The rights of mentally disordered children in New Zealand

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This paper is an edited version of that presented by Diane Sleek at the conference on "The Rights of the Child and Law" held at the University of Canterbury in November 1979 under the sponsorship of the New Zealand Human Rights Commission. It is concerned with procedures for institutionalizing children with mental health problems and with governmental provisions for alternatives to institutional care.

In New Zealand, it is the Mental Health Act 1969 that basically governs the admission of persons into government administered psychiatric hospitals. On the surface, the Act seems to provide for three types of admission. First, there is the admission of those persons (special patients) whose need for hospitalization comes to light when they enter the criminal justice system, with the vast majority of such persons being admitted into hospital under court order.[1] There is also provision for the admission of those persons (committed patients) whom a Magistrate finds to be mentally disordered and in need of court-ordered hospitalization for their own good or in the public interest.[2] Finally, the Act provides for the admission of those persons (informal patients) who arrange for or consent to their own hospitalization.[3] Ignoring special patients, because they constitute

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1 Mental Health Act 1969, ss.42 and 43. Section 43 provides for the hospitalization of special patients with their consent rather than under court order, but it is rarely used. Other provisions for the court-ordered hospitalization of those persons caught up in the criminal justice system can be found in the Criminal Justice Act 1954, ss.39B, 39G, 39J, 47A and the Summary Proceedings Act 1957, s.171(3).

2 Mental Health Act, s.24. The Act also provides for the involuntary admission of such persons without a court order if it is considered expedient to so admit them before a court order can be obtained: s.19. However, a court order must then be sought within 21 days after such an admission: s.20.

3 Section 15:

> Treatment of outpatients and admission of informal patients — (1) The superintendent of a hospital may in his discretion, pursuant to any arrangements made with him in respect of any person who in his opinion would benefit from

only a minor proportion of patients[4] and because their admission is complicated by their criminal status, it would appear from the Act that no person could be admitted to a psychiatric hospital unless he consents or is ordered to be admitted after a judicial process of civil commitment.

There exists, however, a large group of persons whose hospitalization is based neither on their consent nor on a judicial assessment of their need for psychiatric care. This group consists of those children (persons under 20 years old) whose hospitalization is based on their guardians' arrangements with the hospital.[5] It is hard to say just how many such children there are, but in 1976 559 persons under 15 years old were admitted, either for the first or a subsequent time, to a psychiatric hospital and all but 7 of these were admitted pursuant to guardian arrangements.[6] Such children are classified as informal patients, but they could not have arranged for their own hospitalization. A person must be at least 16

> psychiatric care and treatment, whether or not he is mentally disordered within the meaning of this Act, —
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> . . . .
>
> (b) Admit him to the hospital for treatment without any reception order or request that would render him liable to be detained under this Act;

Although this section is quite vague and makes no mention of the consent of the person to be admitted, it provides only for a kind of admission that does not render the person admitted legally liable to be detained under the Mental Health Act 1969 for such detention. Also, it is a basic principle of our legal system that adults, at least, cannot be detained against their will unless certain legal procedures aimed at obtaining a court order are followed.

4 In 1974, for example, only 4.8% of all admissions were of special patients. National Health Statistics Centre of the Department of Health, *Mental Health Data 1974* (Wellington, 1976) 12. Moreover, of the 8,454 patients resident in psychiatric hospitals at the time of the 1976 census, only 2.3% were special patients. National Health Statistics Centre of the Department of Health, *Survey of Occupied Psychiatric Hospital Beds and Psychiatric Day and Outpatients, 1976* (Wellington, 1979) 15 (referred to in this paper as *Survey*).

5 The widespread use of this fourth type of admission has been confirmed in an interview with Dr. S. W. P. Mirams, Director of the Division of Mental Health, Department of Health, July 1979. The source of legal authority for this type of admission is not clear. Although earlier versions of the Mental Health Act 1969 specifically provided for guardian admissions, the present Act does not. See Mental Health Act 1911, ss.24-26, Mental Health Amendment Act 1961, ss.9-11. Conceivably, s.15 of the present Act allows for such admissions within its vague terms, and, presumably the reference to the person not being legally liable to be detained means that his guardian (not the child himself) has the right of discharge. Also, the authority for these admissions could be contained in the Guardianship Act 1968. Under that Act, children are generally subject to the control of their guardians (usually parents) until they reach 20 years of age: ss.3, 6, 21. Included within this control could be the right to hospitalize children needing psychiatric care, regardless of their wishes. The Act provides for the judicial review of guardian decisions in regard to children 16 years of age and over (s.14), but it is doubtful if any hospitalization decisions have been so reviewed.

6 Taken from statistics specially supplied by the National Health Statistics Centre of the Department of Health, June 8, 1979. (Referred to in this paper as *Special Statistics*.)

years old before he can arrange for hospitalization independently of his guardians.[7] Though it is possible some of these children were placed in hospital quite willingly, whether such argeement could be given freely and with understanding is open to question.[8] Moreover, the real point is that their agreement is not even legally necessary.[9] In addition, 755 persons between 15 and 19 years of age were admitted into psychiatric hospitals in 1976 as informal patients.[10] There is no way of knowing how many of these persons admitted themselves, but it seems likely that some did not. Of those that did, it may have been more a matter of "agreeing" with a decision already made by guardians rather than coming to an independent decision.[11] But again, the point is that their consent is not even needed.

Under the Mental Health Act 1969, informal patients need not even be mentally disordered;[12] they need only to be able to benefit from psychiatric care.[13] Nevertheless, over 99% of those resident in psychiatric hospitals in 1976 received a psychiatric diagnosis.[14] Of those residents who were under 15 years old (816 persons), nearly 95% (774) were diagnosed as mentally retarded (mentally subnormal), and of those between 15 and 19 years old (700) over 81% (569) received the same diagnosis.[15] Virtually all the rest were diagnosed as having some form of mental illness.[16] Since there is no reason to suppose 1976 was not a typical year, it is probably safe to assume that by far most of the children now living in psychiatric hospitals, as well as most of those under 15 years old being admitted into such care every year, are mentally subnormal children

7 Mental Health Act 1969 s.15(2). Although s.18A of the Mental Health Act 1969 (as added by the Mental Health Amendment Act 1972, s.3) says that s.15 of the Act does not limit the discretion of hospital boards to informally admit persons to psychiatric hospitals administered by them, it is highly doubtful if they could admit children under 16 years old without guardian consent as under the Guardianship Act 1968 the right of custody of children is vested in their guardians, who are usually their parents, unless a court orders otherwise. See ss.3, 6, 9, 10; also under this Act, it is not until a child reaches 16 years that he may consent to medical procedures: s.25.

8 For example, 288 of these children were not even 10 years old. *Special Statistics,* supra n. 6. Any purported consent given by such young children cannot, of course, be given any great credence. It is interesting to note that the civil commitment process is not even available to admit a person under 10 years old (Mental Health Act, s.21), but what a court cannot do, parents or guardians can.

9 See supra n. 5.

10 *Special Statistics,* supra n. 6. 216 were special or committed patients, supra n. 6.

11 The true voluntariness of informal admissions of adults, who in theory cannot have hospitalization forced on them by relatives or others except by court order is open to great question. See Gilboy & Schmidt, " 'Voluntary' Hospitalization of the Mentally Ill" (1971) 66 N.W.U.L. Rev. 429. How much more questionable then is the so-called agreement of those whose hospitalization can be forced on them by their guardians with no court scrutiny and whose understanding of the situation might be incomplete because of their age, mental condition, or dependency on parental decision making.

12 Defined in s.2 of the Act as suffering from a disorder that substantially impairs mental health so that a person is mentally ill, subnormal, or infirm. Although terms like 'mentally subnormal" are not favoured by mental health professionals, they are the terms used in the statute and, for that reason, in this paper.

13 Section 15.

14 *Survey,* supra n. 4, 29.

15 Idem.

16 Idem.

admitted without their real consent or legal safeguards, but because of parental wishes. Most of the rest are mentally ill children admitted through parental arrangements.[17] In addition, most mentally subnormal persons stay in psychiatric hospitals (called psychopaedic hospitals when they cater for the mentally subnormal) for long periods. Nearly 75% of 1976 residents diagnosed as mentally subnormal (3003 out of 4010) had been continually hospitalized for at least 5 years and nearly 54% (2154) for at least 10 years.[18] Therefore, it seems likely that many mentally subnormal adults in hospital have been there since childhood.[19] They are no longer legally bound to stay,[20] but whether out of lack of knowledge that they can leave or out of lack of desire or ability to leave, they do stay.

So far, the discussion has centered on children admitted into government psychiatric hospitals. There are also large numbers of children admitted into public hospital psychiatric units, all classified as informal patients.[21] It is very difficult to know just how many such children are so admitted every year, but an educated guess is that there are about 260 under 15 years old and an additional 400 15-19 year olds.[22] While these children tend to stay in hospital for only short periods of time[23] and are almost all diagnosed as mentally ill,[24] everything said

17 In 1974, there were probably about 640 persons under 15 admitted into psychiatric hospitals and about 930 15-19 year olds. See infra n. 22 and accompanying text. Also, in 1974, there were 645 admissions of mentally subnormal children under 15 years old into psychiatric and public hospitals: *Mental Health Data 1974,* supra n. 4, 33 and 43. All but a handful of these must have been admitted into psychiatric hospitals: See infra n. 24. On the other hand, only 135 15-19 year old mentally subnormal persons were so admitted in 1974: *Mental Health Data 1974,* infra n. 33 and 43. This indicates that about 800 mentally ill children in this age range are admitted to psychiatric hospitals every year, but considering that in 1976 there were only 124 residents in this category (*Survey,* supra n. 4, 29), they must usually stay only a relatively short time. And if 1976 figures are any indication, only about one-quarter of these admissions could be other than informal: See supra n. 10 and accompanying text.

18 *Survey,* supra n. 4, 44.

19 This conclusion is bolstered by the admissions figures for 1974, which show that nearly two-thirds of all admissions into psychiatric hospitals for mental subnormality are of children under 15 years old: *Mental Health Data 1974,* supra n. 6, 33 and 43.

20 In theory, adult informal patients are free to discharge themselves from hospital care at any time. See supra nn. 3 and 5. However, under the Mental Health Act 1969 (s.16) they may be detained in hospital until a court order can be obtained.

21 *Mental Health Data 1974,* supra n. 4, 2.

22 In 1974, slightly over 35% of all first admissions were into public hospital psychiatric units and nearly 25% of readmissions fell into the same category. For all intents and purposes, the rest were admissions into government psychiatric hospitals. *Mental Health Data 1974,* supra n. 4, 12. Applying these figures to the total number of first admissions for under 15 year olds (360), first admissions for 15-19 year olds (652), readmissions for under 15 years old (543), and readmissions for 15-19 year olds (676) gives the estimates: *Mental Health Data 1974,* supra n. 4, 33 and 43. This, of course, assumes 1974 was a typical year and that the percentage of public hospital admissions was fairly constant across ages.

23 People in public hospital psychiatric units can only be there a short length of time as there are only a few beds in them relative to the number of people admitted. For example, in 1974 there were 3,793 admissions to these units, but only an average of 184 residents at a time: *Mental Health Data 1974,* supra n. 4, 12 and 14.

24 Over 95% of persons admitted into public hospital psychiatric units in 1974 received a psychiatric diagnosis *Mental Health Data 1974* supra n. 4 and infra nn. 32 and 45.

about children in psychiatric hospitals being there without consent or judicial safeguards applies equally to these children. Again, their hospitalization is a matter left up to their guardians and hospital personnel.

This system of guardian admissions into psychiatric care is interesting, but does it have anything to do with children being denied their rights? After all, no one seriously questions the right of parents and doctors to admit children into ordinary medical care without their consent or a court order. If that were the proper analogy to draw, this paper would have little point to it. Rather, the proper analogy must be to children who are beyond the control of their guardians or who have committed a criminal offence (delinquent children). These children come under the provisions of the Children and Young Persons Act 1974 and before they may be taken out of their homes and put into institutional care, there must be a court finding that they fit into one of the categories that show they are beyond control or a finding that they have committed an offence.[25] The guardians of such children cannot make a unilateral decision to commit them to the local Social Welfare Department institution for delinquent children.[26] Committal into psychiatric care, despite its therapeutic label, is much more comparable to the institutionalization of delinquents[27] than it is to the giving of ordinary medical care. Without going into great detail, the following points of comparison can be noted: the attachment of a stigmatizing label, the virtually total deprivation of ordinary liberties, the tendency to relatively long separations from family and

of those admitted into these units in 1974 (23 persons) were diagnosed as mentally Since only .6% subnormal (*Mental Health Data 1974,* supra n. 4 and infra nn. 32 and 45) and mental infirmity is a term that mainly applies to the elderly, the vast bulk of children in these units must come under the category of mentally ill.

25 See Children and Young Persons Act 1974, ss.27 (as amended by Children and Young Persons Amendment Act 1977, s.7) and 34. When a court makes such a finding it may then place children under the guardianship of the Director-General of Social Welfare: ss.31, 36. The Director-General then has the power to put such children into institutional care: s.49.

26 Guardians can, however, arrange for the Director-General to assume control of their children, delinquent or not, and to exercise, as a consequence, the same control over the children as if guardianship had been given by a court, including the power to institutionalize the children: ss.11, 49. It is hard to know how truly voluntary such arrangements can be from the children's point of view, though the Director-General must consult the children involved to whatever extent possible before accepting control of them: s.11. It is also hard to know how voluntary the actions of parents are if, as may sometimes be the case, they make these arrangements as an alternative to having action taken against them or their children under the Children and Young Persons Act 1974 (for neglect, for example). Because of such doubts as to voluntariness and because of the great effects on children of being parted from their families, it might be that s.11 agreements should be subject to court scrutiny before being given effect.

27 Indeed, the therapeutic label had been used in some countries as an excuse for not giving delinquent children any real judicial safeguards against institutionalization in the past, but it is now widely recognised that that label does not really distinguish the institutionalization of delinquent children from that of adult criminals. See the discussion of the American situation in *In re Gault* (1967) 387 US 1, 14-31 — the U.S. Supreme Court case that gave delinquent children proper judicial protections against institutionalization. New Zealand had only a brief flirtation with the idea that delinquents did not need such protections. See J. A. Seymour, *Dealing with Young Offenders in New Zealand — The System in Evolution* (Auckland, 1976) 27-41.

community, and the adoption of the institutionalized role.[28] Indeed, in the area of adult civil commitment, the analogy with criminal institutionalization has been enough recognized for the law to provide some of the same judicial safeguards,[29] though some doubt has been expressed as to their sufficiency.[30] The idea behind this is the basic concept that underlies much of the legal system that no one should be deprived of his basic liberty except after an objective judicial assessment of the need for such deprivation.

Unless there is something special about the institutionalization of mentally disordered children, it would appear that they, too, should receive some legal protection against unwarranted deprivations of their liberty. Could it be contended, for example, that parents (or other guardians) who hospitalize their children always have their children's best interests at heart and always are in the best position to judge whether they should be hospitalized? The former is too naive a contention to warrant refuting and the latter has been refuted by many others.[31] Nor does it appear that the discretion of hospital personnel to refuse informal admissions is a sufficient check on the decisions of the family.[32] The main problem with both of these decisionmakers is a lack of objectivity — parents are too emotionally involved and doctors have a bias towards finding sickness.[33] Only a judicial officer

28 See the discussion of the effects of institutionalization on delinquent children in *In re Gault,* supra n. 27, 23-27. Compare this with the discussion of the effects of institutionalization on mentally ill children in *J.L.* v. *Parnham* (1976) 412 F. Supp. 112, 121-122, 136-137, on mentally subnormal children in Teitelbaum and Ellis, "The Liberty Interest of Children: Due Process Rights and Their Application" (1978) 12 Family L.Q. 153, 180-184, and on both mentally ill and mentally subnormal children in *Institutionalized Juveniles* v. *Secretary of Public Welfare* (1978) 459 F. Supp. 30, 39-40. For a comprehensive review of the literature in regard to mentally subnormal persons and institutionalization, see R. Scheerenberger, *Deinstitutionalization and Institutional Reform* (Springfield), 1976) 19-58. For a description of the effects of institutionalization on mentally ill persons in one hospital, see R. Perucci, *Circle of Madness* (Englewood Cliffs, 1974) 51-65.

29 Thus, unless an adult consents to his admission (see supra n. 3) or is being temporarily detained until a court order can be obtained (see supra nn. 2 and 20), he cannot be institutionalized unless two medical practitioners certify him as mentally disordered and in need of detention and a magistrate agrees with this conclusion after examining him: Mental Health Act 1969, ss.21-24. In addition, although not required by law, many magistrates follow the practice of asking the person if he wants a solicitor and a full hearing, involving, inter alia, the calling of witnesses.

30 See Dolan "Madness and the Law" (1975) 7 V.U.W.L.R. 373. Several mental health professionals interviewed, as well as a magistrate, confirmed that some magistrates do no more than the law requires and tend to rubberstamp doctors' decisions.

31 See the discussion of this in *Institutionalized Juveniles,* supra n.28, 39 and 40. See also Teitelbaum & Ellis, supra n.28, 191-197, and the sources cited there. See also Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions" (1974) 62 Calif. L.R. 840, 850-852, 859-863, and the sources cited there.

32 See *Institutionalized Juveniles,* supra n.28, 39; Teitelbaum & Ellis, supra n.28, 186-190, and the sources cited there; Ellis, supra n.31, 863-868, and the sources cited there.

33 Indeed, parents often pinpoint their children as the source of some family disturbance and refer them to mental health services, only to find out after some investigation that the problem is with the entire family: Interview, Joy Anderton, Social Worker,

who is trained to be objective and to hearing both sides, can possibly act as a sufficient check on these other decisionmakers.[34] In America, there is an increasing recognition of this fact, and the trend now is to give mentally disordered children substantially the same judicial safeguards given to mentally disordered adults, deliquent children, and adult criminals.[35] This is a trend that should be followed in New Zealand. Children should have to undergo at least the same civil commitment procedure as adults before institutionalization and, in addition, should be automatically provided with counsel to speak on their behalf.[36] As pointed out by one Magistrate, without any independent counsel to represent the children, there is little chance of the court hearing any version but the guardians'.[37]

Giving mentally disordered children judicial protection is, however, only the first step in protecting them from unnecessary hospitalization. There is little doubt that one reason hospital personnel accept some of the children admitted by their guardians is that, being faced with choosing between hospitalization and leaving children with parents unable or unwilling to care for them, doctors see hospitalization as the lesser of the two evils.[38] Magistrates too may be likely to come to the same conclusion often enough for many children still to be institutionalized inappropriately even if they got a court hearing first. The other change that

Child and Family Clinic (formerly Child Health Clinic), Wellington Hospital Board, October, 1979. As for doctors, one mental health professional interviewed said that some doctors base their institutionalization decisions solely on whether the person is mentally disordered, over-estimating their ability to help him, and fail to consider whether he needs to be hospitalized.

34 That is not to say that judicial officers will always attempt to fulfil the function of objective assessment (see supra n. 30), but they are the only ones really capable of it.

35 See, for example, *Parnham,* supra n. 28, and *Institutionalized Juveniles,* supra n. 28. Since the original writing of this paper, it appears that this trend has been slowed by two U.S. Supreme Court decisions reversing the *Parnham* and *Institutionalized Juveniles* cases on appeal. See *Parnham* v. *J.R.* (1979) ..... U.S. ....., 61 L. Ed. 2d 101 and *Secretary of Public Welfare* v. *Institutionalized Juveniles* (1979) ..... U.S. ....., 61 L. Ed. 2d 142. However, this trend still exists in state court decisions and statutes. See *Matter of Andrea B.* (1978) 405 N.Y.S. 2d 977 and *In re Roger S.* (1977) 141 Cal. Rptr. 298. See Iowa Code s.229.2 (1977) and Pa. Stat. Ann. tit. 50 ss.7101-7503 (1977). See also the discussion of the state statutes found in *Matter of Williams* (N.J. 1976) 356 A. 2d 468.

36 In New Zealand, unlike in America, there is a substantial difference between an adult civil commitment procedure and the judicial process for adult criminals. See Dolan, supra n. 30. Even delinquent children get more protection than adults being civilly committed. Cp. Children and Young Persons Act 1974, ss.27-30 and 34 with Mental Health Act 1969, ss.21-24. There is a good argument that the civil commitment procedure for adults (one only occasionally used for children as well) needs to be made more stringent in New Zealand, but that is beyond the scope of this paper. At any rate, children being hospitalized are entitled to the same protections as adults being hospitalized. Also, it has been proposed that mental health matters be heard in Family Courts. *Report of Royal Commission on the Courts* (Wellington, 1978) 153.

37 The Children and Young Persons Act, s.29(3) provides for counsel to be appointed to represent the children involved. Such appointment is not mandatory but probably should be. Certainly it should be mandatory in the hospitalization situation because parents cannot fulfil the dual role of asking for commitment and representing a child who opposes it.

38 This is a judgment that may be correct in many cases.

needs to be made, then, is the increased provision of services designed to keep mentally disordered children in the community.

As is well known, a great deal of emphasis has been put in recent years on the idea of shifting the focus of mental health services from hospital care to community care. Depending on the country, this emphasis has been evidenced in the rulings of courts,[39] the passage of statutes,[40] and the promulgation of departmental policy,[41] as well as in the publication of reports, books, and papers.[42] And this new emphasis has had some real effects. For example, in Britain, a 1971 report estimated that in England and Wales there were about 50,000 severely mentally handicapped (mentally subnormal) children and that there were 6,400 mentally handicapped children in hospital care.[43] Assuming that all those in hospital were all severely mentally handicapped, that means less than 13% of such children (under 15 years) were hospitalized.[44] Moreover, a more recent report shows that by 1976, this number had been reduced to about 4,900 in England, Wales and Scotland.[45] There is also considerable support for the idea that *no* mentally subnormal need to be in hospital care.[46] In New Zealand, the closest estimate figured out on comparable criteria is that, as of 1976, there were about 3,300 intellectually handicapped (mentally subnormal) children under 15 years old,[47] and 774 (over

39 See, for example, *Parnham,* supra n. 28.

40 See, for example, Cal. Wel. & Inst. Code s.5358 (West Supp. 1979).

41 See, for example, Department of Health and Social Security, *Better Services for the Mentally Handicapped,* Cmnd. 4683 (London, 1971) referred to here as *1971 White Paper*); Department of Health and Social Security, Better Services for the Mentally Ill, Cmnd. 6233 (London, 1975) (referred to here as *1975 White Paper*).

42 See, for example, L. J. Stein and M. A. Test, (ed.) *Alternatives to Mental Hospital Treatment* (New York, 1978); *Report of the Committee of Enquiry into Mental Handicap Nursing and Care,* Cmnd. 7468-I (London, 1979) (referred to in this paper as *Report*); Joint Commission on Mental Health of Children, *The Mental Health of Children; Services, Research, and Manpower* (New York, 1973).

43 *1971 White Paper,* supra n. 41, 1 and 19.

44 If some of those in hospital were not severely handicapped (defined as roughly equivalent to the World Health Organization's classifications of moderate, severe, and profound retardation, *1971 White Paper,* supra n. 41, 1), then the percentage of hospitalized handicapped would be even lower. It is hard to tell how children are defined in the estimate of 50,000, but since 'children' always seems to mean under 15 years old everywhere else in the paper, it is probably safe to infer the same definition here. Also, the 13% estimate is in line with earlier studies in Britain showing that about 12% of mentally handicapped persons under 16 were in hospital. See B. Spain & F. M. Martin, *Plans and Provisions for the Mentally Handicapped* (London, 1972), 37.

45 *Report,* supra n. 41, 9. This was down from 7,384 in 1970.

46 Ibid. 34-57. This is not a view shared by any of the New Zealand mental health professionals interviewed on the subject. Interview, Dr. Mirams, supra n. 5; Interview, Mike Woodard, Society for the Intellectually Handicapped, Wellington Branch, August, 1979; Interview, Dr. W. F. Bennett, Medical Superintendent, Kimberly Hospital and Training School, August, 1979; Interview, A. Capie, Clinical Psychologist, Society for the Intellectually Handicapped, July, 1979. All of these people hold the view, however, that some of the mentally subnormal children now in hospital care should live in the community and most said they would live in the community but for lack of community residential care places.

47 This was determined by using the 1976 census figures for each relevant age group in the population (found in Department of Statistics, *1976 Census of Population and Dwellings* (Wellington, 1978)) and the prevalence estimates for intellectually handicapped

23%) of these resided in psychiatric hospitals.[48] Moreover, there has only been a slight tendency (and a less than clear-cut one) towards a reduction in the number of children resident in psychiatric hospitals.[49] It would seem, then, that Britain and New Zealand are worlds apart in their progress towards community care for mentally subnormal children, though it should be noted that while Britain has done quite well in the deinstitutionalization of such care, it has not made as much progress in providing community based alternatives to hospital for mentally subnormal children.[50]

Turning to mentally ill children — there is significantly less information about them. As no one seems able to agree on how to define mental illness, there has been no real agreement on its prevalence.[51] Perhaps the best estimate comes from America, where it has been estimated that of a population of about 59 million children there are about 4,500,000 between 5 and 19 years old who are mentally ill.[52] If the proportions are comparable in New Zealand, in 1976 there were about 71,000 mentally ill children in that age range here.[53] And as previously estimated, about 800 are admitted into psychiatric hospitals and 660 into public hospital psychiatric units each year, with few staying for long.[54] It should be noted, however, that there is some feeling that the only reason New Zealand does not have more psychiatric hospitalization of mentally ill children is the lack of available spaces,[55] though it is generally agreed that such children rarely need to be placed in psychiatric hospitals and that, if anything, public hospital psychiatric units are more appropriate.[56] It seems that, in New Zealand, the present balance

children in those same age groups (found in A. A. Morrison, D. M. G. Beasley, and K. I. Williamson, *The Intellectually Handicapped and Their Families, A New Zealand Survey* (Wellington, 1976), 21). It appears that for children, the definition of intellectually handicapped in this survey is roughly equivalent to the definition of severely mentally handicapped used in the *1971 White Paper.* It is said to include those moderately retarded and below by World Health Organisation criteria, as well as mildly retarded unable to live or work independently, but that few children fall into the latter category cp. Morrison, Beasley and Williamson, op. cit. 2.

48 See supra n. 6 and accompanying text.

49 See *Survey,* supra n. 4, 3. In 1966, there were 1,671 resident children, in 1971, 1,791, in 1976, 1,516.

50 The increase in residential community care places for children has not even kept up with the decrease in hospital places. *Report,* supra n. 42, 9.

51 *1975 White Paper,* supra n. 41, 1-2.

52 See *The Mental Health of Children,* supra n. 41, 141, 166. Presumably, there are very few mentally ill children under 5 years old. Note that this is a conservative estimate compared to some mentioned for the entire population in the *1975 White Paper,* supra n. 41, 1-3.

53 Based on 1976 census figures for the relevant age groups. See *1976 Census,* supra n. 47, 5.

54 See supra nn. 17, 22, 23 and 24 and accompanying texts.

55 Interview, Dr. Mirams, supra n. 5; Interview, Joy Anderton, supra n. 33. These people indicated that one reason increased hospitalization would be the result of increased places becoming available is that there are not enough community based residential places available.

56 Idem. See also *1975 White Paper,* supra n. 41, 30-39, 47, which recommends a care system based on public hospital psychiatric units, day care, and community homes (mostly for short term care).

against hospital care of mentally ill children is more a matter of default then of the provision of community based alternatives.

At this point, it would be useful to discuss some of the community care services made available by the government to mentally disordered children in New Zealand. Besides providing beds in psychiatric hospitals and public hospital psychiatric units, hospital boards, using money provided by the Health Department, have begun to build hostels and family homes for the mentally subnormal.[57] These seem mainly to be intended for people leaving hospital care[58] and are all turned over to private agencies (essentially the Society for the Intellectually Handicapped).[59] In addition, the Social Welfare Department provides 80% funding for homes built by such agencies for the mentally subnormal.[60] These are probably intended more as an alternative to family care.[61] So far, there are only 800 beds in homes run by the Society for the Intellectually Handicapped for all age groups.[62] The Social Welfare Department also subsidizes the running costs of these homes by providing a $42 weekly capitation allowance for each child, an $8 a week handicapped child allowance, and a $6 a week family benefit.[63] Despite this, the Society for the Intellectually Handicapped has to find an additional $40-$50 per week per child to keep its homes running.[64] As a result, there is widespread agreement that there are needed for mentally subnormal children not only more places in community based residential homes, but also more money to run the homes already in existence.[65] What is not agreed on is whether these homes should ever be administered by the government or only subsidized.[66]

57 Interview, Mike Woodard, supra n. 46. Presumably, this is being done under the authority of the Mental Health Act 1969, s.8.

58 Idem.

59 Idem.

60 Interview, Alan Nixon, Director of Developmental Services, Department of Social Welfare, August, 1979; Interview, A. Mitchell, Chief Executive Officer in Charge of Community Services, Department of Social Welfare, August, 1979. This is done under the provisions of the Disabled Persons Community Welfare Act 1975, s.17.

61 This is an assumption based on information that hospital boards seem to be occupied with the task of providing an alternative to hospitalization. See supra n. 58 and accompanying text.

62 Interview, A. Capie, supra n. 46. Clearly, if New Zealand were to dehospitalize its mentally subnormal children down to the British rate (see supra nn. 44, 45, 47 and accompanying text) hundreds more places would be needed.

63 Interview, Alan Nixon, supra n. 60. The capitation allowance is authorized by the Disabled Persons Community Welfare Act 1975, s.30, the handicapped child allowance by the Social Security Act 1964, ss.39A-39F, as added by the Social Security Amendment Act 1978, s.9, and the family benefit by the Social Security Act 1964, ss.32-39.

64 Interview, Mike Woodard, supra n. 46. Nevertheless, even at about $90 per week per child, community residential care is considerably less than the $200 for hospital care. Interview, A. Mitchell, supra n. 60. Of course, the initial cost of building community residences acts to offset much of the saving at first.

65 One or the other of these concerns was expressed by nearly every interviewee working in the area. See also *Report*, supra n. 42, 39-45 which recommends a care system based on field services and various kinds of community based homes (for short and long term care).

66 There seems to be quite a split among the mental health professionals interviewed as to whether the government should provide direct services or just money. The only

Unlike mentally subnormal children, mentally ill children do not usually need residential care for long periods of time.[67] But they do need a fair number of short term residential places.[68] In New Zealand, the hospital boards supply no community based homes for such children, but only places in psychiatric and public hospitals. This is because the boards are limited to providing hospital related services.[69] Nor does the Social Welfare Department provide any homes specifically for such children, though some mentally ill children do find their way into the regular family and foster home services for children provided by the Department.[70] As well some mentally ill children are probably cared for in privately run children's homes.[71] These homes receive a two-thirds building subsidy, and there is a $25 capitation allowance as well as the family benefit from the Social Welfare Department.[72] Nevertheless, these subsidies do not cover even two-fifths of actual running costs.[73] It would seem then that mentally ill children have an even greater unfulfilled need than mentally subnormal children for community residential care.[74] One other service provided by the Social Welfare Department should also be mentioned; it is a three month training course available for all residential care workers.[75]

So far, only residential services have been mentioned. There are also government provided services for mentally disordered children living at home. Besides the family benefit and handicapped children's allowance,[76] the Social Welfare Department provides some counselling services for families with mentally disordered children as part of its general child welfare function.[77] It also subsidizes on a

service consistently named as needing to be provided directly by government is special education.

67 Interview, Joy Anderton, supra n. 33. See also *1975 White Paper*, supra n. 41, 30-39, 47.

68 Idem.

69 Interview, Dr. Mirams, supra n. 5. Apparently, some hospital boards do administer community homes for adults. See *Report of the Department of Health* (Wellington, 1979) 24.

70 Interview, Alan Nixon, supra n. 60. These are provided under the Children and Young Persons Act 1974, ss.49, 67-69.

71 These homes are regulated under the Children and Young Persons Act 1974, ss.84-95.

72 *Report of the Social Welfare Department* (Wellington, 1979) 14. This is done under the Children and Young Persons Act 1974, s.6(3).

73 See Department of Social Welfare, *Church Social Services, A Report of An Enquiry into Child Care Services* (Wellington, 1977) 2, 3, 8, whose figures show the Department subsidizes about one-third of the homes' running costs. Although figures given in this report are now out of date, the situation has probably improved only slightly due to the effects of inflation, giving an estimate of a present two-fifths subsidy.

74 Judging from the amount of New Zealand based information on these two groups of children, it would seem the mentally subnormal are the more visible group. And judging from the description of services given in this paper, they are the more helped group.

75 Interview, A. Mitchell, supra n. 60.

76 Note that the handicapped children's allowance could be available for mentally ill children as well as the usual recipients, mentally subnormal children, if the illness is sufficiently disabling: Interview, A. Mitchell, supra n. 60.

77 Interview, Joy Anderton, supra n. 33. This would be provided under the Children and Young Persons Act 1974, ss.5-6 and the Disabled Persons Community Welfare Act 1975, s.11.

small scale counselling services in the field provided by private agencies serving mentally disordered children.[78] It is significant that, along with lack of residential places, the lack of emphasis on counselling services has been the most often mentioned gap in community care for mentally disordered children. It is perhaps as a result of this gap that some of the Child Health Clinics originally organised by hospital boards to deal with children's problems of physical health in the community have turned more and more to dealing with problems of mental health[79] mainly through various counselling techniques. Also hospital boards, through their psychiatric and public hospitals, provide care for children as day and outpatients.[80]

Finally, there are the services provided for mentally disordered children whether living at home or in community residential care. The Department of Social Welfare subsidizes, at the rate of 80%,[81] the building of special educational facilities (pre-school and school) by private agencies serving the mentally subnormal. The Department of Education, and local education boards using money provided by the Department, provide special educational facilities (pre-schools, special schools, special classes, and correspondence school).[82]

Additionally many mentally disordered children, especially mentally ill children, attend regular schools and pre-schools.[83] However, some mentally subnormal children (about 400),[84] are excluded from government schools and they constitute the bulk of children attending schools of the Society for the Intellectually Handicapped.[85] The Department of Education has recently begun a seconded teacher programme for these schools, whereby the Department pays for specially trained teachers to plan the educational programme for the students as well as to teach.[86] It also pays some transportation and equipment costs.[87] Despite this aid to private agencies, the parents of children excluded from government schools do

78 This would be provided under same sections as in n. 77 supra. At present only $100,000 is provided for such services to agencies serving mentally subnormal children. Interview, Alan Nixon, supra n. 60, and only $75,000 is provided for such services to all other voluntary agencies serving children. See *Report of the Social Welfare Department,* supra n. 72, 14.

79 Interview, Joy Anderton, supra n. 33.

80 *Survey,* supra n. 4, 22. In 1976 at the time of the Census 1,181 children were registered as day and outpatients in these hospitals.

81 Interview, Mike Woodard, supra n. 46. Presumably this is provided under the Disabled Persons Community Welfare Act, s.30.

82 Interview, Ash Milne, National Organiser Backward Pupils, Department of Education, October, 1979. These are provided under the Education Act 1964, ss.98-100.

83 There has been an increasing trend in New Zealand schools toward integration of special and regular education. Interview, John Gibson, District Psychologist, Wellington Education Board, October, 1979.

84 Interview, Ash Milne, supra n. 82. This is done under the Education Act 1964, s.114.

85 There are about 600-700 children attending these schools, some of whom are pre-schoolers; the rest mainly consist of children excluded from government schools: Interview, Frances Hartness, Society for the Intellectually Handicapped, October, 1979.

86 Interview, Ash Milne, supra n. 82. Presumably, this is done under the Education Act 1964, ss. 99-100.

87 Interview, Ash Milne, supra n. 82. Wherever there is a seconded teacher, the children's transportation is subsidized and so is equipment for the school up to $1,000. Presumably, this is provided under the Education Act 1964, ss.99-100.

have to pay a fee for the education of their children.[88] Other services provided by various government departments are assessment and diagnostic services,[89] subsidies for administrative staff of private agencies,[90] and a few early intervention centres.[91]

Several things should be obvious from this description of services. First, that there are several large gaps in the provision of community care services. Specifically there are not enough places for residential care outside the home and there is too little emphasis on counselling and field services. Also, the government has not been meeting its responsibility to provide the needed community care services, but rather has relied on private agencies which it inadequately subsidizes. Finally, the organization of government services and subsidies is haphazard, resulting both in overlaps and gaps in services. A prime example of this is two departments, those of Health and Social Welfare, providing money for homes for the mentally subnormal and no one providing money for homes for mentally ill children.

What could be the reasons for this? Certainly it could not be a lack of ideas, programmes, and models, as they abound.[92] Several reasons have been suggested by those working in the field of services for mentally disordered children. Among them are the tendency to be satisfied with stop-gap measures that stifle loud cries for help, the tendency to rely on intuition instead of planning, the tendency to opt for "safe" solutions (like institutionalization) to problems instead of ones that might cause disruption to the community, and the desire to "go it alone" instead of co-ordinating and co-operating. Whatever the underlying reasons, the more important question is "What can be done about it?"

As this conference is focused on the rights of children and the law, legal solutions to the problem of the overinstitutionalization of mentally disordered children are proposed in this paper, but that is not to say the law is the only source of help. One suggestion is that children be required to go through court processes before they are institutionalized.[93] The law should forbid the informal admission of children by their guardians. Moreover, it should not permit anyone under 16 to admit himself informally, as such an admission could easily be forced on a child by his parents.[94] Perhaps, it might even be wise to require court scrutiny of self-arranged informal admissions by children 16 and over to make sure they are truly voluntary.[95] It is not enough to give these protections, however. There should be as well a provision in the law of civil commitment that magistrates are to determine first if the person is mentally disordered. Then if there is such a finding made, he is to determine what form of care is the most appropriate,

88 Interview, Frances Hartness, supra n. 85. This comes to about 50c a day.
89 The Education Department provides these: Interview, Ash Milne, supra n. 82. So does the Health Department through hospital boards: Interview, Joy Anderton, supra n. 33.
90 This is provided by the Social Welfare Department. *Report of the Social Welfare Department,* supra n. 72, 13.
91 These are provided by the Education Department in conjunction with hospital boards: Interview, Ash Milne, supra n. 82.
92 See the publications cited supra in nn. 28, 41, 42, 44.
93 See supra nn. 36 aid 37 and accompanying text.
94 See supra nn. 8 and 11 and accompanying text.
95 See supra n. 11 and accompanying text.

having in mind that he should pick the least restrictive environment possible.[96] Having determined that, the magistrate would issue an order to the appropriate government department to place the person into the care determined most appropriate. In the alternative, the law could provide that after determining that a person is mentally disordered, the magistrate is to issue an order putting that person into the general care of an appropriate government department, which will then have the power to determine which specific kind of care is the least restrictive and most appropriate.[97]

Either way, there must also be changes in the various laws governing services for the mentally disordered so that there will be enough alternative forms of care available to assure there will always be an appropriate form to choose. First, one department, either Social Welfare or Health, should be clearly designated as the one to provide services to the mentally disordered, excepting only those services that are clearly outside its ambit, like educational services. This department should also be given the power to supervise and co-ordinate those few services left to other departments. In addition, the law should require that department to provide community care services, including residences, counselling, and the like, to families and persons in need of them.[98] Services should be provided both directly and through adequate subsidies of private agencies so that government fulfils its responsibility *and* gives people a choice. Finally, New Zealand should follow the lead of Britain and America[99] and give every child the right to an appropriate government provided education.

96 The concept of the least restrictive alternative is one that has arisen in American law in several recent court cases. See, for example, *Parnham*, supra n. 28.

97 This kind of system would be modelled after the provisions of the Children and Young Persons Act 1974 for putting delinquent and neglected children under the guardianship of the Director-General of Social Welfare: ss.31, 36, 49. It would also be possible to require, under such a system, that the department obtain prior judicial approval or that there be periodic judicial review of a decision to institutionalize. This might be necessary if, as at least one person in a position to know alleges, the Social Welfare Department is little better at making objective decisions to institutionalize than are parents.

98 The Disabled Persons Community Welfare Act 1975, s.11 is typical of the way current law reads. It does not require; it merely permits the provision of necessary services.

99 See the Education (Handicapped Children) Act 1970 (UK) and 20 U.S.C.A. ss.1411-1420 (US).

COMMERCIAL SECURITIES

G.G.F. Viskovic S.C. Calderwood

The principal concern of the authors in writing this book has been to provide a clear and comprehensive coverage of the main areas of the law relating to commercial securities.

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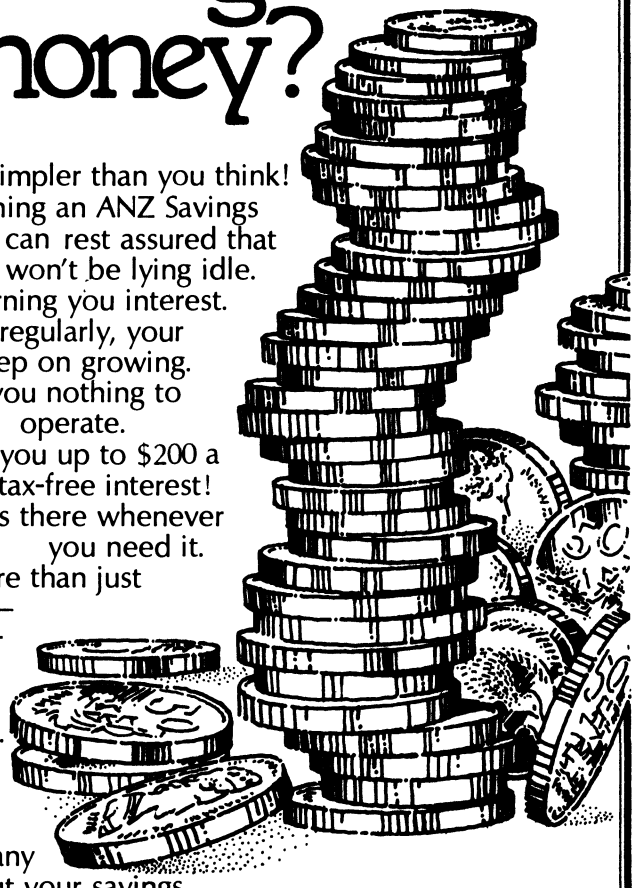

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