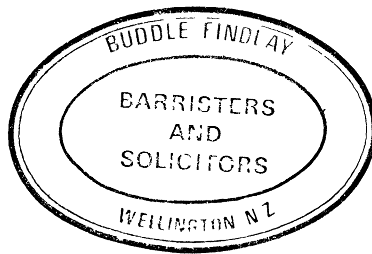
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Civil commitment: a multi-disciplinary analysis

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The relationship between the law and concepts and treatment of mental illness is a complex one. Mental health legislation is determined not merely by the wishes of Parliament and the advice of those concerned in the care of the mentally ill, but also by the moral and social values of the society. As those values change so attitudes to civil commitment[1] *change, bringing agitation for legislative reform. Many countries have amended their laws or have current proposals to do so, but New Zealand has expressed little of the disquiet others have felt at the continued use of involuntary detention. This paper examines the early legislation and its parallel with early psychiatric ideas and practice. The interaction between the present New Zealand legislation and current attitudes and knowledge in the mental health field is viewed from that historical perspective. The conclusion is that the Mental Health Act 1969, with its broad and sweeping powers involuntarily to detain a person alleged to be mentally disordered,*[2] *is no longer an acceptable reflection of the psychiatric thinking and practice carried on in New Zealand today and that the key to legislative reform lies in a change to the legislative definition of mentally disordered.*

I. THE HISTORY OF MENTAL HEALTH LEGISLATION

A. The Earliest Legislation

Even before the first statute concerning the management of the mentally disordered person in 1714,[3] there had grown up a body of case law which showed that certain principles underlay decisions relating to compulsory detention and treatment. As early as 1482 a defendant, when issued with a writ for the false imprisonment of the plaintiff's wife, was advised by the judge that madness itself was not sufficient justification for detention: "You must submit that she was

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1 Commitment should exiist for cases of true medical need, where the person is disordered and in need of care and treatment.

2 Mental Health Act 1969, ss. 19 and 21.

3 Vagrancy Act 1714, which confined the dangerously insane.

mad and suppose that she would have wished to kill herself or do some mischief such as burn down a house."[4]

This medieval Common Law decision seems to justify restraint where it is established that the person is mentally ill and a danger to herself or others, so is very similar to the grounds for commitment in many jurisdictions today.

The first great era of community care was not the present day, but the 17th century. The medieval Common Law, together with the Poor Laws enacted during the reign of Elizabeth I, actually operated as a form of community psychiatry. Under a Poor Law provision, Overseers of the Poor were nominated in every parish and their task was to raise sufficient money by taxation for the necessary relief of the idiots and lunatics who were unable to work.[5] However, treatment as well as support was also meted out by fellow citizens, and a Justice of the Peace manual in 1581 described: "Every man also may take his kinsman that is mad, and may put him in a house, and bind him and beat him with rods, without breach of the Peace."[6]

Community care did not work very well the first time around, and during the 18th century the mentally disordered were increasingly confined to institutions. The reasons for this were in part economic as a revision of the Elizabethan Poor Law and the introduction of the workhouse test made it harder for the mentally disordered destitute to survive in the community. Physical restraints for the deranged were used in the workhouses, and the mentally disordered were regarded as a subspecies of the destitute and antisocial. "Bridewells" (intended for vagrants and petty offenders), prisons and private madhouses became the refuge of the mentally disordered, although no medical care was available and conditions were notoriously bad. Although the 18th century saw no training in psychiatry, some glimmerings of humanity were perceived in the establishment of public hospitals like Bethlem, which were built specifically to admit the insane.

The reforming zeal of the early 19th century saw an awakening of public concern at the plight of the insane. This was helped too by the madness of George III which, when it became generally known, made mental disorder seem more respectable: ". . . it elicited both sympathy and concern. If a sick King could be treated thus what might befall a sick commoner."[7]

Enlightened experiments in the care of the mentally disordered, notably in the Retreat of York, showed the effectiveness of humane treatment, and at the turn of the 19th century, there was already a school of thought which held that lunatic hospitals should be set in the country where there was fresh air, space for exercise and opportunity for occupation such as gardening.[8] The large geo-

4 As cited in Noble "Mental Health Services and Legislation — An Historical Review" (1981) 21 Med. Sci. Law 16.
5 Allderidge "Hospitals, Madhouses and Asylums: Cycles in the Care of the Insane" (1979) 134 Brit. J. Psychiat. 321, 324.
6 Ibid. 235.
7 Supra n. 4, 18.
8 Supra n. 5, 330.

graphically isolated lunatic asylum came into existence, providing custodial care behind locked doors for its involuntarily detained patients.

B. The Nineteenth Century

In 1845 in the United Kingdom a society was formed to defend liberty,[9] and the latter part of the 19th century saw increasing concern over the possible wrongful detention of patients. Agitation for protection resulted in the Lunacy Act 1890 which established an elaborate system of judicial orders and medical certificates for the safeguard of the sane public from wrongful detention. Admission involved a court procedure, like criminal conviction, and although the sane were protected by this legalistic approach, the mentally disordered were denied early and appropriate treatment. There was no provision at this stage for voluntary admission for psychiatric treatment. Unfortunately, this legalistic approach failed because there was no concurrent provision of resources or concern for the improvement of care; it took a special Act of Parliament in 1915 to give the Maudsley Hospital permission to admit voluntary patients. Advances in psyhciatric care could therefore begin, but outside the mental hospital setting.

C. Early New Zealand Mental Health Legislation

Well over a century ago in New Zealand, jails and barracks provided the only refuge for the mentally ill, but gradually lunatic asylums were established; institutions which were a cross between places of healing and places of punishment. The Mental Defectives Act 1911 was a major piece of legislation providing for the first time for the admission of voluntary patients.[10] The New Zealand legislation changed the title "asylum" to "mental hospital" and the "attendant" became the "nurse" in an attempt to restore the institution to its acute treatment function based upon the general hospital model. Out-patient services were initiated with a greater recognition of treatment rather than custodial care of patients. The 1911 Act remained in force until the present Mental Health Act 1969.

II. THE CONCEPT AND TREATMENT OF MENTAL ILLNESS

A. The History

Throughout the Dark and Middle Ages and indeed until the end of the 17th century, the theory of demoniacal possession as the cause of insanity held sway.[11] This was despite the phenomenology of certain disorders such as manic depressive psychoses and schizophrenia having been recognised throughout history. For example, in Ancient Greece, Aristotle expounded on melancholy and mania in relation to hot and cold black-bile giving clear descriptions of the symptoms and signs of manic-depression and schizophrenia.[12] Galen, a Roman physician of great standing, clearly described the hallucinations and delusions of a fellow

9 Lunatics Friend Society 1845.
10 It was not until the Mental Treatment Act 1930 that this provision was available in the U.K.
11 Supra n. 5, 321.
12 As noted in *Mind and Madness in Ancient Greece. The Classical Roots of Modern Psychiatry* (Cornell University Press, New York, 1978) at 231.

physician,[13] while in the 13th century, a professor of theology in Paris gave descriptions of similar phenomena.[14] Although theories of causation remained somewhat dubious, by the early 19th century John Haslem, apothecary to Bethlem Hospital, was able to give precise accounts of the phenomenology of all the major mental illnesses.[15]

Despite such recognition, custodial care was still the only response medicine could offer and the Victorians placed the psychotic patient behind locked doors and high walls. Psycho-therapy was regarded as identical with charlatanry and the "institutional psychiatrist was only fitted to act as society's custodian of its degenerate and dangerous members".[16] The judicial procedure for admission coupled with lock-up inside, gave mental illness a stigma from which it has never fully recovered. However, the recognition of "shell shock" as a legitimate psychiatric condition during the First World War tended to contradict the idea of mental illness as a lower social class phenomena.[17]

At the end of the 19th century, although systematic clinical observation delineated the concepts of schizophrenia which have endured for eighty years, no useful treatment had been found for the commonest types of mental disorder.[18]

B. Medical Discoveries and Psychiatric Progress

At the beginning of the 20th century, ten per cent of British mental hospital beds were filled with patients suffering from a condition called general paresis of the insane.[19] The symptoms had been described as early as 1820[20] but not until 1913 was the spirochaete treponema pallidum identified as the causative agent in syphilis. Preventive measures amongst the community were employed and the incidence declined, but not until penicillin was discovered and employed in the treatment of this spirochaetal infection, were incarcerated patients given the chance of a cure and discharge. Similarly, pellagra[21] resulted in insanity and incarceration until it was discovered this century that a dietary deficiency of the vitamin nicotinic acid was the cause of the disease.

Further fundamental changes took place in the 1950's. Until this period in New Zealand there was a continuing upward trend in the numbers of people resident in psychiatric hospitals proportionate to the total population of the country. The peak was reached at the end of the Second World War when

13 Hunter & Macalpine *Three Hundred Years of Psychiatry 1535-1860* (Oxford University Press, London, 1970) at 18.
14 Ibid. 1-4.
15 Haslem *Observations on Madness & Melancholy* (2nd ed. Callow, London, 1809).
16 Meyer Gross Slater and Roth *Clinical Psychiatry* (Balliere, Tindall & Cassell, London, 3rd ed. 1969) at 2.
17 *"A Health Service for New Zealand"*, Government White Paper presented to the House of Representatives (Government Printer, Wellington, 1975) at 43.
18 Book Review "Great Books in Psychiatry", Edward Hare (1981) 138, Brit. J. Psych. 262.
19 Siegler and Osmond *Models of Madness, Models of Medicine* (Macmillan, New York, 1974) xxi.
20 Supra n. 18, 263.
21 Supra n. 19, 146.

498.9 people per 100,000 of population were resident in mental hospitals.[22] Since that time there has been a well-sustained fall until in 1979[23] the number of residents in mental hospitals in New Zealand was the lowest it had been since 1882. This trend was also reflected in the rates of committal. In 1954 the rate was 87.9 per 100,000 of population, while in 1969 (when the present Act came into force), the rate of committal was 70.1 per 100,000 of population.[24] In 1979 the rate was 68.3. In the United Kingdom, the same trend may also be observed with the numbers resident in mental hospitals increasing until about 1954.

The declining numbers of committed patients in mental hospitals was not the result of any legislative change, but rather the consequence of major developments in drug treatment. The drug group known as phenothiazines was of particular significance because it enabled doctors to control the disturbed behaviour of many psychotic patients. The drugs did not cure illness, but enabled the symptoms to be relieved so as to enable real contact to be made with patients who had previously been cut off from the real world around them by their psychotic illness. The prognosis in many disorders became greatly improved, enabling patients to be treated outside hospital, and reducing the average length of stay in hospital.[25]

The 1950's and 1960's also saw significant development in other areas of mental health care, and non-physical approaches like behaviour therapy became available. Treatment and rehabilitation, rather than care and control, became the aim of the mental hospitals, and there was a growing realisation that long-term in-patient treatment was becoming less necessary.

C. Mental Illness as an Abstraction

Despite the changes in the care and treatment of the mentally disordered, and the strong pressure for protection of human rights which occurred after the Second World War, the New Zealand legislation remained little affected. The 1969 Mental Health Act gives a great deal of freedom to doctors, enabling them to use the criteria "mentally ill and requiring care and treatment" to cover a wide variety of circumstances. Such flexibility offers little safeguard to the patient against wrongful committal or abuse of the use of detention. The difficulty lies in the concept of mental illness itself. The term "mental illness" is open to the widest interpretation, embracing as it can do, both the social and moral influences of a society at any given point in time. The term is therefore, in effect, a total abstraction[26] in that it can be made to represent any category of sickness of the mind or deviant behaviour. To be efficacious in terms of the diagnosis and treatment of mental illness, the concept of mental illness must be so narrowed that it avoids corruption by the social and moral influences of the day. How

22 *Mental Health Data* 1979, Dept. of Health, Wellington, p.3.
23 The latest statistics available.
24 Supra n. 22, 9. These rates are for committed and special patients together, and comprise the average figure for all registrations for 1950-4 and 1965-9.
25 Great Britain Dept. of Health and Social Services *Better Services for the Mentally Ill* (H.M.S.O., London, 1957; Cmnd. 6233) 11.
26 Trotter *Collected Papers* (Oxford University Press, London, 1941).

can such a narrowing and redefinition of the concept be achieved? It is submitted that the answer lies in the concept of the syndromal definition of disease as embodied in the historical determination of clinical medicine.

The clinical description or syndromal definition of disease was described by Clare in "Psychiatry in Dissent":[27]

> One of the earliest ideas of disease, indeed it was held by Hippocrates and his disciples, was that of a combination of signs and symptoms observed to occur together so frequently and so characteristically as to constitute a recognizable and typical clinical picture.

Physical disease has been described as a disturbance of part-function, the diagnosis resting on a demonstration of a disturbance in an organ or bodily system. Likewise, in mental disorder, the part-functioning disturbance is shown by a disturbance in one or more of the recognised mental functions — perception, learning, thinking, remembering, feeling, emotion, motivation. Disturbances in perception or memory are the psychiatric equivalents of, for instance, disturbances in the liver or lymphatic system.[28] If the signs (what is observed by the clinician) and the symptoms (what is complained of by the patient) are the observable phenomena, then the entity diagnosed according to this syndromal definition of disease becomes an abstraction of those phenomena.

The concept of mental illness has its roots firmly placed in clinical medicine which is as old as man itself. Clinical medicine is best described as a practical art,[29] and as such, bases itself on the study of the observable phenomena of the conditions that afflict mankind. This diagnostic process, as well as giving the syndromal definition of disease, often includes a treatment regime to relieve suffering and where determined scientifically, an aetiology or cause. Throughout history, the over-riding philosophy of clinical medicine has been to alleviate suffering. The aetiology of the disease was not the first concern of the physician, but rather the recognition of the ailment and its treatment.

Scientific principles and research have revealed the causes of many of the afflictions of mankind and this has paved the way for more effective preventive and treatment measures. Such a process has tended to confirm the efficacy of the clinical method of defining illnesses. The experienced clinician will not only be able to elicit signs and symptoms, but be able to draw these together to spell out an entity. Having established the entity, the clinician knows that such a disease will follow a certain course and prognosis.

Clinical medicine has provided an efficacious, reliable and incorruptible method of identifying mental illness by collating the phenomenology of conditions. It is only by such means that the interposing of abstractions can be reduced to a minimum and thereby the corrupting influences of social and moral views similarly reduced as factors in the commitment criteria. When the syndromal definition of disease is espoused, the term "mental illness" will be reduced in application only

27 Clare *Psychiatry in Dissent* (Tavistock Publications, London, 1976).
28 Ibid. 18.
29 Supra n. 26.

to the major phenomenological sub-grouping of symptoms of the schizoprenias and manic depressive psychoses. These groupings equate to disturbances in part-function of recognised mental functioning. When so diagnosed, these illnesses can be seen as conditions which have always afflicted mankind, and to be maintained as pure entities they must be seen within the context of clinical medicine. This is not to say that as far as aetiology is concerned, social and other environmental factors which can play an important part in precipitating these conditions are to be ignored. It is instead an endeavour to isolate and therefore reduce the reasons for the act of committal.

III. THE MENTAL HEALTH ACT 1969

A. Definitions

By section 2 of the Mental Defectives Act 1911 a mental defective was a person who, because of his mental condition, required "oversight, care or control for his own good or in the public interest". The present legislation provides that mentally disordered means that a person is mentally ill and requiring care and treatment for a mental illness. A second category of mentally disordered is that of the mentally infirm as defined in section 2 of the Mental Health Act 1969.

Besides providing no guide as to what care and treatment means, the 1969 Act gives no definition at all of mental illness. The lack of definition is the basic concern of this paper, and in the authors' view, the way to solving questions raised by the very concept of civil commitment lies in legislative change to the definition of mentally disordered. The present legislation offers little safeguard to the patient against possible wrongful detention. The medical certificate for committal requires merely that a medical practitioner states that in his opinion a person is "mentally disordered within the meaning of the above-mentioned Act". The meaning of "mentally disordered" is given in section 2 as "mentally ill".

Within the authors' experience it is known that in 1970 large numbers of disturbed people were committed from the psychiatric unit of a public hospital because (a) they were too difficult for the unit to manage, and (b) committal as opposed to voluntary transference to a mental hospital was ordered, to enable control to be maintained over the patients. The past decade has seen a growing trend in psychiatry away from such authoritarian practice with a greater awareness of the benefit to the patient of voluntary admission and consent to treatment. Such trends do provide some protection against erroneous detention, and the discretionary nature of the doctor's own particular viewpoint leads to the need for greater legal safeguards.

Although the broadness and imprecision of the classification is obvious, New Zealand, like many other jurisdictions, has failed to provide any proposals for greater clarity. Even the British Government White Paper 1978[30] which aimed at amending the Mental Health Act 1959 (U.K.) failed to present any proposals for amending the general definition of mental disorder.[31] Neither did the White

30 Review of the Mental Health Act 1959 (H.M.S.O., London, 1978; Cmnd. 7320).
31 Bean "The Mental Health Act 1959: Rethinking an Old Problem" (1979) 6 Brit. J. Law and Society 99.

Paper contain any proposals for defining mental illness. The stated reason for this failure was "the difficulty of producing a definition which would be likely to stand the test of time".[32] This is illustrative of the imprecise yet enduring science that psychiatry still is. The mentally infirm category in section 2 of the N.Z. Act is capable of a more precise interpretation in requiring the infirmity to arise from "age, deterioration of or injury to the brain", and therefore offers less scope for the subjective evaluation of the doctor. The need for care and treatment in this category remains vague however.

B. Admission Procedure for Committed Patients

Section 19 of the 1969 Act provides an emergency procedure whereby a patient is admitted without a reception order. This procedure can be initiated by any person of 21 years or over who alleges that the "person" is mentally disordered and should have care and treatment in the interest of the person's welfare or the public interest. Two medical certificates[33] stating that in the opinion of the practitioner the person is mentally disordered and should be detained for care and treatment, must accompany the section 19 application. Under section 19 the superintendent must notify a District Court, and the judge must make an inquiry and decide whether to issue a reception order.

Section 21 allows a person with an interest in the case to apply to a District Court Judge for a reception order in respect of a person alleged to be mentally disordered.[34] The judge must examine the person, call for two medical certificates, and may call for witnesses as to the person's mental condition. If only one medical practitioner certifies that the person is mentally disordered, the judge may still make an order for detention, pending a final determination.

The essence of improved safeguards lies in the definition of mentally disordered, but further protection could be provided by changes in the admission procedure. Committal does not require the certificate of a psychiatrist — that of a general practitioner who may not be fully cognisant of diagnostic entities and treatment in the psychiatric field, will suffice. In the authors' view, one of the two medical certificates required under sections 19 and 21 should be that of a trained psychiatrist whenever possible.

In New Zealand, the District Court Judge makes the final determination as to whether a person is to be detained or not. The accusation is made,[35] undoubtedly justifiably, that some judges uncritically accept the medical certificates as a determinant of the need for detention. Yet the judge as a lay person in a medical field would have some difficulty in over-riding a medical view of mental disorder, although he is trained to weigh and balance the various competing interests. Arnold made the suggestion[36] that a tribunal made up of a psychiatrist, social

32 Supra n. 30, para. 1.17.
33 Section 19(4) gives a discretion to the superintendent to receive the patient on only one appropriate certificate.
34 Section 35 empowers the medical officers of health and the police to apply for a reception order in certain cases.
35 Arnold "The Mental Health Act 1969" (1968-70) 5 V.U.W.L.R. 391, 399.
36 Ibid. 398.

worker and judge could take the place of the judge alone, examining the person alleged to be mentally disordered and vetting the medical certificates. In terms of protection against erroneous detention such a tribunal would provide a stronger bulwark against error. However, such a legalistic approach at that stage of the procedure could produce results similar to those of the Lunacy Act 1890 (U.K.) — a delay in treatment for those genuinely in need of it. It would not be practicable to constitute such a panel for section 19 emergency commitments. However, an admission tribunal instead of a judge alone for a section 21 commitment could provide a third and independent medical assessment, as well as the benefits of a lay person and judge.

C. *Review Procedure*

Section 55 directs that the superintendent keep the case of every committed patient under review. The efficacy of this as a review procedure appears discretionary as the superintendent need only peruse the nurse's notes in the clinical records, before deciding whether or not a patient should cease to be committed.[37] The person therefore with the power to discharge a patient has no parallel duty to actually see the patient for the purposes of review. In practice a superintendent should ensure that all committed patients are kept under medical review, but there is no legislative provision to secure this.[38]

Section 73 provides for the discharge of a committed patient when the patient is fit for this, and subsection (13) defines fit for discharge as being when detention is no longer necessary for the patient's own good or the public interest. The discharge statistics of Porirua Mental Hospital in 1979[39] would suggest that at Porirua at least, successful review and discharge is taking place, yet the patient has very limited scope to initiate such review. Section 74 provides the only viable review procedure in the face of the superintendent's unwillingness to discharge. The section provides that a High Court Judge may direct an inquiry into the detention of a committed patient, and if satisfied that the person is not mentally ill, does not require detention or treatment, or is illegally detained, the judge can direct discharge. Such a procedure is not only unwieldy in itself, but erroneous in granting the power of discharge solely to judicial determination. The section 74 review could be supplemented by a review hearing at first instance, by a body similar in constitution to the Mental Health Review Tribunal established in the United Kingdom under the 1959 Act. The existence of these tribunals is to ensure that persons are not unnecessarily deprived of their liberty. The tribunals consist of a legal chairman, psychiatrist and lay member, and can discharge a patient if satisfied that the patient is not suffering from mental disability, that it is not necessary to continue detention, and that if released the patient would not act in a manner dangerous to himself. The legal, social and medical approach is therefore interwoven in the decision-making process. At the hearing the applicant/patient can address the tribunal, give evidence and call witnesses, and

37 This is the usual procedure for the s. 53(2) requirement.
38 Section 73(3). The patient can apply to the Minister for an inquiry to be held by a District Court Judge.
39 Mental Health Data 1979. Dept. of Health, Wellington, Table 6.

may be legally represented.[40] In New Zealand such a procedure could provide a valuable safeguard against erroneous detention, particularly if instituted within twenty-one days of a reception order.[41] The tribunal could also be helpful if the lay member was an experienced social worker, who could investigate the home circumstances, and enlist other agencies to find alternative placement.[42]

IV. HUMAN RIGHTS

"There are fashions and cycles in mental health legislation just as there are in any other area of law".[43] Legislative change is a response to the ethos of a particular era. The 1970's particularly saw an expansion in demands for the protection of human rights, with the United Nations adopting a Declaration on the Rights of Disabled Persons in 1976.[44] This declaration includes the mentally ill and strongly re-affirms the principle that such people have the same civil and political rights as their fellow citizens. It also refers to the need for proper legal safeguards against any possible abuse whenever there is a justification for a limitation or suppression of these rights.[45] A large number of appellate court cases in the U.S.A. concerning mental illness have had a substantial impact on patients' rights and have provoked new legislation and considerable interest in the law schools of the U.S.A.[46]

Greater interest in the human rights aspect of commitment was found by the authors in American as opposed to British journals, but one reason for this could be the very high rates of committal apparent in the U.S.A. A 1955 comparative survey[47] found that England and Wales had 70 per cent voluntary admissions, while the U.S.A. had only 10 per cent voluntary admissions.

The commitment of an individual to a mental hospital is clearly a deprivation of liberty. In response to a much greater awareness of this deprivation many writers have advocated the abolition of commitment for the mentally ill.

1. *Arguments put forward by those advocating abolition of commitment*

(a) The basic argument is that involuntary commitment produces unacceptable numbers of improper committals. People who are not mentally disordered are deprived of their liberty because society regards the mental hospitals as a repository for the overflow of social deviants. Although the social disruption to

40 Wood "Mental Health Review Tribunals" (1970) 10 Med. Sci. Law 90.
41 In the U.K. the committed patient can apply once during the initial six months of detention.
42 The superintendent may well wish to discharge a patient (possibly brought to the hospital under s. 35) but have no alternative placement.
43 Curran and Harding *"The Law & Mental Health: Harmonising Objectives"* (W.H.O. Publications, Geneva, 1978) 21.
44 Resolution 3447 adopted by the General Assembly during its thirtieth session. General Assembly Official Records, Supplement No. 34 (A/10034), New York, 1976.
45 Various states of the U.S.A. have enacted reform legislation in which mental patients are presumed to be fully legally competent unless special action is taken before the courts to have them declared incompetent.
46 Supra n. 43, 32.
47 W.H.O. Comparative Survey 1955 as cited in Curran and Harding supra n. 43, 11.

families, friends and the public caused by severely disturbed behaviour may be very great, this is still not sufficient reason in a free society to deprive people of their liberty. When such behaviour leads to crime, the criminal justice system takes over. A professor of law claimed that[48]

> [Society's] duty to protect the liberty of all persons must lead us to forego commitment in those few cases where many persons might agree it is warranted. Unless the system can be demonstrably reformed, too little benefit will be provided at the expense of far too much deprivation of liberty.

(b) Socially disruptive deviant behaviour should not necessarily be seen as evidence of mental disorder; neither should an impaired ability for rational thought and action. The abolitionist view is that irrationality is really a moral, social and legal judgment made when the specific thought or action is compared to the dominant social standards. The mentally disordered person may not be capable of deciding in his or her own best interests, but then neither are many who are living freely in society. This view raises the debate over acceptance of the medical model versus the moral model.[49] At present the medical view has gained ascendancy in the U.S.A. and Professor Morse predicts that as long as the debate remains unresolved the group with the power to define disorders will retain the ability to over include deviant behaviour as mental disorder.[50]

(c) Professor Morse argues that even if the medical model is accepted, the problem of diagnostic reliability still remains, and in answer to the view that being dangerous to oneself or others should be additional criteria in the definition, he argues that prediction of danger is not accurate enough. Lack of predictive accuracy can lead to incorrect incarceration.

(d) The therapeutic aim of committal is the provision of care and treatment, but this aim presupposes firstly that care and treatment will be available, and secondly, that the disorder is treatable. Lack of expert staff and financial shortages can render satisfactory care and treatment a myth, so the aims of commitment are unattainable. Hospitalisation is not necessary for the efficacious treatment of the majority of committed patients. However, if there was no commitment a greater number of people would be forced into the criminal justice system following the commitment of a prescribed act. Such people would be punished with treatment provided in jails.

2. *An answer*

Civil commitment must be looked at as a multi-faceted phenomenon. Its very existence stems from the state's paternalism in deciding what is in the best interests of its citizens, the current trends in psychiatric care, and the resources a country is prepared to inject into health services. The need is to strike a balance between liberty and paternalism. The argument against socially deviant behaviour alone being interpreted as evidence of mental disorder is a compelling one. Pressure from the police, family and friends can be so overwhelming that the definition of

48 Morse "A Preference for Liberty: The Case against Involuntary Commitment of the Mentally Disordered" (1982) 70 Calif. L.R. 54.
49 Siegler and Osmond op.cit. 19, 16.
50 Supra n. 47.

"mental disorder" is often applied in a very wide sense. Social deviants who are not mentally ill should not be involuntarily detained as at present. However, such a limitation must be accompanied by expanded opportunities for voluntary care and services. A family which can no longer cope with a disruptive member must have some alternative avenues for help.

The major flaw in the concept of abolishing commitment is that the truly mentally ill would be deprived of treatment. The preceding arguments base the concept of a committable disorder on purely behavioural symptoms. Yet many mentally ill patients do not declare their disturbance by overt behavioural acts alone because their experience may be predominantly subjective. In such conditions as schizophrenia and manic-depression, the person may undergo subjective changes in mood, thought, volition and perception; this could affect the person, maximally, with profound anxiety or depression leading to self-destructive thoughts, fear or even terror, total loss of motivation, passivity feelings, delusional thoughts or hallucinations. Such changes would amount to major distress and may or may not be accompanied by overt acts. The person may suffer torment through such subjective experiences but may only show this overtly by, for example, withdrawal from contact.

The clinical-medical approach has shown clearly that such diagnostic entities as manic-depression and schizophrenia exist, and that diagnosis, when made following strict guidelines, is both quick and accurate. A high degree of concordance exists between psychiatrists when the true clinical medical model is applied, but unhappily that model can be corrupted when society's reactions are included in the definitions used. Modern treatment for the acutely disturbed schizophrenic and manic-depressive is most effective and can very often relieve suffering in a matter of a few days or weeks. The person should be encouraged to accept treatment voluntarily, and only where the disorder substantially impairs the ability to understand or communicate about the possibility of treatment, should the patient be committed for treatment. Not to hospitalise would be inhumane, so there is incompatibility between liberty and humaneness. Psychiatric units in general hospitals can and do provide for such acute treatment, and with the growth of day hospitals, community mental health services, and hospital hostels, incarceration in a mental hospital should eventually prove limited.

V. CONCLUSION

Civil commitment should be severely limited, by the substitution of a narrow and precise definition for "mentally disordered". Such a definition has been proposed in part by Dr Alan Stone[51] and is two-fold:

1. Commitment should exist for cases of true medical need, where the person is suffering from a reliably diagnosed condition, the immediate prognosis for which is major distress unless treatment is provided, and the disorder substantially impairs the person's ability to understand or communicate about the possibility of treatment.

51 A. Stone *Mental Health and Law: A System in Transition* (U.S. Dept. of Health Education and Welfare, Maryland, 1975) 66-70.

The term "reliably diagnosed condition" should be defined using the syndromal definition of mental disorder. Within that definition the criteria that should be applied are:

(i) altered perceptions (auditory, somatic hallucinations);

(ii) thought disorder (including delusional thinking);

(iii) altered mood state (psychotic depression, mania);

(iv) loss of volition, withdrawal and self-neglect.

The application of the foregoing criteria could be either

(a) in the interpretation section of new mental health legislation under "reliably diagnosed condition", or

(b) included within the certifying document as a guideline to the medical practitioner, or

(c) distributed by the health department to medical practitioners as suggested desirable criteria to follow in commitment procedure.

The authors would expect that the medical practitioners providing the medical certificate would be sufficiently trained and experienced to facilitate accurate diagnosis within the above criteria. Any one of the criteria may be sufficient to indicate true medical need, but the more complete the picture the more accurate is the determination of "the reliably diagnosed condition".

2. Secondly, commitment should exist for situations where society's interest is overwhelming. This is the dangerousness element and must be confined to those who are a danger to themselves or others because of their mental disorder. For example, many people who become severely depressed see suicide as the only answer to their problems. It is within the authors' experience that with appropriate treatment, the depressive illness resolves and with resolution, the suicidal alternative disappears, showing that the suicidal urge can present as a symptom of mental illness. Therefore, civil commitment under this second limb will require a less severe test than that proposed for the first definition. This definition should limit commitment to those cases who are either a danger to themselves or others because of a reliably diagnosed condition. The element of major distress is not specifically included in the definition, as it is inherent in the dangerousness itself. The criterion of inability to communicate is also deleted from the definition because society's interest over-rides that of the individual.[52]

52 A person can plan and commit suicide without suffering from any mental disorder, and likewise, a person can constitute a danger to others without suffering from mental disorder. The former will be free to end his own life, while the latter will be dealt with by the criminal justice system.