

## ARTICLE

**The Therapeutic Potential of Mental Health Law**

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Mental illness and addiction have far-reaching economic and social implications that are set to worsen if New Zealand does not take radical action to address the problem. There is limited scope for clinicians to consider the proportionality of their decisions under the current Mental Health (Compulsory Assessment and Treatment) Act 1992; many of the practices permitted by the Act contradict contemporary scientific and sociological understandings of the mechanisms that promote mental wellness. Using the United Nations Convention on the Rights of Persons with Disabilities, this article aims to promote therapeutic and rights-compliant mental health policy, to the extent that these aims are consistent. It suggests that law reform promoting recovery-oriented treatment is the most appropriate mechanism of effecting change. However, an independent review and reporting body is needed before any such reform occurs to prevent inefficient policy-making.

**I Introduction**

Mental illness and addiction affect 50–80 per cent of New Zealanders.<sup>1</sup> In 2017, anxiety disorders were the eighth-highest cause of death and disability combined. Similarly, depressive disorders were the fifth-highest cause of disability in 2017. Concerningly, self-harm in New Zealand, as a cause of both premature mortality and death and disability combined, is significantly higher than the mean rate of its global comparator group. In 2016, depressive disorders cumulatively accounted for the sixth-highest cause of the most

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1 Kevin Allan *New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commission* (The Office of the Health and Disability Commissioner, February 2018) at 21.

death and disability.<sup>2</sup> Premature death of people with both physical and long-term mental health and addiction conditions cost the economy \$6.2 billion annually.<sup>3</sup> In 2017, more people received a benefit for “psychological and psychiatric conditions — such as stress, depression, bipolar disorder and schizophrenia — than those with an intellectual disability, cancer, or musculo-skeletal disorders”.<sup>4</sup> People experiencing mental illness are a vulnerable group due to stigmatisation and discrimination. As a result, they are more likely to become homeless or experience inappropriate incarceration than the general population.<sup>5</sup> Consequently, there is a risk of abuse of state power against these individuals either through direct mechanisms or tolerance of inappropriate therapies.<sup>6</sup>

Using the lens of therapeutic jurisprudence, this article evaluates whether, and if so, how, Aotearoa New Zealand might address the negative outcomes of the current mental health legislation to produce more therapeutic outcomes.<sup>7</sup> Therapeutic jurisprudence studies the law as a social force, which has the potential to produce either beneficial (therapeutic) or harmful (anti-therapeutic) outcomes.<sup>8</sup> It aims to introduce consideration of the impact of a legal decision on therapeutic values into the calculus of policy-making, which calls for analysis of empirical evidence.<sup>9</sup> Research indicates that the recovery model of healthcare is an important aspect of securing therapeutic outcomes for consumers of mental health services.<sup>10</sup> For people experiencing mental illness, recovery means “gaining and retaining hope, understanding of one’s abilities and disabilities, engaging in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self”.<sup>11</sup> Protection of human rights is one mechanism of protecting patient autonomy, which is central to the recovery model. Therefore, the aim of this article is to explore means of reforming the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) to, first, produce more therapeutic outcomes and secondly, make it rights compliant to the extent that the aims are consistent.<sup>12</sup>

Following this introduction, Part II will outline the current mental health law, including patient rights under the MHA and relevant human rights instruments. Part III then outlines five major issues with the MHA: first, the lack of a legal requirement of incapacity; secondly, indefinite community treatment orders (CTOs); thirdly, the ineffective challenge

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- 2 Institute for Health Metrics and Evaluation “New Zealand” IHME: Measuring what matters <[www.healthdata.org](http://www.healthdata.org)>. Comparator groups were chosen based on the GBD regional classifications, known trade partnerships, and socio-demographic indicators.
  - 3 Victoria Institute of Strategic Economic Studies *The economic cost of serious mental illness and comorbidities in Australia and New Zealand* (The Royal Australian and New Zealand College of Psychiatrists, 2016) at 17.
  - 4 Nicholas McBride “Thousands with mental health conditions stuck on benefit for years” (21 June 2017) Stuff <[www.stuff.co.nz](http://www.stuff.co.nz)>.
  - 5 World Health Organisation *Mental health action plan 2013-2020* (2013) [WHO] at 8.
  - 6 Ian Freckelton and Warren Brookbanks “Mental Health Law” in Ian Freckelton and Kerry Peterson (eds) *Tensions and Traumas in Health Law* (The Federation Press, Sydney, 2017) at 52.
  - 7 David Wexler and Bruce Winnick “Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research” (1991) 45 U Miami L Rev 979 at 990.
  - 8 Warren Brookbanks “Introduction” in Warren Brookbanks (ed) *Therapeutic Jurisprudence: New Zealand Perspectives* (Thomson Reuters, Wellington, 2015) at 4.
  - 9 Wexler and Winnick, above n 7, at 983.
  - 10 Janice Connell and others “Quality of life of people with mental health problems: a synthesis of qualitative research” (2012) 10:138 Health Qual Life Outcomes. See also Martin Knapp and others *Investing in recovery: Making the business case for effective interventions for people with schizophrenia and psychosis* (Centre for Mental Health, 2014).
  - 11 WHO, above n 5, at 39.
  - 12 Brookbanks “Introduction”, above n 8, at 9.

procedures under the MHA; fourthly, the anti-therapeutic nature of seclusion; and fifthly, the lack of oversight over coercive practices. Part IV will outline proposals for reform: first, to replace the current legal test with an “incapacity to consent to psychiatric treatment” test; secondly, to establish an independent review and reporting body (IRRB); thirdly, to introduce a right of mandatory review of compulsory status; and fourthly, to adopt a recovery model of treatment. I will then in Part V analyse whether law reform is the most appropriate mechanism of effecting the change desired. Finally, I conclude that law reform is both a desirable and necessary change to improve the therapeutic outcomes of service-users.

## II Current Law

### A *Legal test of mental disorder*

Section 2 of the MHA defines “mental disorder” for the purposes of compulsory assessment and involuntary treatment as:

- ... an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—
- (a) poses a serious danger to the health or safety of that person or of others; or
  - (b) seriously diminishes the capacity of that person to take care of himself or herself...

The two-part s 2 test requires first, an abnormal state of mind, and second, consequences of, or a specified severity of, the abnormal state of mind.<sup>13</sup> This is a legal definition, and as such might not equate with medical classifications of mental disorder.<sup>14</sup> It should also be noted that a person cannot be subjected to compulsory treatment by reason only of their political, religious or cultural beliefs, sexual preferences, criminal or delinquent behaviour, substance abuse or intellectual disability.<sup>15</sup>

Defining mental disorder is complicated, and as such the determination of each requirement of the test is a matter of judgement.<sup>16</sup> However, in *Re Application by X* the Mental Health Review Tribunal (MHRT) approved a four-step approach to determining whether a person is mentally disordered for the purposes of the MHA.<sup>17</sup> Clinicians and the MHRT must determine:<sup>18</sup>

- (i) ... what behavioural phenomena are characteristic of the patient.
- (ii) ... whether or not those behavioural phenomena should be regarded as constituting delusions or disorders of mood, perception, volition or cognition in accordance with a meaning of ordinary usage.

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13 John Dawson “Judicial Review of the Meaning of ‘Mental Disorder’” (2003) 10:1 *Psychiatry, Psychology and Law* 164 at 167 at 25.

14 *Re H* [1996] NZFLR 998 (FC) at 1001.

15 Section 4.

16 Sylvia Bell and Warren Brookbanks *Mental Health Law in New Zealand* (3rd ed, Thomson Reuters, Wellington, 2017) at 27.

17 *Re Application by X* MHRT09/130, 25 March 2010.

18 At [53].

- (iii) ... whether such delusions or disorders, if apt descriptors of the behavioural phenomena, give rise to an abnormal state of mind (whether of a continuous or immediate behaviour).
- (iv) [If as a result of these considerations, the patient appears to have an abnormal state of mind, then] ... whether or not that abnormal state of mind is of such a degree that it poses a danger to the health or safety of the patient or others or seriously diminishes the capacity of the patient to take care of himself or herself.

The s 2 test for whether a person has a mental disorder does not require mental incapacity, although this is a relevant consideration.<sup>19</sup> However, the MHA provides that responsible clinicians (RCs) should obtain patient consent to treatment “wherever practicable”, even if the RC is authorised under the MHA to treat the patient without their consent.<sup>20</sup> Where a patient consents to treatment, they may withdraw consent at any time. If treatment continues after this point, the patient is deemed to be treated without consent.<sup>21</sup>

Currently, the courts and MHRT assess the first limb of the test, an “abnormal state of mind”, objectively. The objective approach has been criticised as potentially widening the definition because it is judged from the assessor’s ideas of ‘normality’. However, the disadvantage of a subjective approach is that it is hard to know another person’s mind.<sup>22</sup>

In considering para (a) of the second limb of the test, the courts or MHRT assess the risk required for “serious danger” by balancing considerations of likelihood, proximity and frequency. The abnormal state of mind must be connected to the danger posed to the health and safety of the patient or others, which includes physical, emotional and psychological health and wellbeing.<sup>23</sup>

Paragraph (b) of the second limb constitutes both objective and subjective considerations. The courts and MHRT compare what an ordinary person is capable of achieving, within the limitations of the patient’s background, with the patient’s functioning in fact.<sup>24</sup> Furthermore, the patient’s capacity must have diminished as a result of their abnormal state of mind.<sup>25</sup> However, a patient need not lack capacity to meet the requirement of diminished capacity. This limb of the test requires the assessor to balance competing rights to health and self-determination. Some authors suggest that diminution of care needs to be particularly terrible to justify intervention, and that the courts and MHRT should “focus on the risk of dangerous outcomes” rather than securing care.<sup>26</sup>

## B *Committal process*

Anyone who believes that a person may be suffering from a mental disorder may initiate the committal process, by asking the Director of Area Mental Health Services (the DAMHS) for an assessment of the person.<sup>27</sup> A certificate from a health care practitioner must

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19 Jeremy Skipworth “Should Involuntary Patients with Capacity Have the Right to Refuse Treatment?” in John Dawson and Kris Gledhill (eds) *New Zealand’s Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 213 at 220.

20 Sections 59(2)(a) and 59(4).

21 Section 63.

22 Bell and Brookbanks, above n 16, at 28.

23 At 35–36.

24 *Re C* DC Auckland CAT132/99, 28 August 2000 as cited in Bell and Brookbanks, above n 16, at 38.

25 Bell and Brookbanks, above n 16, at 38.

26 At 39.

27 Section 8.

accompany the application, which states that upon examination there are reasonable grounds to believe that the proposed patient is mentally disordered.<sup>28</sup> An RC is assigned to every person falling under the MHA.<sup>29</sup> They must consult with the proposed patient's family when conducting examinations, unless it is not reasonably practicable or in the patient's best interests.<sup>30</sup>

The office of the DAMHS then arranges an initial examination of the patient by a psychiatrist, or a suitably qualified medical practitioner (or nurse) if no psychiatrist is available.<sup>31</sup> The health practitioner, who cannot be the same person as the practitioner who issued the certificate,<sup>32</sup> then issues a certificate of preliminary assessment in which they will declare the patient as either mentally disordered or not.<sup>33</sup> A mentally disordered patient is then required to undergo assessment and treatment for five days, either as an inpatient or outpatient.<sup>34</sup>

If the RC considers that the patient is still mentally disordered after the first period of assessment and treatment, then the patient must undergo further assessment and treatment for 14 days.<sup>35</sup> Finally, before the completion of the second period of assessment, the RC must make a certificate of final assessment. The final certificate determines whether the patient is fit to be released from compulsory status or not.<sup>36</sup> If the RC considers that the patient is not fit to be released, they must apply to the court for a compulsory treatment order (CompTO) under Part 2 of the MHA.<sup>37</sup> Pending the determination of the CompTO application, the patient is treated and assessed in accordance with the second period of assessment.<sup>38</sup> Thus, the committal process is staggered leading up to the stage of issuing a CompTO.<sup>39</sup>

Family Court judges hear and determine applications for CompTOs where practicable.<sup>40</sup> The procedural requirements contained in ss 19–26 of the MHA apply to all hearings for CompTOs. The judge must examine the patient, consult with the RC and consider the patient's views on the proposed course of assessment and treatment.<sup>41</sup> The entry requirements for a CompTO do not match the exit criteria.<sup>42</sup> The entry criteria require that compulsory status is necessary in the circumstances; therefore, a CompTO may not be necessary where a patient's family or carers can contain the danger.<sup>43</sup> This is, accordingly, a high threshold for intrusion on personal autonomy.<sup>44</sup> However, a patient is only fit to be released when they are no longer mentally disordered.<sup>45</sup> The CompTO may

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28 Section 8B.

29 Section 7.

30 Bell and Brookbanks, above n 16, at 116.

31 Section 9.

32 Section 9(3).

33 Section 10.

34 Section 11(2)(b).

35 Section 13.

36 Section 14.

37 Section 14(4).

38 Section 15.

39 John Dawson and Kris Gledhill "Introduction" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 17 at 24.

40 Section 17.

41 Section 18.

42 *Waitemata Health v Attorney-General* [2001] NZFLR 1122 (CA) at [91].

43 At [85]–[86].

44 At [88].

45 At [118].

be either a CTO or an inpatient CompTO.<sup>46</sup> The effect of the CompTO is that the patient is required to accept treatment for their mental disorder, as directed by the RC, during the first month.<sup>47</sup> After the one-month period, the patient must consent to the treatment unless a psychiatrist considers that the treatment is in the best interests of the patient or it is not possible to get their consent and the patient requires emergency treatment.<sup>48</sup> CompTOs expire after six months unless extended by the court for a further six months.<sup>49</sup>

### C *Patient rights when treated under the MHA*

Patients have a variety of rights when treated under the MHA. First, they have the right to apply for review of their condition by a judge under s 16 during both the first and second periods of assessment and treatment.<sup>50</sup> Additionally, all patients subject to a CompTO have the right to apply for review of their condition by the MHRT.<sup>51</sup> RCs must conduct a formal review of patients subject to CompTOs not later than three months after the date of the CompTO, and thereafter at six-month intervals.<sup>52</sup> Any person who has received the patient's certificate of clinical review may apply to the MHRT for review.<sup>53</sup> Alternatively, the MHRT may itself decide to conduct a review at any time or if the requirements for the formal review have not been met.<sup>54</sup>

In addition to the right to review, patients acquire rights in Part 6 of the MHA, which supplement the rights affirmed in the New Zealand Bill of Rights Act 1990 (the NZBORA) and the rights enjoyed by all health service consumers under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (the Code).<sup>55</sup>

A patient's rights under the MHA include the right to be kept informed of their rights as a patient (or proposed patient)<sup>56</sup> and the right to treatment and to be informed about treatment.<sup>57</sup> The right to be informed about treatment includes the right to an explanation about expected benefits and side-effects of any treatment before treatment commences. Moreover, patients have the right to independent psychiatric and legal advice.<sup>58</sup> Patients have the right to company except in circumstances where the RC specifies that seclusion is necessary for the care or treatment of the patient or the protection of other patients.<sup>59</sup> The patient, or someone on their behalf, may complain that the rights specified in Part 6 have been denied or breached, and a district inspector (DI) will investigate the allegation of breach.<sup>60</sup> The DI reports their findings to the DAMHS, who then takes steps to rectify the issue.<sup>61</sup> However, the MHA leaves the remedy to the DAMHS' discretion. The patient may

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46 Section 28(1).

47 Section 59(1).

48 Sections 59(2) and 62.

49 Sections 33–34.

50 Sections 11(7) and 12(12).

51 Section 79.

52 Section 76.

53 Section 79(1).

54 Sections 79(2)–(3).

55 Ministry of Health *The Mental Health Act and human rights: A discussion document* (2017) at 9.

56 Section 64.

57 Sections 66–67.

58 Sections 69–70.

59 Section 71.

60 Section 75(1).

61 Section 75(2).

refer their case to the MHRT for further investigation if dissatisfied with the outcome of the complaint to the DI.<sup>62</sup>

The patient, or anyone on their behalf, may also complain to the Health and Disability Commissioner (HDC) about any of the services received under the MHA, particularly where the complainant feels that the treatment provided under the MHA was not provided in a way that minimised harm to the patient. Additionally, competent patients may complain to the HDC that involuntary treatment breaches their right to refuse treatment. However, the HDC has discretion to take no further action at any time after a preliminary assessment and therefore most complaints are in fact not formally investigated.<sup>63</sup>

A patient's rights under the NZBORA include the right of "everyone" to refuse to undergo any medical treatment.<sup>64</sup> However, "everyone" has been interpreted to mean "every person who is competent to consent".<sup>65</sup> This, along with right 7(7) of the Code, which provides that every consumer of health and disability services has the right to refuse services and withdraw consent to services, means that doctors and the superintendent thus cannot impose treatment on competent patients admitted under the MHA.<sup>66</sup> In addition to this, s 19 of the NZBORA affirms the right to be free from discrimination, which includes the ground of disability.<sup>67</sup> Lastly, right 4(4) of the Code provides that every consumer has the right to provision of services in a manner that minimises potential harm to, and optimises the quality of life of, that consumer.

In addition to these domestic protections, parties must comply with the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which Aotearoa has signed and ratified.<sup>68</sup> The CRPD clarifies the application of the rights in the Universal Declaration on Human Rights 1948 and the International Covenant on Civil and Political Rights 1966 (ICCPR) to persons with disabilities.<sup>69</sup> Therefore, Aotearoa has assumed an obligation under international law to ensure and promote the full realisation of all the rights it contains.<sup>70</sup> Indeed, one of the purposes of the NZBORA is to affirm Aotearoa's commitment to the ICCPR. Article 1 of the CRPD states that persons with disabilities include those who have long-term mental impairments, which is understood to include mental illness and psychosocial disability. The use of the non-exclusive word "includes" provides for wider flexibility in interpreting the term "disability" so that persons with other conditions may also be covered.<sup>71</sup>

There are also procedural protections under the MHA. These include patient representation during the committal process,<sup>72</sup> the right to natural justice,<sup>73</sup> and judicial

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62 Section 75(3).

63 Health and Disability Commissioner Act 1994, s 38. See also Health and Disability Commissioner *Annual Report for the Year Ended 30 June 2019* (2019) at 17.

64 Section 11.

65 *Re S* [1992] 1 NZLR 363 (HC) at 374.

66 At 374.

67 Human Rights Act 1993, ss 21(h)(iii) and (v).

68 United Nations Convention on the Rights of Persons with Disabilities 2515 UNTS 3 (opened for signature 13 December 2006, entered into force 3 May 2008) [CRPD].

69 International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976); and Universal Declaration of Human Rights (entered into force 10 December 1948).

70 CRPD, art 4.

71 Ministry of Health, above n 55, at 10.

72 Section 19.

73 Section 20.

inquiry by the High Court into the legality of the detention of people in hospital.<sup>74</sup> However, the Court retains the discretion to excuse the patient from attending the hearing or it can dispense with a hearing if no person wishes to be heard in respect of the application.<sup>75</sup> DIs are lawyers appointed by the Minister of Health and are independent from the Ministry of Health (MoH) and health and disability services. The three-pronged role of the DI is to: ensure patients subject to CompTOs are cared for in accordance with statutory requirements; monitor the safety of mental health and disability services; and investigate complaints and conduct inquiries.<sup>76</sup> Therefore, DIs are “watchdogs of patients’ rights”.<sup>77</sup>

In summary, patients may apply to the court or MHRT for review of their condition and are entitled to be released if they are no longer “mentally disordered”. Furthermore, a patient or any other person may lay a complaint to a DI for breach of patient rights contained in Part 6 or to the HDC about any of the services provided under the MHA. Alternatively, competent patients compulsorily treated may file a court claim for a breach of both ss 11 and 19 of the NZBORA, although that is subject to patients having sufficient time and funds as well as willingness to go through the added stress and anxiety the adversarial process of a court case involves.<sup>78</sup> In my opinion, the legal protections available to patients are insufficient given the consequences for patients of the decisions made under the MHA.

### III Issues with the Law

#### A *The lack of a legal requirement of incapacity*

The first major issue with the MHA is that the s 2 test does not require that patients lack capacity before they can be subjected to compulsory treatment. The MHA allows the court to override competent patients’ right to refuse treatment once they meet the criteria for mental disorder by requiring them to accept treatment for their condition. Therefore, Aotearoa does not recognise the rights of patients, who come within the MHA, to refuse general psychiatric treatment regardless of their capacity to consent.<sup>79</sup> Empirical research has shown that there is a portion of involuntary patients whose decision-making capacity is not significantly impaired.<sup>80</sup> Therefore, denial of the right to refuse treatment for competent patients is inconsistent with the rights-based approach to healthcare promoted by the Code.<sup>81</sup> As such, this article argues that so-called substitute decision-making breaches arts 5, 12 and 25 of the CRPD.

First, art 12 of the CRPD guarantees equal recognition before the law, which implies that legal capacity is a universal attribute inherent in all persons. Legal capacity encompasses both legal standing and legal agency: that is, the ability to hold and exercise

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74 Section 84.

75 Sections 19 and 26.

76 “Mental Health District Inspectors” (2 October 2017) Ministry of Health: Manatū Hauora <[www.health.govt.nz](http://www.health.govt.nz)>.

77 Mental Health Foundation *Legal Coercion Fact Sheets* (2016) at 26.

78 T Cronin and others “A comparison of mental health legislation in five developed countries: a narrative review” (2017) 34 *Irish Journal of Psychological Medicine* 261 at 267.

79 Skipworth, above n 19, at 222.

80 At 213.

81 At 213.



rights and duties.<sup>82</sup> Legal capacity must be upheld for persons with disabilities on an equal basis with others because it is necessary for the exercise of civil, political, economic, social and cultural rights.<sup>83</sup> The MHA employs a model of substitute decision-making because it allows patients with a mental disorder to be treated without their consent.<sup>84</sup> Substitute decision-making is concerned with mental capacity. However, the MHA also denies patients their legal capacity, through denial of their right to refuse treatment and subsequent deprivation of liberty. Importantly, there is a distinction between legal and mental capacity, as exemplified in art 12 of the CRPD, under which perceived or actual deficits in mental capacity cannot justify the denial of legal capacity.<sup>85</sup>

The protections offered by art 12 and the subsequent interpretation by the United Nations Committee on the Rights of Persons with Disabilities (UNComRPD) are laudable. The intentions are to prevent unnecessary and prejudicial removal of a person's legal capacities, avoid paternalistic substitute decision-making and to avoid discriminatory assumptions about persons with disabilities.<sup>86</sup> Denial of legal capacity is justifiable in extreme circumstances, namely where a person lacks competence. A total prohibition on substitute decision-making may prejudice incompetent patients because it could expose this vulnerable group to the adverse consequences, such as a decline in health, resulting from not taking actions that they are unequipped to take.<sup>87</sup> However, denial of legal capacity in one sphere does not equate to a total denial of legal capacity: for example, patients may still exercise their capacity in other areas, such as by voting or getting married, where they are still recognised as persons before the law.<sup>88</sup> The MHA breaches art 12 by denying competent patients their legal capacity to refuse treatment.

Secondly, art 5 of the CRPD prohibits all discrimination on the basis of disability as guaranteed also by s 19(1) of the NZBORA. Article 2 of the CRPD defines "discrimination" as any distinction, exclusion or restriction on the basis of disability which impacts the person's fundamental rights. Generally, States have the ability to deny legal capacity, but it must be on the same basis for all persons and cannot be based on a personal trait such as gender, race, or disability.<sup>89</sup> However, as John Dawson illustrates, there are areas in which we limit a person's legal capacity which are justifiable, because the limitation is based on the distinction between the person's capacities compared to others, to perform the task safely.<sup>90</sup> For example, it is justifiable to prevent a blind person from driving.<sup>91</sup> Similarly, an inflexible approach to discrimination is undesirable.

I suggest that the detention and involuntary treatment of persons based on an apparent or diagnosed mental illness under the blanket approach of the MHA is discriminatory. It presumes that all people experiencing mental illness are incompetent to consent to treatment. This presumption is inconsistent with evidence, which shows that roughly two-thirds of patients treated under the MHA would have the capacity to consent

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82 United Nations Committee on the Rights of Persons with Disabilities *General comment no 1: Article 12: Equal recognition before the law* (CRPD/C/GC/1, 19 May 2014) [UNComRPD] at [13].

83 At [8].

84 At [27].

85 At [13].

86 John Dawson "A realistic approach to assessing mental health laws' compliance with the UNCRPD" (2015) 40 *International Journal of Law and Psychiatry* 70 at 72.

87 At 72.

88 At 72-73.

89 UNComRPD, above n 82, at [32].

90 Dawson, above n 86, at 73.

91 At 73.

to treatment. The justification of differential treatment grounded in self-harm is also discriminatory. The law allows for competent refusals of treatment for *physical* illness, even where it may lead to the consumer's death. Additionally, the rationale of risk of harm to others is discriminatory. Other people who pose a similar risk, for example those with contagious diseases, are not subject to preventative detention for treatment, or at least there is a much higher threshold for their detention and treatment.<sup>92</sup> Therefore, it follows that the MHA discriminates against competent patients, by denying them their legal capacity, because it is not based in a distinction of capacity with other competent people in a similar position.

Lastly, art 25 of the CRPD imposes an international obligation on Aotearoa, requiring all health and medical professionals to obtain the free and informed consent of persons with disabilities prior to any treatment.<sup>93</sup> However, the MHA makes no reference to the right of competent but mentally ill people to refuse treatment on the same basis as mentally well people. Where a person has capacity to consent, the MHA should require free and informed consent before treatment to comply with art 25.

Thus, the primary issue with the MHA is that it takes a blanket approach, treating competent patients the same as the incompetent. Treating competent patients without their consent unreasonably denies them of their legal capacity. This is discriminatory because it is not on an equal basis with other competent patients, who pose a similar risk of harm to themselves and others.

### B *Indefinite CTOs*

The second major issue with the MHA is that it permits indefinite CTOs.<sup>94</sup> Both the number of applications for CompTOs (or extensions) and the number of orders granted have increased since 2004.<sup>95</sup> Indeed, all forms of coercion under the MHA increased between 2005 and 2011, including electroconvulsive treatment and seclusion.<sup>96</sup> Worryingly, AJ O'Brien's comparative study found that Aotearoa's use of CTOs was amongst the highest in the world.<sup>97</sup>

Section 22 of the NZBORA states that everyone has the right not to be arbitrarily arrested or detained. Article 14 of the CRPD similarly guarantees the right to liberty and security for persons with disabilities. The CRPD clearly states that deprivation of liberty based on the existence of a disability would violate art 14 if it is not on an equal basis for all. The UNComRPD is of the opinion that provisions such as s 2 are discriminatory and breach art 14.<sup>98</sup>

The United Nations High Commissioner for Human Rights also adopts this approach because the detention practices are partly justified by the person's disability. Under this interpretation, it has been argued that art 14 does not mean that the State cannot lawfully

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92 Sarah Gordon "The Recovery of Compulsory Assessment and Treatment" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 268 at 273.

93 UNComRPD, above n 82, at [41].

94 Dawson and Gledhill, above n 39, at 22.

95 Ministry of Health *Office of the Director of Mental Health Annual Report 2016* (December 2017) at 72-73.

96 Gordon, above n 92, at 273.

97 New Zealand Human Rights Commission | Te Kāhui Tika Tangata *Consideration of New Zealand's initial report under Article 35 of the Convention on the Rights of Persons with Disabilities* (22 August 2014) at [51].

98 Ministry of Health, above n 55, at 12.

detain persons with disabilities for their care and treatment or to prevent harm to others. Rather, the State must justify the restriction of liberty on neutrally defined legal grounds which apply equally to all persons, without reference to disability.<sup>99</sup> However, Ian Freckelton and Warren Brookbanks adopt a narrower interpretation, proposing that art 14 restricts the imposition of involuntary status on patients where the restriction of liberty is justified purely by their disability. Therefore, it remains open for States to order involuntary status where a person poses an unacceptable risk to themselves, or others within the community, due to their disability.<sup>100</sup>

In my opinion, this narrow interpretation is more tenable than the UNComRPD's radical interpretation. Additionally, the High Commissioner's interpretation is only realistic if reform abolishes the MHA and institutes a single standard for capacity. However, a single capacity standard is not desirable for forensic patients and could have unexpected ramifications in other areas of the law, such as criminal law.

Detention encompasses both inpatient CompTOs and CTOs because they involve a high level of control over a person's whereabouts.<sup>101</sup> While the narrow interpretation of art 14 permits detention, indefinite CTOs amount to arbitrary detention, as such breaching both art 14 of the CRPD and s 22 of the NZBORA. Accordingly, there is a very real possibility that some patients have been compulsorily treated for over 20 years without an independent review of their condition.<sup>102</sup>

Indefinite detention is not accepted in a criminal setting where there is a proved wrong; it is therefore unclear why it should be tolerated as a default strategy for innocent people simply because they pose a risk by reason of their disability. The indefinite detention of patients unjustifiably amplifies the risks posed by mental health patients.

### *C Ineffective challenge procedures under the MHA*

The lack of independent review resulting in indefinite detention of patients' subject to CTOs is part of a larger issue: the challenge procedures in the MHA are largely ineffective, which in turn breaches art 13 of the CRPD. Article 13 guarantees the right to access to justice. Yet there is both a low uptake of the right to review by patients and a low success rate of MHRT review, which is at least in part due to extra-legislative factors.

Only a small proportion of compulsory patients apply to the MHRT for discharge and an even smaller proportion of discharges are granted. In 2016, the MHRT received 62 applications for review of CompTOs under s 79 and less than 10 per cent of those applications were successful.<sup>103</sup> In comparison, the success rate in Canada is 31 per cent and in the United Kingdom 34 per cent. The MHRT process relies on patients having knowledge of the MHRT and how to apply for review, which could explain the low uptake.<sup>104</sup> Furthermore, the MHRT holds relatively few proceedings each year, which likely contributes to the lack of independent review of a large number of patients on indefinite treatment orders.<sup>105</sup>

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99 Freckelton and Brookbanks, above n 6, at 56.

100 At 56.

101 Kris Gledhill "A 'Rights' Audit of the Mental Health Act" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 285 at 293.

102 Mental Health Foundation, above n 77, at 27.

103 Ministry of Health, above n 95, at 70.

104 Mental Health Foundation, above n 77, at 27.

105 Gledhill, above n 101, at 297.

Additionally, a review of MHRT decisions between 1994 and 2012 identified that implicit factors such as “insight” and “compliance with medication”, which are not found in the legislation, appear to influence discharge decisions.<sup>106</sup> This review prompts a concern that extra-legislative factors may play a role in decision-making, which they should not. The MHRT reviews a patient’s condition to assess whether they are still mentally disordered for the purpose of release from compulsory status.<sup>107</sup> However, it is concerning that necessity of detention is not required for this assessment due to the differential standards for entry and exit from compulsory status. This discrepancy with the necessity requirement under s 27(3) in the committal process is unsound. There is no reason why necessity of detention suddenly becomes irrelevant at the review stage when it was determinative at the committal stage. This consideration of extra-legislative factors in decision-making is inappropriate, particularly when not balanced against necessity, which *is* a legislative factor.

The United Nations Working Group on Arbitrary Detention reported that they were concerned that “in practice, compulsory treatment orders are largely clinical decisions, and it is difficult to effectively challenge such orders” in Aotearoa.<sup>108</sup> The implicit factors are largely informed by clinical evidence; therefore, it is not hard to see why this is the case. Consequently, there is a net-widening effect in CTOs, because they are being used as a default mechanism for dealing with patients. The prominence of implicit factors and privilege given to medical opinion in decision-making creates a deficiency in procedural fairness of the MHRT review process.<sup>109</sup>

MHRT oversight has been ineffective to address this problem. Therefore, it is arguable that patients subject to the MHA cannot fully realise their right to access to justice due to the ineffective challenge procedures.

#### D *The anti-therapeutic nature of seclusion*

The fourth issue is that the practice of seclusion under s 71 of the MHA is anti-therapeutic. The sole constraint on placing a patient in seclusion is that it shall be used only where, and only for as long as, it is necessary for the care or treatment of the patient or the protection of other patients.<sup>110</sup> In 2016, 10.8 per cent of patients in adult mental health services were secluded at some time during the reporting period. People who were secluded were often secluded more than once (on average 1.8 times). Length of seclusion events varied: 74 per cent of events lasted *less than 24 hours* while 12 per cent lasted for *longer than 48 hours*.<sup>111</sup> However, the report does not specify how much longer the seclusion events lasted when longer than 48 hours. Additionally, the MHA does not stipulate a maximum period of seclusion. This article argues that seclusion breaches the rights enshrined in arts 14 and 17 of the CRPD, as well as ss 9 and 22 of the NZBORA. Article 14 and s 22 relate to liberty and security of the person. Article 17 guarantees the right to respect for mental and physical integrity while s 9 states that everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment.

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106 Kate Diesfeld “Implicit Factors for Discharge by the Mental Health Review Tribunal” in John Dawson and Kris Gledhill (eds) *New Zealand’s Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 114 at 115.

107 Mental Health (Compulsory Assessment and Treatment) Act, s 79.

108 Mental Health Foundation, above n 77, at 11.

109 At 27.

110 Section 71(2)(a).

111 Ministry of Health, above n 95, at 36.

The primary rationale for the use of seclusion in a mental health setting is that it is a form of therapy.<sup>112</sup> However, there is concern about the overuse and counter-therapeutic effects of restraint and seclusion under mental health policy.<sup>113</sup> The impact of seclusion on a person is the same as solitary confinement in prison. Investigations of solitary confinement indicate that it is potentially psychologically damaging for those who experience it. It has led to declining mental functioning, hallucinations and delusions; and caused depression, withdrawal and psychotic behaviour.<sup>114</sup> From a therapeutic view, coercion and seclusion damage the therapeutic relationship between clinicians and patients because the power imbalance is highlighted in these circumstances.<sup>115</sup> Therefore, the evidence contradicts the justification for seclusion.

Furthermore, seclusion rooms in health and disability units also resemble prison segregation cells due to the stark physical environment and lack of patient control over their environment.<sup>116</sup> Health and disability units are meant to provide a therapeutic environment for healing unwell people, whereas prison segregation rooms are intended to punish prisoners. MoH Guidelines recommend that patients should be provided with personal belongings and things to do while secluded. However, none of the rooms visited by Dr Shalev, when compiling her report on seclusion and restraint in Aotearoa, fulfilled this recommendation. The report also found that seclusion and restraints were not always used as emergency last resort tools for the shortest time possible. Clinical staff were found to have used the seclusion rooms for incorrect purposes. In all types of institutions visited, basic necessities, such as access to drinking water, natural light and means of communicating with staff were not always provided.<sup>117</sup> The conditions imposed on service-users in seclusion rooms are potentially damaging to their mental and physical well-being, which is anti-therapeutic.

Every consumer has the right to services of an appropriate standard, which includes services that minimise potential harm to, and optimise the quality of life of, that consumer.<sup>118</sup> Consequently, seclusion may amount to arbitrary detention, breaching art 14 of the CRPD and s 22 of the NZBORA, for lack of a therapeutic basis. Even if seclusion is a justifiable limitation on s 22, the lack of a maximum period of seclusion coupled with ineffective challenge procedures creates a dangerous situation where a patient may be secluded for years. For example, Ashley Peacock, who has autism and an intellectual disability, as well as severe schizophrenia, was secluded for two-and-a-half years with only 30 minutes of daily outdoor activity.<sup>119</sup>

I propose that indefinite seclusion is not justifiable given its potentially psychologically harmful effects. Furthermore, the conditions of seclusion units breach art 17 because patients are subjected to similar treatment as used for the punishment of prisoners, even though they have not committed an offence. If seclusion is a justifiable limitation on the

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112 Mental Health Commission *Seclusion in New Zealand Mental Health Services* (April 2004) at 7.

113 Freckelton and Brookbanks, above n 6, at 64.

114 Mental Health Commission, above n 112, at 7.

115 At 7.

116 Sharon Shalev *Thinking Outside the Box? A review of seclusion and restraint practices in New Zealand* (Human Rights Commission, April 2017) at 43.

117 At 44–46.

118 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, right 4(4).

119 Kirsty Johnston "Autistic man Ashley Peacock remains locked up a year on" *The New Zealand Herald* (online ed, New Zealand, 21 May 2018).

right to liberty in all cases, then at the least the units should provide a therapeutic environment.

In my opinion, the combination of the psychological harm caused by seclusion and the appalling conditions of seclusion units amount to a breach of s 9 of the NZBORA. There is no therapeutic justification for placing patients in such degrading conditions.

#### *E Lack of oversight over coercive practices*

The fifth issue is the lack of oversight under the MHA once a CompTO is ordered. To begin with, the reporting of mental health statistics by the Director of Mental Health (DMH) is problematic. Many of the annual reports from the DMH are not consistent and are difficult to understand. Some years reported figures as percentages and in others the figures were population-adjusted. These inconsistencies did not facilitate comparative analysis: while the reports provided a snapshot of the particular year, they did not give insight into trends. Moreover, the reports appeared to be written so as to show the figures in the best light. For example, the 2016 Report showed that Aotearoa's use of seclusion had dropped since a seclusion reduction policy was implemented in 2009. However, it fails to mention that Aotearoa has one of the highest rates of seclusion in the world.<sup>120</sup>

In addition, the staggered committal process falls away once a patient is subject to compulsory treatment. The staggered process leading up to the detention and treatment of patients provides for points of checks and balances. However, once the CompTO has been issued there is less oversight to ensure that compulsory treatment is necessary, or that the patient still meets the requirements for compulsion. This is a result of the lack of mandatory judicial review and infrequent MHRT hearings. I believe fewer patients would experience indefinite CTOs and seclusion if the same system of checks applied at the CompTO stage.

The lack of oversight means that there is a lack of data from reporting. Consequently, it is difficult to ascertain Aotearoa's true mental health needs. Inadequate reporting exacerbates the other issues that I have identified; remedying a problem depends on first recognising it.

These five major issues highlighted clearly illustrate the need for reform in this area.

## **IV Reform Proposals**

### *A An "incapacity to consent to psychiatric treatment" test*

My first suggestion is for an "incapacity to consent to psychiatric treatment" test to replace the s 2 test for mental disorder. Intervention would be based on evidence of impaired mental function relevant to the particular task.<sup>121</sup> As required by s 5 of the NZBORA, the courts and MHRT must apply the capacity test in a way that ensures that any limitation on liberal rights is demonstrably justified in a free and democratic society. Therefore, treatment without consent and detention are only justifiable when it is a proportionate response to the person's situation, which requires that treatment is necessary.<sup>122</sup> Reform should bring psychiatric practice in line with general medical practice, and where not

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120 Gordon, above n 92, at 272.

121 Dawson, above n 86, at 79.

122 At 74.

possible to do so it should clearly justify the disparity. Well-drafted mental health laws could improve both patient care and clinical outcomes by promoting clinical best practice.<sup>123</sup> A capacity test provides equal recognition before the law for psychiatric patients (art 12) because RCs would require free and informed consent (art 25), which matches general medical practice for physical illness. Therefore, the law would no longer discriminate against competent psychiatric patients because the test does not rely on mental disability (art 5). However, it still recognises that certain mental functions are necessary for performing certain tasks.<sup>124</sup>

In summary, an “incapacity to consent to psychiatric treatment” test is beneficial because it is consistent with general health practice, international human rights law and research evidence. I am not advocating for the abolishment of detention; there are sound reasons for detaining certain patients in some scenarios, such as where people pose an unacceptable risk to the community. However, I propose that we remove unnecessary coercion by giving competent patients the right to refuse treatment.<sup>125</sup>

Admittedly, a capacity test has some drawbacks. First, it may violate the patient’s other fundamental rights by giving increased recognition to the rights discussed above. For example, refusal of treatment may deprive the patient of access to the highest standard of care.<sup>126</sup> Despite this risk, I maintain that the introduction of such a test is justified; defensive application of the current test allows for increasing and unchecked discrimination of psychiatric patients. Therefore, while a capacity test is rights compliant, it would also ensure more therapeutic outcomes for consumers. In my opinion, a capacity test would shift consumer attitudes from apathy and disengagement with their treatment plan to active engagement with their recovery by giving them more agency.

A capacity test also raises the risk of involuntary, competent patients who refuse treatment being detained without treatment, potentially affecting the safety of wards for both patients and staff.<sup>127</sup> A review of empirical studies showed that while refusal is not uncommon, it is not a major problem. Rather, in reality most patients either lack capacity upon admission or consent to treatment, meaning they can be treated, or refusals are short-term. Most who refuse give good reasons for doing so, for example medication side-effects, which can often be accommodated; in addition, treatment refusal can be solved by negotiation between patients and staff. Therefore, most refusals are generally resolved rapidly and never require review by courts or other bodies.<sup>128</sup>

A third risk is that capacity is difficult to assess. Findings of mental state are applied to the decision-making task at hand. Additionally, the capacity threshold increases with severity of consequences of the treatment. Therefore, a patient’s competence may vary depending on the type of treatment or their capacity may fluctuate over time.<sup>129</sup>

While the right to refuse will inevitably incur certain costs, I propose that the importance of increased respect for patient autonomy outweighs the increased costs. The current regime has been in place for 26 years, yet clinical outcomes for service-users have not improved. Compulsory CTOs do not produce significantly different outcomes when compared with standard care.<sup>130</sup> Moreover, a capacity test is a paradigm shift, which may

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123 Skipworth, above n 19, at 226.

124 Dawson, above n 86, at 74.

125 Skipworth, above n 19, at 225.

126 Cronin and others, above n 78, at 268.

127 Skipworth, above n 19, at 219.

128 At 223.

129 At 216.

130 Gordon, above n 92, at 270.

reduce the influence of assessor bias for Māori to help address the overrepresentation of Māori under the MHA.<sup>131</sup> Admittedly, there is a risk that a capacity test would create a vicious cycle where compulsorily treated patients begin to refuse treatment once they are well enough, causing a decline in their mental health. However, the small proportion of patients who under a capacity test would be at risk because they do not think that they require treatment are no better served by the current regime, which already creates a vicious cycle by focussing on curing illness so that, for example, accessing support services becomes difficult for patients who no longer meet the threshold for specialist care.<sup>132</sup> On the other hand, I propose that autonomous patients are more likely to “buy into their treatment”, whereby because treatment would no longer be a forced ultimatum and doctors would therefore have to convince patients of the benefits of treatment, non-compliance after discharge would reduce.

### *B The establishment of an IRRB*

My second suggestion for reform is to institute an IRRB with a two-pronged function. First, it would review court and MHRT decisions under the MHA. The IRRB will have the power to order reconsideration of decisions that do not apply the statutory test appropriately, which will ensure that treatment remains necessary. Secondly, it would monitor whether compulsion was appropriate in all cases by requiring RCs, the courts and MHRT to report coercive uses of the MHA. The place of DIs would remain important. Since patients will not have direct contact with the IRRB, DIs, who are watchdogs of individual patients’ rights, would work in conjunction with the IRRB as a watchdog of systemic rights compliance. Through these functions, the IRRB would address clinical attitudes, collect data for policy making and formulate a service development plan for mental health and addiction services.

An independent body is necessary to avoid a conflict of interests. Whereas Australia, Canada, England, Scotland and Ireland have some form of commission with an independent monitoring mechanism or initiative to reduce involuntary treatment, in New Zealand the MHRT is funded by the MoH, which is responsible for the implementation of the MHA, and as such provides inadequate oversight.<sup>133</sup>

Oversight by the IRRB will help address clinical attitudes to ensure that reform is effective. While law reform can address Aotearoa’s non-compliance with international obligations, it is unlikely to address the issue of increasing coercive uses of the MHA. The interpretation of the “serious danger” limb of the test, which governs compulsion, has expanded over time, as clinicians often “continue to apply their own clinical and moral intuition in the face of legal criteria that are perceived as restrictive”.<sup>134</sup> The IRRB would add an additional layer of protection to the existing system by ensuring that MHRT and court decisions apply the test consistently. I propose that critical oversight of decision-making will create a golden standard of relevant considerations for CompTO reviews. This will assist clinicians by providing guidance on when to release patients from compulsory status, thereby lessening concerns associated with incorrect discharge. While an

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131 Ministry of Health, above n 95, at 25.

132 Allan, above n 1, at 41.

133 Mental Health Foundation, above n 77, at 27.

134 Dawson and Gledhill, above n 39, at 22; and Sarah E Gordon and Anthony O’Brien “New Zealand’s mental health legislation needs reform to avoid discrimination” (2014) 127(1403) NZMJ 55 at 62.



independent body is unlikely to provide a complete solution to increasing coercion, it will provide a level of critical analysis that is currently lacking.

Furthermore, the IRRB will collect data for effective policy-making. The MoH no longer collects data on people accessing mental health and addiction services in a central database. Without such accurate data, there is a risk of inefficient policy-making and diminished accountability for politicians.<sup>135</sup> It is difficult to verify claims made in reports by the DMH about the efficacy of current mental health policy, and consequently anyone attempting such a task must visit multiple sources of data to make inferences, which may or may not be accurate. The *Rising to the Challenge* service development plan for mental health policy expired in 2017; ultimately, the IRRB will use this data to formulate a new service development plan. Currently, however, there is an incongruity between usage of mental health and addiction services and funding.<sup>136</sup> A development plan based on accurate statistics would ensure that funding is spent in areas that require it most, thereby harmonising funding and access to these services.

### C *An automatic right of review of legal status*

My third proposed solution is to create a right to mandatory judicial or MHRT review of legal status at periodic intervals and whenever a CompTO is renewed.<sup>137</sup> Automatic review is required to protect the best interests of patients who lack capacity on admission under a capacity test. The review process would ensure that patients still meet the legal requirements for compulsion, reducing the likelihood of arbitrary detention. Additionally, automatic review would bring New Zealand law in line with other culturally similar jurisdictions, such as Ireland, Ontario and Scotland.<sup>138</sup> Ultimately, mandatory review will ensure that any limitation on the right to liberty and security is demonstrably justified in a free and democratic society, as required by s 5 of the NZBORA. Periodic review of compulsory status will effectively abolish indefinite CTOs by ensuring that treatment is necessary and proportionate under the capacity test, consequently improving access to justice for psychiatric patients.

However, since the right not to be subjected to arbitrary detention is overarching, the State may have to bear the burden of mandatory review as a means of positive action to protect vulnerable consumers.<sup>139</sup> This means the mandatory review process will inevitably increase the case load of the courts and MHRT, thus increasing the costs of review. For this reason, any reform should retain the shared division of workload between the court and MHRT.

### D *A recovery-oriented model of treatment*

One of the foreseeable consequences of increased review for some patients is additional anxiety and distress due to the adversarial nature of the process. For that reason and others, my fourth suggestion for reform is the adoption of a recovery model of care in psychiatric practice, which would alleviate the intermittent stress of review procedures. A recovery-oriented approach prioritises supporting people to achieve their own goals. A

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135 Allan, above n 1, at 42.

136 At 9. Usage has increased by 73 per cent over 10 years, yet funding only increased by 40 per cent.

137 Dawson and Gledhill, above n 39, at 25.

138 Cronin and others, above n 78, at 263.

139 Gledhill, above n 101, at 297.

service based on this model requires listening and responding to the consumers' perspective of their condition, delivering services based on an equal partnership, offering consumers a choice on treatment and therapies and utilising peer-support workers.<sup>140</sup>

Research suggests that a recovery-oriented model is more appropriate and therapeutic than coercive care. Acknowledging that some patients may never be fully cured of their mental illness, recovery is rather defined as a process of changing one's attitudes, values, feelings, goals, skills and roles.<sup>141</sup> In so doing, recovery enables the patient to live a satisfying, hopeful and purposeful life even within the limitations caused by illness.<sup>142</sup> Accordingly, symptoms are not as important under the recovery model because it teaches patients how to identify and deal with their mental illness. Recovery shifts focus from symptoms to key indicators of success, which include housing, employment, education, social and family relationships, and wellbeing.<sup>143</sup> The capacity test that I propose falls within a recovery model of care because it affords maximal respect to autonomy within justifiable limitations.

A recovery model would provide a continuum of care and thus better accommodate people with moderate mental health needs. The current system's focus on intensive cases, where people are most unwell, does not support the road to recovery. Those with moderate mental health needs do not meet the threshold for specialist care; focussing on "curing people" creates difficulties in accessing support services for cases once they fall below this threshold. Consequently, there is a gap in the continuum of care. The lack of support for both groups leads to an overreliance on GP prescribed medication without addressing worsening outcomes.<sup>144</sup> Prescriptions for mental health have increased by 50 per cent over the past 10 years and cost the New Zealand economy \$63.34 million in 2017.<sup>145</sup>

Another key aspect of recovery-oriented treatment is active and effective involvement of carers, who are often family members. Consultation with family under the current model only occurs in 61 per cent of cases, mostly during the patient's initial assessment. The main reason that family were not consulted was that the service providers deemed it not reasonably practicable in the circumstances. However, 28 per cent of the time it was not known why the family were not consulted.<sup>146</sup> Consultation with carers is not without consequences, because they are often at a high risk of harm when the patient experiences psychotic episodes. This being the case, the system needs to provide support to carers. Promisingly, evaluations from Finland have shown that an "Open Dialogue" model could produce better outcomes for consumers when compared to traditional treatment models for psychosis. There, family involvement models resulted in fewer relapses and psychotic symptoms as well as improved employment status.<sup>147</sup> Consultation could improve outcomes for all service users, and it is potentially more culturally appropriate for Māori

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140 WHO, above n 5, at [50].

141 William Anthony "Recovery from mental illness: The guiding vision of the mental health service system in the 1990s" (1993) 16(4) Psychosocial Rehabilitation Journal 11.

142 Freckelton and Brookbanks, above n 6, at 66.

143 WHO, above n 5, at [50].

144 Allan, above n 1, at 41.

145 Pharmaceutical Management Agency "Year in review 2017" (21 November 2017) PHARMAC <[www.pharmac.govt.nz](http://www.pharmac.govt.nz)>.

146 Ministry of Health, above n 95, at 33.

147 Allan, above n 1, at 46.

consumers: under the “Te whare tapa whā” model of care, taha whānau (family) is one of the four dimensions essential for well-being.<sup>148</sup>

Furthermore, a recovery-oriented approach would reduce seclusion. Current guidelines around seclusion are insufficient, since clinicians have used seclusion units inappropriately. Speaking in an Australian context, Kirby J has observed that “mental health law can sometimes be used to control the behaviour of individuals merely to relieve family, neighbours, and acquaintances from embarrassment, rather than to assist the individuals primarily concerned to be themselves”.<sup>149</sup> At the minimum, recovery-oriented treatment demands stricter guidelines around its use. Abolishing seclusion is a longer-term aspiration because it requires significant resources. Aotearoa would need to research alternative ways of controlling patient violence within treatment facilities, by training staff and improving monitoring of current seclusion events. An important corollary is that we need to address the current high staff turnover in the sector to ensure consistent practices and efficient training.<sup>150</sup>

As such, I propose modification of seclusion units in the interim to provide a more therapeutic environment for patients, for example by decorating the space with murals, providing patients with personal belongings, creating engaging recreation areas, using weighted anti-anxiety blankets and providing patients with entertainment or things to do while secluded. These modifications would better protect the mental and physical integrity of people subjected to seclusion. Modified seclusion units and stricter oversight by the IRRB would render seclusion more rights consistent until the practice is abolished. Promisingly, Recovery Innovations Incorporated’s adoption of a new approach to compulsory treatment shows that crisis services can successfully adopt recovery approaches that do not rely on seclusion and mechanical/chemical restraint.<sup>151</sup>

The recovery model would also advocate for early intervention to maximise effective treatment.<sup>152</sup> Mental disorders begin before the age of 18 years old for most people who experience a mental disorder as an adult.<sup>153</sup> Moreover, Aotearoa’s youth suicide rate is among the highest in the OECD.<sup>154</sup> Investing in early intervention would likely reduce the economic burden of mental health conditions and address the high youth suicide rate.<sup>155</sup>

Lastly, a recovery model would utilise peer-support workers. International research has found that professional peer-support workers are as beneficial for consumers as treatment by professionals, providing improved clinical, subjective and social outcomes. Peer-support workers are in a unique position to empower consumers by connecting them to the community, resources and support networks. Furthermore, peer-support workers are more cost-effective than other professionals working in comparable roles.<sup>156</sup> Accordingly, integrating more peer-support workers into the mental health sector is a potential cost-effective option for reducing strain on the current workforce. In light of the understaffing difficulties that currently face the sector, peer-support workers will provide expedient and effective relief.

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148 At 46.

149 *Harry v Mental Health Review Board* (1994) 33 NSWLR 315 (CA) at 322.

150 Mental Health Foundation “MHF welcomes mental health inquiry” (media release, 23 January 2018).

151 Gordon, above n 92, at 271.

152 Allan, above n 1, at 31.

153 At 20.

154 Ministry of Social Development *The Social Report 2016* (June 2016) at 48.

155 See Allan, above n 1, at 27. Premature death costs the economy 2.6 per cent of GDP.

156 At 47–48.

I suggest that reform should introduce a set of “Mental Health Principles” into the MHA that outline therapeutic strategies. The principles would become mandatory relevant considerations for decision-making at all levels of interaction with the MHA. A good example of this is s 11 of the Mental Health Act 2014 (Vic), which explicitly references promoting recovery and therapeutic outcomes. Furthermore, the Victorian Act requires that carers for patients are involved in the decision-making process and that carers should have their role recognised, respected and supported.

## **V Is Law Reform the Most Appropriate Mechanism of Effecting Change?**

I suggest that law reform is the most appropriate mechanism for effecting meaningful change in clinical practice. As outlined above, there are real issues with the law as it stands currently and legislative reform implementing the proposed solutions is the best method of addressing these problems.

Although more funding under the present MHA could address most of the issues raised in this article, this is an inefficient solution. Increasing funding would address outcomes without addressing the substantial shortcomings of current practice. The MHA is anti-therapeutic because its application often has damaging effects on consumers. Examples of the MHA’s anti-therapeutic effects include the practice of seclusion and the state of seclusion units in Aotearoa. Ultimately, Aotearoa requires accurate reporting of the mental health needs of the population to formulate effective mental health policy and to direct funding to the areas that require it most. Until an IRRB is established, it is near impossible to know the most efficient distribution of any increased funding in this sector. Furthermore, funding would not address the net-widening effect of CTOs, which has meant that Aotearoa has one of the highest uses of CTOs in the world.

In addition, the MHA is 26 years old and as such has not evolved with changing scientific and social understandings of mental illness. From a therapeutic perspective the MHA does not give decision-makers much scope to consider the proportionality of their decision, which is a necessary element in the calculus of their decision-making.

Although reform has the potential to exacerbate the issues identified in this article if legislators adopt a pro-compulsion approach, I propose that recent empirical research and ethical analyses, if utilised by legislators, will largely mitigate the risks of reform. In my opinion, the potential payoffs of law reform are worth this risk.

## **VI Conclusion**

This article has explored how Aotearoa should reform its mental health legislation to produce more therapeutic outcomes. Dissatisfaction from both staff and service-users is a recurrent theme in criticism of the mental health system. The five issues with the law outlined in this article are contributing factors to the increasing burden of mental illness. I propose that no amount of funding mitigates the damage caused by coercive practices and consequently, law reform is a practical and effective mechanism for achieving the changes necessary to promote therapeutic outcomes. The stringent rights protection demanded by the CRPD, while therapeutic, is not necessarily realistic or workable. Accordingly, rights compliance cannot be the focus of reform in my opinion. Rather, my suggestions for how Aotearoa could reform its mental health law include: adoption of a capacity test; establishing an IRRB; creating a right of automatic review of legal status; and

incorporating “Mental Health Principles” into the MHA to promote recovery-oriented treatment.

The reforms suggested in this article strike an appropriate balance between rights compliance and efficient laws. While some of these suggestions are resource intensive, others provide cost savings: for example, decreased detention, coupled with a narrower capacity test, will set off the added costs of mandatory review of legal status and the implementation of the IRRB. Additionally, while recovery-oriented care will likely require large expenditure when first adopted, utilising peer-support workers and the continuum of care under this model will reduce the economic burden of mental illness in due course. Ultimately, the IRRB is the guardian of efficiency, combatting bad mental health policy through accurate statistical analysis, to ensure that any restructure best serves consumers. I propose that these solutions will improve clinical outcomes for consumers of mental health services.