Breaking the Ambivalence towards Mental Health:

An International Revolution?

1. The rights of those diagnosed with mental disabilities have been so far strikingly neglected on the world stage, as illustrated by the failure of international human rights law to effectively address the human rights abuses suffered by the mentally disabled to date.

2. The extent of ambivalence in the international arena towards the rights of the mentally disabled is shown by the dearth of binding treaties which deal with persons with disabilities - out of the seven adopted in the last 55 years, only one refers to the issue of disability.[1] This is despite the fact that persons with disabilities make up one of the largest global minority groups, and that the rights of this class have been systematically violated in virtually all societies.[2]

3. Calls to put an end to this legal and social impasse have however resulted in a modern-day revolution in respect to the rights of this invisible group of people. The 2001 initiative[3] to consider proposals for a "*comprehensive and integral international convention to protect and promote the rights and dignity of persons with disabilities*" means that for the first time in legal history a Disability Rights Convention is being pursued.

4. This paper examines the current advance to protect and elevate the rights of the mentally disabled, together with its implications for all professionals working within the area of mental health. Three topics of interest are specifically explored:

    1. The progress made so far in respect to the rights of the mentally disabled within the paradigms of international human rights law;

    2. The proposed International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities;

    3. What the New Convention means for the practice of psychiatrists of today: Conceptualization of the "medical" and "social" models.

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1 The rights of children with disabilities are protected in Article 23 of the Convention on the Rights of the Child.

2 Aaron A. Dhir *Human Rights Treaty Drafting through the lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities,* 41 Stanford Journal of International Law, p182.

3 Resolution 56/168 put forward by the Mexican Government in the United Nations General Assembly. The resolution called for consideration of a Convention.

Development of International Human Rights Law in respect to Rights of the Mentally Disabled 1971-2006

"Mental Health laws, policies, programs, and projects should: embody human rights and empower people with mental disabilities to make choices about their lives; give legal protections relating to the establishment of quality mental health facilities; establish robust procedural mechanisms for the protection of those with mental disabilities; and ensure the integration of persons with mental disabilities into the community."[4]

International Human Rights Instrument	Legal Status in New Zealand	Description
International Covenant on Civil and Political Rights ("ICCPR")	Non-binding: There is no covenant remedy available domestically. Ratified by New Zealand in 1978. Principles of the ICCPR contained in the New Zealand Bill of Rights Act 1990.	Recognition that "*the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy is civil and political rights, as well as his economic, social and cultural right*s."[5] An individual complaint based on a breach of the Covenant can be brought before the UN Human Rights Committee.
International Covenant on Economic, Social, and Cultural Rights[6] ("ICESCR")	Non-binding. Ratified by New Zealand in 1978.	Central international protection of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[7] No individual complaint based on a breach of the Covenant can be brought before an international body, although a draft Optional Protocol is currently being considered which may make this possible. It is noted that all instruments below also do not provide an individual complaint system.

4 WHO Resource Book on Mental Health, Human Rights and Legislation (2005)

5 Preamble to the ICCPR.

6 Adopted 19 Dec.1966, G.A. Res. 2200 (XXI), U.N. GAOR, 21st Session. (entered into force 3 Jan 1976).

7 Paul Hunt and Judith Mesquita, *Mental Disabilities and the Human Right to the Highest Attainable Standard of Health*, Human Rights Quarterly, 2006, p340

UN Declaration on the Rights of Mentally Retarded Persons 1971[8]	Non-binding	Recognition of the need for the assistance of mentally retarded persons to develop their abilities in various fields of activities and of promoting their integration as far as possible in normal life.
UN Declaration on the Rights of Disabled Persons 1975[9]	Non-binding	Recognition that disabled persons have the same civil and political rights as other human beings. Calls for national and international action to ensure that the instrument would be used as a common basis and frame of reference for the protection of these rights.
World Programme of Action concerning Disabled Persons 1982[10]	Non-binding	Promotion of effective measures for prevention of disability, rehabilitation and the realization of the goals of "full participation" of disabled persons in social life and development, and of "equality'.
Declaration of Caracas on Restructuring of Psychiatric Care 1990[11]	Non-binding	Promotion of community-based service models integrated into social and health care networks.[12]
Council of Europe's Recommendation on Psychiatry and Human Rights[13]	Non-binding	Consideration that the time had come for the member states of the Council of Europe to adopt legal measures guaranteeing respect for human rights of psychiatric patients.
Standard Rules on Equalization of Opportunities for Persons with Disabilities 1993 ("Standard Rules")[14]	Non-binding	Broad range of commitments to ensure that equal opportunities are available to persons with disabilities in all fields. Significant for the right of persons with disabilities to

8 G.A. res. 2856 (XXVI), 26 U.N. GAOR Supp. (No. 29) at 93, U.N. Doc. A/8429 (1971)
9 General Assembly resolution 3447 (XXX) of 9 December 1975
10 Adopted by the General Assembly 1982, G.A. Res. 37/51, U.N. GAOR, 37th Session, Supp. No.51, U.N. Doc. A/37/51
11 Regional Conference on the Restructuring of Psychiatric Care in Latin America, convened by PAHO.WHO, 11-14 Nov, 1990.
12 Declaration of Caracas.
13 Recommendation 1235 (1994) Eur. Parl. Ass. 10th Sitting.
14 G.A. Res. 48/9, R. 14(2), U.N. GAOR, 85th plen. Mtg., U.N. Doc A/Res.48/96 (1993)

		participate, as well as the important role played by the organizations representing persons with disabilities.[15]
UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991 ("MI Principles")[16]	Non-binding	Detailed minimum human rights standards concerning mental health care, which are applicable to persons with mental "illness" and anyone else in a mental health care facility.
Montreal Declaration on Intellectual Disability 2004[17]	Non-binding	Recognition of human rights of persons with intellectual disabilities, including the right to health, and the interconnections between this and other rights.[18] It represents an important step in standard setting because the rights and obligations surrounding intellectual disabilities had previously received little attention.[19]
Council of Europe's Recommendation on the Protection of the Human Rights and Dignity of Persons with Mental Disorder[20]	Non-binding	Aim to enhance the protection of the dignity, human rights and fundamental freedoms of persons with mental disorder, in particular those who are subject to involuntary placement or involuntary treatment.
Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health 2005[21]	Non-binding	Development of a common analytical framework in respect to the right to health in the context of mental disabilities. The right to health is "unpacked" in terms of freedoms, entitlements, non-discrimination and

15 Paul Hunt and Judith Mesquita, *Mental Disabilities and the Human Right to the Highest Attainable Standard of Health*, Human Rights Quarterly, 2006, p337

16 G.A.Res. 6/119, U.N. GAOR, U.N. Doc A/RES/46/119 (1991)

17 Adopted 6 October 2004 at the Pan-American Health Organization/World Health Organization Conference on Intellectual Disability. Available at www.aamr.org/pdf/DeclarationMTL.pdf

18 Paul Hunt and Judith Mesquita, *Mental Disabilities and the Human Right to the Highest Attainable Standard of Health*, Human Rights Quarterly, 2006, p337.

19 Ibid. p337.

20 Recommendation Rec(2004) 10, Comm. Of Ministers, 896th Meeting, Rec.N0 (2004) 10 (22 Sept. 2004)

21 U.N ESCOR, Comm'n on Hum. Rts., 61st Session, Agenda Item 10, U.N. Doc.E/CN/4/2005/51 (2005)

		equality, participation, international assistance and cooperation, monitoring and accountability.[22]

Overview of Current Domestic Human Rights Law in respect to the Rights of the Mentally Disabled

5. As illustrated below, neither does domestic legislation afford sufficient protection for the rights of the mentally disabled. Criticism can be principally laid in respect to the lack of entrenchment of the New Zealand Bill of Rights Act.

Domestic Legislation	Legal Status	Description
New Zealand Bill of Rights Act 1990	Primary Legislation. Not superior legislation. Can be displaced by other legislation.	An Act— (a) To affirm, protect, and promote human rights and fundamental freedoms in New Zealand; and (b) To affirm New Zealand's commitment to the International Covenant on Civil and Political Rights. Rights most pertinent to the mentally disabled: (i) Right not to be subjected to torture or cruel treatment (ii) Right not to be subjected to medical or scientific experimentation (iii) Right to refuse to undergo medical treatment (iv) Liberty of the person
Human Rights Act 1993	Primary legislation	Provision of better protection of human rights in New Zealand in general accordance with United Nations Covenants or Conventions on Human Rights. Provides a comprehensive set of prohibited grounds of discrimination, which includes disability.
Mental Health Compulsory Assessment and Treatment Act 1992	Primary legislation	An Act (i) to redefine the circumstances in which and the conditions under which persons may be subjected to

[22] *The Right to the Highest Attainable Standard of Health,* General Comment No.14, U.N. ESCOR, Comm.On Econ., Soc. And Cult. Rts., 22nd Session, U.N. Doc. E/C.12/2000/4 (2000)

		compulsory psychiatric assessment and treatment, (ii) to define the rights of such persons and to provide better protection for those rights, and (iii) generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder.
Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003	Primary legislation	Provision of a system for the compulsory care and rehabilitation of persons who have an intellectual disability and who have been charged with, or convicted of, an offence.
Criminal Procedure (Mentally Impaired Persons) Act 2003	Primary Legislation	To reform the law: (a) provide the courts with appropriate options for the detention, assessment, and care of defendants and offenders with an intellectual disability: (b) provide that a defendant may not be found unfit to stand trial for an offence unless the evidence against the defendant is sufficient to establish that the defendant caused the act or omission that forms the basis of the offence:

"***International law has made significant advances in protecting the rights of [marginalised groups]. In stark contrast, not only is there no international treaty that comprehensively guarantees the rights of those with disabilities, but the desire to codify has been virtually non-existent.***"

-*Aaron Dhir, Member of the Rehabilitation NGO Delegation to the United Nations Working Group Meeting and the fifth Ad Hoc Committee Meeting in respect to the proposed* ***International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities.***[23]

6. Whilst it is clear that there is a range of detailed international standards which have had a bearing on the human rights of persons with mental disabilities, it is commonly accepted that contemporary international human rights law does not confer sufficient protection on those who are arguably the most vulnerable in society.[24]

7. One of the key problems has been lack of effective implementation. The Secretary-General of the U.N. Commission on Human Rights in its July 2003 report noted that "*one of the major obstacles to the implementation of existing human rights standards for persons with mental disabilities is the lack of specific guidelines on their application.*" It is similarly accepted that although UN human rights treaty bodies are considered to have potential in this field, they have generally been underused in advancing the rights of persons with disabilities.[25]

8. Various shortcomings of substantive provisions under International Human Rights Instruments have also been noted. Particular concern has been expressed in respect to the MI Principles[26] for promoting a paternalistic medical model perspective rather than a rights-based approach.[27] An example can be found in the Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health which highlights that the core right to give informed consent is subject to extensive exceptions and qualifications in the MI Principles. As a result, their combined effect is seen to "*have rendered the protection almost meaningless*."[28]

9. As a result, in the context of what may be described as international

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23 Aaron A. Dhir, *Human Rights Treaty Drafting through the lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities,* 41 Stanford Journal of International Law, p181

24 There is a concern that despite the international initiatives, people with disabilities are all too often subject to an invidious discrimination which prevents them being able to enjoy a normal life. L Frost "*Mental Disability Rights in International Law*" Institute of Law, Psychiatry and Public Policy, University of Virginia, 1997.

25 Quinn and Degener, *Human Rights and Disability, The Current Use and Future Potential of Human Rights Instruments in the Context of Disability,* (2002) U.N. Doc. HR/PUB/02/1.

26 See footnote 16 above.

27 Aaron A. Dhir, *Human Rights Treaty Drafting through the lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities*, 41 Stanford Journal of International Law, p188

28 U.N ESCOR, Comm'n on Hum. Rts., 61st Session, Agenda Item 10, U.N. Doc.E/CN/4/2005/51 (2005)

apathy towards the rights of the mentally disabled, the advent of a binding International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities is considered to be a long-awaited for "centerpiece" of international human rights law designed specifically and only, for persons with disabilities.

The Proposed International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities: The Questions Raised

> *"A thematic Convention is the strongest way to ensure that those with disabilities remain 'visible.'* "[29]

10. The Convention drafting process is currently underway, attracting world-wide debate and comment through calls for submissions to the 'Ad Hoc Committee on a Comprehensive and Integral International Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities', which was given the task in 2001 to consider the proposals for the new Convention.

11. Significantly, a session held by the Committee in 2003 resulted in the formulation of a forty-member Working Group, which has prepared a first draft of the Convention for consideration at the latest session held by the Committee in Jan 2006.

12. Numerous issues have been raised already and which are being vigorously debated by the Working Group itself, member states, and international NGOs. The following examples aim to show a brief insight into the matters currently being explored, particularly from the perspective of Aaron Dhir, uniquely placed as Member of the Rehabilitation NGO Delegation to the United Nations Working Group Meeting and the fifth Ad Hoc Committee Meeting, and who was also co-counsel in **Starson v Swayze,**[30] the landmark Canadian case in mental health law.

A. Definition of Disability

13. Whilst recognizing that there are many potential definitions of "disability", a key contention is that the definition should not be restrictive, and it should acknowledge that disability can be permanent, temporary, episodic, and perceived and that it has a range of implications for social identity and behaviour, and largely depends upon context.[31]

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29 Quinn and Degener, *Human Rights and Disability, The Current Use and Future Potential of Human Rights Instruments in the Context of Disability,* (2002) U.N. Doc. HR/PUB/02/1, p297.

30 [2003] 2003 SCC 32

31 Expert Group Meeting on an International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, Bangkok Recommendations, 2003.

14. Importantly, National Human Rights Instruments from across Africa have recommended that any definition of discrimination must "*recognize the impact of dual or multiple discrimination faced by individuals such as women, children, refugees, minorities or persons with multiple disabilities or other status*."[32]

B. Equality/ Non-discrimination

15. One of the most vigorously debated issues has been in respect to the duty of state parties to reasonably accommodate those with disabilities.

16. Whilst it has been agreed that there is a need for a concept such as reasonable accommodation, it is being disputed as to whether a failure to reasonably accommodate should itself constitute discrimination.

17. As *Dhir* states a good case can be made for a strong rights-based approach to this debate, in consideration of General Comment No. 5 of the Committee on Economic, Social and Cultural Rights which interprets accommodation as a corollary to nondiscrimination by specifically containing a definition of disability that includes a "denial of reasonable accommodation based on disability…"

C. The Right to Physical and Psychological Integrity

18. Forced psychiatric hospitalization and treatment immediately bring this fundamental right into issue.

19. It is contended by the World Network of Users and Survivors of Psychiatry ("WNUSP") that the "*Right to autonomy of mind and body to reject unwanted treatments is….crucial. The Convention should prohibit unwanted medical interventions as a form of torture or cruel , inhuman or degrading treatment..."*[33]

20. In the domestic arena, *Minkowitz*, a self-described survivor of psychiatry comments:[34]

> Recognising forced interventions as a form of torture goes to the heart of the issue of free will versus coercion. Psychiatric violence breaks the will by destroying mental integrity, identity, and personality, through the involuntary use of methods that act on the mind through the brain.

21. Further domestic commentary in response to *Minkowitz*'s proposition

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32 The Regional Workshop on Promoting the Rights of Persons with Disabilities: Towards a New UN Convention, Final Declaration (2003)

33 WNUSP Submission to the UN Ad Hoc Committee 2003

34 Tina Minkowitz, *No-Force Advocacy by Users and Survivors of Psychiatry*, Mental Health Commission, 2006, p14

is provided by *Ellis:*[35]

> What I do fundamentally disagree with is the second proposition, that forced psychiatric interventions constitute *Torture*. That provocative proposition is worthy of far more considerable analysis that can be applied here. It is light years ahead of its time, particularly in New Zealand.
>
> …The article fails to analyse why such behaviour is torture, rather than lesser ill-treatment. At best a claim of ill-treatment might be arguable in Domestic law. It might have more success before one or other or both the relevant United Nations Committees, The Human Rights Committee, or the Committee Against Torture, as breaches of articles under the respective conventions those Committees have jurisdiction over. Again, ill-treatment is a better prospect than torture.

22. It is accepted however on the international plane that the proposition that forced psychiatric interventions constitute torture, must be compromised on a practical level in order to reach consensus. *Dhir* suggests [36] that the only acceptable qualification would involve a governing principle that limits forced treatment to the rarest of occasions, i.e. where the patient lacks the capacity to give or withhold informed consent.

23. In regard to determining how an assessment of capacity might be made, the Supreme Court of Canada provides guidance in **Starson v Swayze,**[37] by endorsing the proposition that an individual should not be considered incapable of consenting to treatment simply because he/she denies having a mental illness. Rather there must be a sufficient nexus between the denial of the illness and the illness itself: The denial must be because of the illness.[38]

24. Calls for alternatives to antipsychotic medications have also been made. WHO studies have shown a correlation between low reliance on this medication and recovery and in **Fleming v Reid,**[39] distressing side-effects have been highlighted.

25. Finally, criticism has been made in respect to basing a psychiatric committal on a likelihood of harm,[40] which presupposes that psychiatrists have the ability to predict potential future dangerousness. It is noted that the American Psychiatric Association had argued that psychiatrists should not be permitted to make such

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35 Tony Ellis, *Human Rights and Compulsory Medical Treatment*, Commentary in *No-Force Advocacy by Users and Survivors of Psychiatry*, Mental Health Commission, 2006, p30.

36 Aaron A. Dhir, *Human Rights Treaty Drafting through the lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities*, 41 Stanford Journal of International Law, p203

37 [2003] SCC 32

38 Dhir, Ibid. p216

39 [1991] 4 O.R.3d 74, 84.

40 Dhir, Ibid. p209.

predictions.[41] This is a highly contentious and debatable issue which is beyond the scope of this article.

26. As a corollary to this idea, *Dhir* states that "*a physician's determination of dangerousness leading to a forced psychiatric admission should not result in the automatic finding that an individual is also incapable of consenting to treatment or managing finances, and thus an accompanying loss of further rights.*"[42] It is contended that individuals who have been involuntarily detained should not be then medicated against their will simply because of their detained status.[43] Compulsory assessment should not automatically mean compulsory treatment.[44]

What the New Convention means for the Practice of Professionals of Today: Conceptualization of the "Medical" and "Social" Models

> "*There are clear and fundamental differences between the approaches of medicine and the law. The one tends towards an individualised and paternalistic 'caring', the other is founded on universal ethical concepts of liberty and rights*."[45]

27. The dichotomy between parens patriae power and the principle of patient autonomy is considered to be a problematic and pervasive issue in mental health law world-wide.

28. English academic commentary[46] alludes to the fact that these opposing models of thought are difficult to reconcile in individual cases, and that access to the Courts and, significantly, development of Mental Health Tribunal jurisprudence is an essential part of balancing the viewpoints of the doctor, and social worker with those of the patient:

> …the power to enforce detention or serious restrictions may be advisable and sought by an experienced and caring psychiatrist and a specialist social worker on well-founded medical and social grounds, but if it is resisted by the patient as a serious and unnecessary

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41 In its brief as amicus curiae in **Barefoot v Estelle** 463 U.S. 880 (1983), the Association stated that these predictions are wrong in at least two out of every three cases.

42 Aaron A. Dhir, *Human Rights Treaty Drafting through the lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities*, 41 Stanford Journal of International Law, p210

43 Which would be a New Zealand Bill of Rights Act consistent meaning. See **Moonen v Film and Literature Board of Review** [2000] 2 NZLR 9.

44 Section 58 of the Mental Health (Compulsory Assessment and Treatment) Act 1992:
58 Treatment while undergoing assessment
Every [patient] who is undergoing assessment pursuant to section 11 or section 13 of this Act shall be required to accept such treatment for mental disorder as the responsible clinician shall direct.

45 John Wood, *Control and Compassion: The uncertain role of Mental Health Review Tribunals in the management of the mentally ill* , 1999, in D.Webb and R. Harris *Mentally Disordered Offenders:Managing People Nobody Owns*, Routledge Taylor and Francis, London, 127-140.

46 Wood, Ibid. p128.

> limitation on freedom, some sound method of adjudication between the two views is essential.[47]

29. The power struggle between the two paradigms has not surprisingly been translated into one of the principal themes of the proposed Convention which in its final form, will be the "*end result of negotiating the tensions between the two opposed theoretical models*."[48]

30. The argument in favor of a rights-based approach focusing on individual dignity rather than a medical-based approach focusing on treatment has been made before the Ad Hoc Committee, noting that the time has come to promote the "social model" of disability and the move to a "rights-based paradigm."

31. In terms of the impact that this may have on the practice of professionals domestically, it may be considered by some as a long-awaited opportunity for New Zealand to align its legislative framework with contemporary thinking and advances made in international human rights circles in regard to the rights of the mentally disabled.

32. *Bell and Brookbanks* [49] notes that in New Zealand parens patriae civil commitment exists as an independent legal institution:

> ..current New Zealand law governing the compulsory treatment of mental patients does not differentiate between competence and incompetence and has, in effect severed the relationship (if indeed it ever existed) between civil commitment and incompetence for person. This has meant that in New Zealand parens patriae civil commitment exists as an independent legal institution and does not depend upon a prior judicial determination of incompetence for person. Under New Zealand law a person may be treated without his or her consent both before his or her case has been considered by a judge and after a court has made a compulsory detention order.[50]

33. Given that it may appear that New Zealand still affirms the notion that compulsory admission implies incompetence for all purposes, not simply for the purpose for which compulsion is sought, there may be legitimate grounds for judicial testing of a patient's competence to consent or refuse consent to treatment.[51]

34. Of particular concern in the domestic setting is the view that those diagnosed with mental disabilities are currently denied the full benefit

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47 Ibid. p128.

48 Aaron A. Dhir, *Human Rights Treaty Drafting through the lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities*, 41 Stanford Journal of International Law, p191.

49 Sylvia Bell and Warren Brookbanks *Mental Health Law in New Zealand*, 2nd Edition, 2005, Brookers

50 Bell and Brookbanks, Ibid. p239.

51 Ibid.

of rights-based procedural protections. This can be immediately shown in the relatively few number of cases which appear before the Mental Health Review Tribunal each year (approx 100) compared to the high number of cases before the Family Court (approx 5000 plus).

35. Whilst proper analysis of the reasons for this phenomenon has been canvassed in other recent material by the authors,[52] argument can be made here that domestic mental health jurisprudence has not evolved in a manner that affords the same level of procedural protection to individuals in the criminal justice system. In the Canadian context, one commentator notes:

> Courts have been overly reliant on paternalistic model of mental health law and…such reliance has led to the under-development of procedural protections for individuals facing involuntary treatment.[53]

36. An important consideration is that police stations and mental health hospitals unsurprisingly share three striking similarities:
    (i) Involuntary detention;
    (ii) Possible seclusion; and
    (iii) Occasional physical restraint.

37. However, whilst one place of detention necessarily invokes the right to due process on behalf of its detainees under entrenched criminal law principles, the other may fall victim to the absence of procedural guarantees, merely because it implicates the detention of the mentally ill.

38. An example can be found in the forms[54] prescribed under the current mental health scheme. Whilst there is an obligation to notify the Director of Area Mental Health Services of the reasons for the opinion on the patient's condition as to whether he/she fits the criteria of a mental disorder, there is no similar duty in respect to informing the patient him/herself of the reasons for his/her detention.

39. If examined dispassionately, without regard to a professional's genuine concern that the obligation to inform may be against the best interests of the patient or counter-productive, this practice may be seen as (i) breaching one of the most fundamental tenets of the rule of law: the right to reasons for one's detention, and (ii) breaching the whole ethic of human rights law: the right to be treated with dignity.

40. A similar illustration is based on Court judgments in respect to review procedures open to those detained under MHCAT. It would come as

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52 "*Mental Health: The Cinderella of the Detention System*", 2006

53 Isabel Grant, *Mental Health Law and the Courts,* 29 OsGoode Hall, L.J. 747 (1991)

54 See "Certificate of Preliminary Assessment", "Certificate of Further Assessment", and"Certificate of Final Assessment". Reproduced in Bell and Brookbanks or available from the Ministry of Health.

no surprise that such judgments show scant regard to the human rights of a mentally ill person and which do not meet the procedural guarantees prescribed by law. For example, where is the jurisprudence in respect to the burden of proof-does a mentally ill person have to show sanity or vice versa? Where is the right to an automatic review? See where a declaration of inconsistency was issued.

41. In the European Court of Human Rights, an Oct 2006 case[55] has held that in respect to a complaint that a person's involuntary psychiatric treatment had been unjustified, in the sense that it had not been ordered in a procedure "prescribed by law":

> ..the reasoning of the Court decision to prolong his psychiatric detention had been very superficial and insufficient to show that his conduct had been dangerous for the purposes of paragraph 1 of that provision. As such, therefore, it had been inadequate to meet the requirements of a procedure prescribed by law within the meaning of Article 5.1 of the Convention.

42. It is clear that far more reasoned decisions are required.

43. In line with the move to a more rights-based approach to the rights of the mentally disabled is the current deferential attitude towards the psychiatric profession as a whole. It is viewed that there should not be absolute deference to the opinion of psychiatrists when involuntary detention is challenged. *Wood* comments:[56]

> There is at the same time an understandable belief that the judgment of relevant professionals-here largely psychiatrists and social workers-cannot be left to the standards of the individuals themselves, backed up by rules and vigilance of their own professional bodies. Indeed professional self-regulation alone is unlikely to be regarded in modern times as adequate protection for an individual whose liberty has been seriously curtailed.

44. The fact that criticism has already been made in respect to basing a psychiatric committal on a psychiatrist's ability to predict potential future dangerousness may be further illustrative of the need for a serious re-assessment of a mentally disabled person's right to due process. **Re M**[57] may represent the potential for an action under the Bill of Rights where detention because of a person's potential dangerousness may be questioned as "arbitrary".

45. **Chu v District Court at Wellington and Director of Area Mental**

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55 Gajcsi v Hungary, Application no. 34503/03, 3 October 2006.

56 John Wood, *Control and Compassion: The uncertain role of Mental Health Review Tribunals in the management of the mentally ill* , 1999, in D.Webb and R. Harris *Mentally Disordered Offenders:Managing People Nobody Owns*, Routledge Taylor and Francis, London, p127.

57 [1992] 1 NZLR 29

Health Services Wellington CIV 2006-485-001572 is also significant for a challenge made by way of habeas corpus when a mentally ill person's right to family is breached:[58]

> It seems to me to be quite plain that whatever Parliament intended under s9(2)(d) it certainly intended that the proposed patient be treated with as much dignity as possible in the circumstances; that he or she have the purpose of the examination and the intention of the examination carefully explained in the presence of a caregiver or other person concerned with their welfare, distinct from the applicant and other personnel working for the Mental Health services.

Conclusion

46. It is hoped that the current international discourse in respect to the new Convention will inform law reform and the development of rights-based mental health law jurisprudence on the domestic plane.

47. Certainly, there is room for a major challenge to the NZ Mental Health legislation in respect to whether it measures up to the protection offered by the NZBORA. **Chu v District Court at Wellington and Director of Area Mental Health Services Wellington CIV 2006-485-001572** and its antecedent, **Keenan v Director of Mental Health Services Dunedin CIV 2006-412-000494** have already been earmarked as the vehicles for this full-scale attack on NZ's impoverished status of the rights of the mentally disabled before the law.

48. This challenge will raise fundamental issues of human rights in respect to a mentally disabled person's right to a lawyer in private and without delay, right to silence, right to family, right to be treated with dignity, and right to a proper rights-based reasoned judgment when one's right to review is exercised.

TONY ELLIS
BARRISTER

[58] HC, 24/07/2006; Fogarty J, Wellington, CIV 2006-485-001572