of patients' rights.

Most of the new statutes have substantially limited the use of involuntary commitment. Community health centres have been established throughout the country. The "halfway house" and community residence have been recognized in some states as viable alternatives to hospitalization. State hospitals may change into "crisis orientated facilities" for acutely disturbed people.

Patients' rights have been given explicit statutory recognition in many states. The following rights have been included: to communicate

25. McGarry, A. L., and Kaplan, H. A.
"Overview: Current Trends in Mental Health Law", American Journal of Psychiatry, June 1973.

with persons outside the facility, to keep clothing and personal effects, to be employed if possible, to administer property, to have testamentary capacity, to make contracts, to education, to habeas corpus, to independent psychiatric examination, to retain driving licences, to marry and not to be subject to unnecessary mechanical restraint. Incompetency in exercising these rights must be specifically judically determined.

The right to legal representation in commitment hearings and mechanisms for review and for explanations of legal rights have been included in a number of new statutes. As McGarry and Kaplan state . . . "Legal representation of patients' rights and interests indicates a fundamental change in attitudes towards the mentally disabled: no longer is the mental patient passively subject to the legal, economic and personal consequences of his illness . . . he may, with legal assistance if necessary, affirmatively and actively continue to control his own life".

The mentally disabled in New Zealand are legally neglected. There are inadequate safeguards prior to, and during the commitment procedure. The appeal provisions are unwieldy and anomalous. Patients' rights after commitment are ignored. Statutory change is needed which

(a) considers psychological and sociological factors, and

(b) provides adequate and enlightened protection for this large group of people. After all — twice as many New Zealanders lose their liberty by being involuntarily committed to mental hospitals than by being sentenced to prison.[26]

It's worth thinking about — there is a one in eight chance that you will be a mental patient at some state of your lifetime.[27]

NANCY ELLEN DOLAN

26. There were 5140 committed mental patients in 1971 — Census of Mental Hospital Patients 1971 issued by the Department of Health, Wellington. There were 2519 prisoners at the beginning of 1973 — Annual Report of Justice Department 1973.
27. The chances for a female are one in seven.