Inconsistencies between the New Zealand Bill of Rights Act 1990 and the Mental Health (Compulsory Assessment and Treatment) Act 1992*

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* This paper is in final draft form only. It is not to be referred to in any publication without the Author's express written consent. It does not represent the views of the NZ Mental Health Commission.

Contents

Executive Summary

1. The primary question in this opinion is are there inconsistencies between the New Zealand Bill of Rights Act 1990 ("NZBORA") and various specified sections of the Mental Health (Compulsory Assessment and Treatment) Act 1992 ("MHCAT").

2. The answer is a resounding yes—major systemic inconsistencies.

3. Particular concerns arise from the lack of rights accorded to proposed patients (ss2A and 8), the ability to compulsorily detain and medicate of the certification of a single psychiatrist (ss9 and 10), the absence of an appeal right, and the inadequacies in substance and procedure of the various review procedures especially ss16 and 84.

4. Consideration of patients' or human rights in the context of mentally ill offenders is a delicate subject. Any human rights lawyer could be forgiven for approaching the topic with a degree of skepticism.

5. Undoubtedly those involved in the detention of mental ill persons have good intentions, but see the **Roulet** judgment of the Supreme Court of California[1]:

> History is haunted by the accusing cries of those locked away "for their own good." It would be small solace to a person wrongly judged mentally incompetent that his road to commitment was paved with good intentions.

6. The loss of liberty, and associated stigma, of being detained in a mental ward is "**massive**",[2] and deserves significant protection, indeed some would say more protection than those subject to criminal proceedings, but significantly less are in practice applied.

7. Prime and fundamental human rights for any mental health patients are **discrimination** and **inherent dignity**. These are centrepieces of any understanding of, and protection of the rights of the mentally disabled.

8. Systemically in numerous cases these and other rights contained in the NZBORA, are not applied. The application of the NZBORA to patients, and proposed patients, is notable for its absence.

9. In my opinion a wholesale systemic failure to accord fundamental human rights to the mentally disordered occurs in New Zealand. This failure occurs because the NZ Government has failed to incorporate

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1 See **In Conservatorship of Roulet** (Cal. 1979), 23 Cal. 3d 219

2 **People v. Burnick** (1975) 14 Cal.3d 306, 319-322 [121 Cal.Rptr. 488, 535 P.2d 352], **this court explicitly recognized that civil commitment to a mental hospital, despite its civil label, threatens a person's liberty and dignity on as massive a scale** as that traditionally associated with criminal prosecutions…

international human rights treaties into domestic law to permit international rights to be challenged in domestic courts, failed to adequately train judges and officials (including medical staff and lawyers either defending or "prosecuting" detainment) on our international and domestic obligations.[3] These failures are assisted by an absence of literature devoted to the human rights and the mentally disabled, a major lack of jurisprudence, and institutional capture at the coal face.

10. Whilst no doubt the legislature believed the MHCAT was an advance on the rights contained in the previous legislation. In practice it has the potential to be, if married with the NZBORA**,** but the NZBORA is systemically not applied to mental patients.

11. One is reminded of the famous words of Justice Brandeis in **Olmstead v. United States**[4]

> Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.

12. The process of compulsory detainment, (accompanied by compulsory treatment) by a single psychiatrist, and the absence of an automatic right of appeal before a judicial body is out of step with international trends, and combined with the practical absence of meaningful rights reduces mental patients to a type of second class citizenry, on par with blacks in apartheid regimes requiring passbooks, or with early (1933) Nazi discriminatory laws, and is such that it may not be justified in a free and democratic society.[5]

13. The *most crucial patient right concerns mechanisms of appeal*[6]*.* In New Zealand there is no appeal, instead we have a totally ineffective s16 review, which as currently interpreted ousts the NZBORA.

14. The system is regrettably infected with not just paternalism (we know what is best for you) but also with *sanism*.[7] (Identifying prejudice toward the mentally ill among "well-meaning citizens" as

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[3] What for example will happen as a result of the awareness training needed to implement Article 8 of the **UN Convention on Disabilities**, no training budget was allocated to the judiciary on enactment of the NZBORA cf £15 Million pounds for judicial training for the Human Rights Act in England and Wales.

[4] (1928) 277 U.S. 438,439

[5] Cf **Thwaites v Health Services Centre Psychiatric Facility** [1988] 3 W.W. R. 217 where the Manitoba Court of Appeal found the absence of 'dangerousness provision not justified in a free and democratic society.

[6] *Placement and treatment of Mentally ill offenders Legislation and Practice in EU Member States*, Final Report, Central Institute of Mental Health, Manheim, Germany, February 15, 2005 pp1-247, 29

[7] Michael L. Perlin, "*Sanism*," 46 SMU L Rev. 373, 374 (1992)

the same "quality and character of other prevailing prejudices such as racism, sexism, heterosexism and ethnic bigotry," which in turn is reflected in our legal system).

15. The cover of the WHO Mental Health and Legislation Guide 2003[8] is confirmation of my basic thesis that **discrimination and dignity** are at the forefront of mental health rights[9]. It reads:

> All people with mental disorders have the right to receive high quality treatment and care delivered through responsive health care services. They should be protected against any form of inhuman treatment and discrimination.

16. The absence of an active legal community with a substantial interest in protecting the right of the mentally ill does little to inspire confidence that the even rights that do exist are effectively implemented. See The Rights Illusion—where Perlin[10] notes:

> As long as mentally disabled individuals are not assured of access to adequate, ""regularized," and well-structured counsel, many of the questions to which scholars, clinicians, litigators, and courts devote their time and energy will have little ultimate impact, and all of the "rights talk" and law reform efforts of the past two decades will be little more than an illusion.

17. Whilst there is a small core of lawyers performing sterling services to those detained or proposed to be detained in the mental health system, they are few and far between and poorly funded.

18. In short there are major and fundamental inconsistencies between the NZBORA and MHCAT and New Zealand's other obligations under international treaties, and difficulties in overcoming these inconsistencies.

19. In writing his paper I have been influenced by the writings of many including Baroness Hale (UK), Micheal Perlin (US), and the EU research papers which somewhat update the seminal paper of Wachenfeld MG (1991): *The Human Rights of the Mentally Ill in Europe. Nordic Journal of International Law* Vol. 60: 110-292.[11] That

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8 Mental Health Legislation and Human Rights, Mental Health Policy and Service Guidance Package, World Health Organisation, 2003.

9 Regrettably, space and time do not allow for a detailed consideration of the WHO guide. But readers are urged to consider this for themselves.

10 Perlin p373-407

11 This work presents a full picture of the jurisprudence of the European Court of Human Rights and the reports from the European Commission of Human Rights that discuss issues affecting the mentally ill. In this study, discussion begins on the topic of deprivation of liberty, which is described at page 126 as one of the most intrusive actions any government may take, short of execution. Other topics include the right to judicial review of continued detention, the use of psychiatric examinations in detention and other proceedings, civil rights of the mentally ill in diverse settings,

study took two years, this merely weeks, and therefore it can only skim the surface of the systemic problems found.

20. Such a study would be a useful contribution in any society. In whatever small way this mini-study helps, I hope it raises calls for a similar major study such as Wachenfield's.

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privacy and family issues, human rights standards in respect to the physical conditions and facilities in a hospital setting, long-running debates with regard to medical treatment, and case-law which concerns itself with the status of protection of the rights of the mentally ill.

[12] This paper has benefited from the peer review by Andrew Butler and Phillipa McKenzie, although not all their comments have been adopted due to philosophical differences and the inability to turn this paper into a book. The assistance of Ms Alison Wills Barrister, is acknowledged in this rewrite but the opinions are my own.

Introduction

> *Mental health law is a perpetual struggle to reconcile three overlapping but often competing goals: protecting the public, obtaining access to the services people need, and safeguarding users' civil rights.*[13] Brenda Hale

Approach to Analysis of NZBORA and MHCAT

21. Consideration of patients' or human rights in the context of mentally ill offenders is a delicate subject.

22. My task is to research and describe issues of inconsistency between the New Zealand Bill of Rights Act 1990 ("NZBORA"), and various specified sections of the Mental Health (Compulsory Assessment and Treatment) Act 1992("MHCAT"):

23. The analysis on the rights of patients, and proposed patients, excludes analysis of the rights of special and restricted patients.

24. Due of the absence of jurisprudence on mental health issues in the superior courts[14] particularly on the NZBORA rights, and Human Rights Act rights, and also the absence of a s7[15] NZBORA report, and as well as the absence of explicit literature on the subject, it is difficult to meaningfully describe inconsistencies between the

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[13] Rt Hon The Baroness Hale of Richmond. DBE. PC. A Lord of Appeal in Ordinary. *Justice and equality in mental health law: The European experience*, International Journal of Law and Psychiatry 30 (2007) 18-28 (Available online) (Hereafter "Hale") p18

[14] High Court and above. Major cases on mental rights could be countered on one hand.
See the comparison drawn by Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases,* Law and Human Behavior, Vol. 16, No. 1, Justice and Mental Health Systems Interactions. (Feb., 1992), pp. 39-59. (Hereafter Perlin)

> A contrast between the development of case law in Virginia and Minnesota is especially instructive. Notwithstanding the fact that Virginia is approximately 15% more populated than Minnesota,(*approx 6 million to 4 million, I assume the difference should be 50% not 15%)* in the decade from 1976 to 1986, there were only two published litigated civil cases in Virginia involving questions of mental hospitalisation. While in Minnesota during the same period of time, there were at least 101 such cases.65 Virginia has no tradition of providing vigorous counsel to the mentally disabled," whereas Minnesota does make such provision.
> See also Report by the Mental Health Commission, *Te Haererenga mo te Whakaoranga 1996-2006: The Journey of Recovery for the New Zealand Mental Health Sector,* 30 April 2007, available at www.mhc.govt.nz. Overview of the report is provided in *The Capital Letter*, *A Weekly Review of Administration, Legislation and Law*, 30 TCL 15, 1 May 2007. See extract:
> …*Troubling, is a lack of jurisprudence in the area with reporting of mental health cases from the Family Court irregular, and findings infrequently appealed. The result is "little reported judicial commentary by senior judges on mental health matters" with the specific provisions of the 1992 Act rarely tested. Of an annual average of 160 applications to the Mental Health Review Tribunal from people wishing to be released from compulsory status, many are subsequently withdrawn, and less than 5% are successful*…

[15] s7 requires the Attorney-General to advise the House on any inconsistencies with the NZBORA. The Bill was however introduced in 1987, pre NZBORA, and did not metamorphise into legislation until 1992

NZBORA and the MHCAT.

25. Additionally the rights centred interpretation necessary many be influenced by recent international developments.

26. Any such analysis must of course also reflect the counterpart relevant NZBORA sections.

27. Consequentially I propose to limit the analysis to some aspects of sections that I consider significant being ss 2, 4, 8, 9, 10, 16, 84 MHCAT, and ss 4, 5, 6, 9, 10, 18, 19, 22, 23(5), of the NZBORA, obviously the depth of the analysis, is limited, by the magnitude of the task.

28. Even if there were extensive jurisprudence and literature in this field, which there patently is not, any NZBORA approach needs consideration of a **Moonen** approach, and a ss 4,5 and 6 analysis.

29. Also required is analysis from an international and comparative perspective, as an interpretation of what rights may apply for instance in respect of the ICCPR, are a good guide to what could be argued to mean for the NZBORA, and as stated above the UN Convention of the Rights of Persons with Disabilities may also now assist.

30. A standard **Moonen v Film and Literature Board of Review** [2000] 2 NZLR 9 principle applies, if there is a tenable NZBORA meaning it must be preferred.[16]

31. Both **Moonen** and the later case of **Living Word**, which comments on Moonen, were cases heard by the Courts of Appeal of 5 judges. **Living Word Distributors Limited v Human Rights Action Group (Wellington)** [2000] NZCA 179 quoting Moonen states:

> In *Moonen* the court discussed the impact of the Bill of Rights on the correct interpretation and application of the 1993 Act, and in particular s3. It is helpful to repeat paras [15] and [16] of that judgment:
>
> [15] Under s14 of the Bill of Rights, everyone has the right to freedom of expression, including the freedom to seek, receive, and impart information and opinions of any kind in any form. This right is as wide as human thought and imagination. Censorship of publications to any extent acts as a pro tanto abrogation of the right to freedom of expression. The rationale for such abrogation is that other values are seen as predominating over freedom of expression. Nevertheless the extent of the pro tanto abrogation brought about by censorship legislation must, in terms of s5 of the Bill of Rights, constitute only such reasonable limitation on freedom of expression as can be demonstrably justified in a free and democratic society. If the Court considers that the right to freedom of expression has by censorship legislation been made subject to an unreasonable limitation, which cannot be demonstrably justified in a free and

[16] The writer, and Antony Shaw were Counsel for Mr Moonen.

> democratic society, there arises a breach of s5 of the Bill of Rights. Yet because s5 is subject to s4, that breach does not invalidate the legislation. The inconsistency is recognised but the legislation stands. Section 4 says as much, having relevance and effect, as it does, only if there is an inconsistency.

32. The Court of Appeal further illustrated that relevant provisions of the Bill of Rights must be given full weight in the construction of the Act. Section 6 of the Bill of Rights requires that where an enactment can be given a meaning that is consistent with the rights and freedoms contained in the Bill of Rights, that meaning shall be preferred to any other. Therefore, an enactment which limits the rights and freedoms contained in the Bill of Rights should be given such tenable meaning and application as constitutes the least possible limitation.

33. In **Hansen v The Queen** [2007] NZSC 7, 22 February 2007 the **Moonen** approach is discussed and an additional approach is adopted. See Tipping J at paragraphs 93-94:

> [93] It is appropriate to say something about the way this approach fits with what was said by the Court of Appeal on this subject in *Moonen v Film and Literature Board of Review.* In that case a rather differently arranged and constructed sequence was suggested as being helpful, albeit the Court recognised that other approaches would probably lead to the same result. The *Moonen* approach was not intended to be mandatory. In any event that sequence was suggested in a case which involved words that were in themselves conceptually elastic and therefore intrinsically capable of having a meaning which impinged more or less on freedom of expression. It was not a case like the present in which the words "until the contrary is proved" are said to be capable of having two conceptually distinct meanings, one involving inconsistency with the presumption of innocence contained in s 25(c) of the Bill of Rights and the other involving no or at least less inconsistency. It is important to note that in view of the way the case was argued for the appellant, the Crown was not required to address argument to the proposition that the presumption of innocence is incapable of justified limitation.
>
> [94] There is a difference between a case in which there are two conceptually distinct meanings and a case in which the issue concerns the point at which, on a possible continuum of meaning, the appropriate meaning should be found. In the continuum type of case, there may be good reason to adopt the approach set out in *Moonen*, if only because it will usually be difficult to determine where Parliament intended the meaning to fall on the continuum. The point at which a tenable meaning ceases to limit or least limits the right or freedom may well represent the appropriate point at which to fix the meaning. But in a case like the present, where the two potential meanings are conceptually quite different and distinct and, as I shall shortly indicate, there is only one candidate for Parliament's intended meaning, I consider that the approach earlier outlined is the one which will best serve the relationship between ss 4, 5 and 6.

Fundamental Rights of Mentally Disordered

34. The fundamental human rights of people with mental disorders and disabilities, are according to a 2006 article by Baroness Hale:[17]

> (1) People with mental disorders and disabilities should be enabled to receive the treatment and care they need.
>
> (2) This applies equally to all people, without discrimination on grounds such as sex, racial or ethnic origin, religion, membership of a particular religious or social group, or the nature of their disability.
>
> (3) The emphasis is upon enabling not enforcing: a person's right to choose what may be done to his body or his mind remains intact unless and until it is taken away in accordance with proper processes of law.
>
> (4) Enforcing may be part of enabling but should be carefully controlled and apply much more narrowly than the availability of treatment and care. The minimum criteria for an acceptable enforcement process are:
>
> > (i) logical and defensible grounds for intervention;
> >
> > (ii) a fair process which enables the contrary case to be put and heard;
> >
> > (iii) appropriate and humane conditions of treatment and care.
>
> (5) Underlying and overriding all of these is respect for the essential dignity and humanity of all people.

35. Importantly the fifth right enumerated by Baroness Hale, Underlying and overriding all of these is respect for the essential dignity and humanity of all people, is contained in s 23(5) NZBORA.

36. The rights not to be treated in a *degrading or inhumane* way contained in s9 NZBORA—are also applicable.

37. Baroness Hale[18] surmises:

> Viewed from the point of view of the patient or even the objective outsider, a great deal of what goes on in psychiatric hospitals has the potential to be inhuman or degrading. But the Strasbourg court has imported a concept of medical necessity into its assessment of what amounts to inhuman or degrading treatment. In **Herczegfalvy v Austria**,[19] the Court started well:

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17 Hale, Ibid pp 19/20

18 Hale, Ibid pp 23-24

19 1992 ECHR 437

> "82. **The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with**. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit of no derogation."
>
> [**Bold added**]

But then it gave the game away:

> "The established principles of medicine are admittedly decisive in such cases: as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has convincingly been shown to exist."
>
> Mr. Herczegfalvy had been force-fed, forcibly given psychotropic drugs, and most worryingly kept for more than two weeks in handcuffs and tied to a security bed, but the Court decided that
>
> "83... the evidence before the Court is not sufficient to disprove the Government's arguments that, according to the psychiatric principles generally accepted at the time, medical necessity justified the treatment in issue."
>
> …

38. Hale further points out that conversely, forcible medical treatment, which would not be permitted in a prison, is permitted in hospital. Her Ladyship states that the forcible administration of medication to a protesting patient is surely inherently degrading, unless it can be justified by the *Herczegfalvy* concept of 'medical necessity', which must be 'convincingly shown'.

39. **Herczegfalvy v Austria**, (medical necessity)[20] **Gajcsi v Hungary,**[21] (right to reasons), and **R v Wilkinson** (medical necessity**),**[22] as will be seen are all-important cases.

40. Baroness Hale clearly considers that **Herczegfalvy v Austria** and **R v Wilkinson** raise issues as to whether treatment is inhuman or degrading. With respect, **Gajcsi v Hungary** which post dates Baroness Hale's article, makes clear that detailed reasons are required for detention and continued detention in psychiatric facilities. The significance of these cases is that mentally disabled people need

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20 1992 ECHR 437

21 Application no. 34503/03, 3 October 2006

22 [2001] EWCA Civ 1545; [2002] 1 WLR 419

to be treated with dignity and respect and convincing reasons and consideration need to be demonstrated as to why a person is detained.

41. If those convincing reasons and consideration are not demonstrated, whilst it could be argued that a MHCAT detention was lawful, it may be nevertheless arbitrary under s22 of the NZBORA. It is plain that our jurisprudence needs to incorporate the values shown in **Herczegfalvy v Austria, R v Wilkinson,** and **Gajcsi v Hungary.** This reinforces my earlier view that we have insufficient jurisprudence in the field as none of these issues have yet been squarely faced, except in passing in a case concerning an application for a writ of habeas corpus in respect of an intellectually disabled person. In **Togia v Regional Disability Care Agency,** High Court, CIV 2007-485-358, 4 April 2007 Simon France J states:

> [26] Two issues arise-first whether the reasons are deficient, and second whether the consequence of inadequate reasons is that the detention authorised by the resulting decision is unlawful an arbitrary. I do not consider these two issues to be unrelated. There is a spectrum from a fully reasoned decision to an exercise of power unaccompanied by any explanation at all. I consider it is plausible that in certain circumstances the latter situation could cast doubt on the validity of the detention. It is not an area for absolutes where one would say that a lack of reasons could never invalidate the detention. The case of Gajcsi v Hungary (ECHR 03/01.2007, Application 34503/03) would tend to support Mr Ellis's submission that a detention may be viewed as arbitrary for this reason.

42. In **Taunoa v Attorney-General** (2004) 7 HRNZ 379 a prisoners rights case (currently awaiting the Supreme Court judgment as to the interface between ss 23(5), and s (9), and the level of compensation), the High Court observed:

> *New Zealand Bill of Rights Act*
>
> [255] Two sections are particularly relevant relating to allegations of torture or other improper "official" conduct. Section 9 states:
>
> **9 Right not to be subjected to torture or cruel treatment**
>
> Everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment.
>
> And s23(5) states:
>
> **23 Rights of persons arrested or detained**
>
> (5) Everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person.

43. However, in the context of mentally ill patients or proposed patients,

s19 is also of considerable importance:

> **19 Freedom from discrimination**
>
> (1) Everyone has the right to freedom from discrimination on the grounds of discrimination in the Human Rights Act 1993.
>
> *Human Rights Act 1993*
>
> 21 Prohibited grounds of discrimination
>
> (1) For the purposes of this Act, the prohibited grounds of discrimination are—
>
> (h) disability, which means—
>
> …
>
> (iii) psychiatric illness:
>
> (iv) intellectual or psychological disability or impairment:
>
> (v) any other loss or abnormality of psychological, physiological, or anatomical structure or function:
>
> …

44. That discrimination is the second of the Baroness Hale's two listed rights is important. It is of importance for many reasons; one being discrimination on the grounds of *psychiatric illness* is unlawful by virtue of s21 Human Rights Act 2003.

45. Interestingly Bell and Brookbanks,[23] briefly discuss s21. But its significance is now far greater as Disability Law has finally rightly become an international human rights issue.

46. This is obvious from the passing of the UN Convention on the Rights of the Persons with Disabilities ("Convention") adopted by the UN General Assembly on 6 December 2006:

> Speaking at a press conference after the Assembly session, Ambassador Don MacKay of New Zealand, chairman of the committee that negotiated the convention, described today's adoption as "an historic event," adding that those involved in the process "can I think be pleased with the convention that we have. It is in effect an extraordinarily far-reaching convention.[24]

47. '**Discrimination**' appears at least 27 times in the Convention, including in Articles 3 and 5:

> **Article 3 - General principles**

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[23] *Mental Health Law in New Zealand*, 2" ed, Wellington, Brookers, 2005 (Hereafter Bell and Brookbanks)

[24] www.un.org/apps/news/story.asp?NewsID=20975&Cr=disab&Cr1

> The principles of the present Convention shall be:
>
> Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
>
> **Non-discrimination;**
>
> Full and effective participation and inclusion in society;
>
> Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
>
> …
>
> **Article 5 - Equality and non-discrimination**
>
> 1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law. 2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds. 3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided. 4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.[25]

48. Similarly Baroness Hale's point 5, Article 3 of the Convention, s23(5) NZBORA**,** and Article 10(1) of the International Covenant on Civil and Political Rights (ICCPR) recognize the rights to inherent dignity and respect.

49. The meaning attributed to various rights contained in the Convention and other international instruments is bound to influence the meaning attributed to the rights contained in NZBORA, and the MHCAT.

NZBORA and MHCAT- the statutes

50. The interface between NZBORA and MHCAT is the underlying theme of this work, NZBORA being the set of fundamental rights and guarantees applicable to all people in New Zealand, and MHCAT providing for the specific rights of persons in New Zealand who may be subjected to compulsory psychiatric assessment and treatment.

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[25] Regrettably, discussion of discrimination, how other nations address this issue, and the impact of the use of the term of discrimination 27 times in the new Convention would take considerable time and effort and could not be addressed here. It needs a separate paper.

51. The relevant provisions of NZBORA under examination are sections 4, 5, 6, 9, 10, 22, 23(1) and 23(5), set out in Appendix C. Section 10 is briefly discussed at page 41 and s23(1) at page 21.

52. Sections 4, 5, and 6 in the mental health context goes to the heart of how the interpretation of MHCAT is affected by NZBORA. See page 35.

53. Section 9, provides for the right not to be subject to degrading or disproportionately severe treatment. Baroness Hale[26] strongly articulates that such a right may be prima facie breached in psychiatric hospitals if stringent conditions are not applied.

54. Section 22 provides for the right not to be arbitrarily detained. The interface between this right and the right to compulsorily detain lies at the heart of understanding a human rights approach to this topic. See pages 18, 36, and 50.

55. Section 23(5) provides for the right to be treated with humanity and with respect for the inherent dignity of the person, which underlies all other rights of the person and which must be read into every provision of MHCAT. See pages 27, 37, 48, and 49.

56. For the key provisions discussed under MHCAT see Appendix D. They are sections 2A, 4, 8, 9, 10, 16, 63A, 70 and 84.

57. Sections 2A and 63A, discussed on page 21 onwards, embodies the refinement and extension of the protections under MHCAT by a subsequent amendment to the Act in respect to "proposed patients".

58. Section 4 prohibits compulsory assessment and treatment under a person's political, religious, or cultural beliefs, sexual preferences, criminal or delinquent behaviour, substance abuse, or intellectual disability. See page 30 for analysis in respect to criminal behaviour.

59. Sections 8, 9 and 10 describe the substantive and procedural processes under which a person can be detained on mental health grounds. For discussion of the various issues that arise from this process, amongst which is the question as to what point a person is detained under MHCAT, see pages 19-27.

60. Section 16 provides for one of the most frequently used rights of a mental health patient to challenge their detention under MHCAT. A critique of this important right of review, with its inherent flaws, is given at page 29 onwards.

61. Section 70 provides for a patient and proposed patient's fundamental right to a lawyer, a right described by Perlin as the single most important factor in the disposition of cases in involuntary civil

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[26] Rt Hon The Baroness Hale of Richmond. DBE. PC. A Lord of Appeal in Ordinary. *Justice and equality in mental health law: The European experience*, International Journal of Law and Psychiatry 30 (2007) 18-28 (Available online)

commitment systems.[27] See page 20.

62. Section 84 describes the inquiry power of a High Court Judge to determine whether a person is unlawfully detained under MHCAT. The effectiveness of this provision is examined at page 42.

Sanism: An odious form of discrimination

63. All forms of discrimination are odious.[28]

64. The particular form of discrimination that prevails in the mental health system is what Michael Perlin calls *sanism*, it is endemic throughout the whole system. Sanism infests the approach to rights jurisprudence by many of the players including, the Medical Staff, District Inspectors, Counsel for the Mental Disabled, and the Courts.

65. The Supreme Court of Montana in **KGF** quoting Perlin stated:

> 60 The use of such stereotypical labels-which, as numerous commentators point out, helps create and reinforce an inferior second-class of citizens-is emblematic of the benign prejudice individuals with mental illnesses face, and which are, we conclude, repugnant to our state constitution. 18) See generally Michael L. Perlin, On "Sanism," 46 SMU L Rev. 373, 374 (1992) (identifying prejudice toward the mentally ill among "well-meaning citizens" as the same "quality and character of other prevailing prejudices such as racism, sexism, heterosexism and ethnic bigotry," which in turn is reflected in our legal system); Winick, at 45 (stating that because people with a mental illness "already have been marginalized and stigmatised by a variety of social mechanisms, self-respect and their sense of their value as members of society are of special importance to them" throughout legal proceedings).

66. Back in NZ, Bell and Brookbanks[29] describe sanism as:

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[27] Michael Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases, Law and Human Behaviour*, Vol.16, No.1, Justice and Mental Health Systems Interactions (Feb 1992) pp39-59.

[28] In **Quilter v Attorney-General**[28] [1998] 1 NZLR 523 a Court of Appeal of 5 Judges considered Article 26 of the ICCPR, where Thomas J (dissenting but not on this point) stated at 540:

> **discrimination in all its forms is odious**. It is hurtful to those discriminated against and harmful to the health of the body politic. As such, it is or should be repugnant in a free and democratic society. There are, in other words, no "reasonable limits" prescribed by law which could be demonstrably justified in a free and democratic society. Discrimination and democracy are inherently antithetical.

[29] *Mental Health Law in New Zealand*, 2" ed, Wellington, Brookers, 2005 p5, Citing M L Perlin, *The Hidden Prejudice: Mental Disability Law on Trial*, Washington, American Psychological Association, 2000, 10.

> Sanism is the reliance, consciously or unconsciously, of judges and jurors upon reductionist, prejudicial stereotypes in their decision-making. It involves the subordination of statutory and case law standards as well as the legitimate interests of mentally disabled persons who are the subjects of litigation. Sanism is based primarily on stereotype, myth, superstition and de-individualisation. It is perpetuated, as the Fooks case demonstrates, by "ordinary common sense" and heuristic reasoning in an unconscious response to events in everyday life and the legal process.

67. This sanism infection inevitably influences the meaning given to rights under NZBORA, or more poignantly the lack of recognition that rights even exist.

68. This sanism approach with its accompanying failure to recognise rights is reflected in the low level of interest from legal practitioners, and the Courts in the area, which is not unique to New Zealand, like Bird Flu, or SARS, sanism is truly international.

69. Rosenthal[30] comments:

> The United Nations has appointed three Special Rapporteurs on Human Rights and Disability who have found that people with mental disabilities experience some of the harshest conditions of living that exist in any society… and that People with mental disabilities are often deprived of liberty for prolonged periods of time without legal process

70. Liberty and security of the person and arbitrary detention are mainstream human rights areas. An inability to challenge liberty interests in the same way as sane persons would be discriminatory.

71. Time and space prohibit anything more than a fleeting discussion of this important area. Clearly the advent of the new UN Convention on the Rights of the Disabled will stimulate debate, which will be assisted by consideration of the following:

> **UN Convention on the Rights of the Disabled**
>
> Article 14 - Liberty and security of the person
>
> 1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
>
> a. Enjoy the right to liberty and security of person;
>
> b. Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law,

[30] Eric Rosenthal & Clarence J. Sundram, *The Role of International Human Rights in National Mental Health Legislation* Department of Mental Health and Substance Dependence, World Health Organization, 2004 (Rosenthal), page 3.
http://bazelon.org/legal/resources/internationallaw.pdf

> and that the existence of a disability shall in no case justify a deprivation of liberty.
>
> 2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.
>
> **ICCPR Article 9**
>
> 1. Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law…
>
> 4. Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.

72. If one gives a wide a meaning to "arrest" or "detention" which one would need to, on autonomous Covenant meanings of the word, then a proposed patient would be detained. See General Comment 8[31]:

> 1. Article 9 which deals with the right to liberty and security of persons has often been somewhat narrowly understood in reports by States parties, and they have therefore given incomplete information. The Committee points out that paragraph 1 is applicable to all deprivations of liberty, whether in criminal cases or in other cases such as, for example, mental illness, vagrancy, drug addiction, educational purposes, immigration control, etc. It is true that some of the provisions of article 9 (part of para. 2 and the whole of para. 3) are only applicable to persons against whom criminal charges are brought. But the rest, and in particular the important guarantee laid down in paragraph 4, i.e. the right to control by a court of the legality of the detention, applies to all persons deprived of their liberty by arrest or detention. Furthermore, States parties have in accordance with article 2 (3) also to ensure that an effective remedy is provided in other cases in which an individual claims to be deprived of his liberty in violation of the Covenant.

73. By analogy, see paragraph 6 of **Secretary of State v JJ**[32] where the English Court of Appeal considers whether control orders made by the Secretary of State under the Prevention of Terrorism Act 2005 amount to a deprivation of liberty**:**

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31 General Comment 8: Right to liberty and security of persons (Art. 9) : 30/06/82, Sixteenth Session, 1982.

32 [2006] EWCA Civ 1141

Do the orders amount to deprivation of liberty?

6. There is a degree of common ground between the parties:

(i) The concept of 'deprivation of liberty' is autonomous

(ii) The best guidance in relation to the nature of 'deprivation of liberty' is provided by the decision of the Strasbourg Court in Guzzardi v Ital (1980 3 EHRR 333)

(iii) The difference between deprivation of liberty, contrary to Article 5, and restrictions upon liberty of movement, contrary to Article 2 to Protocol No 4, is one of degree or intensity.

74. The NZBORA provisions are:

22 Liberty of the person

Everyone has the right not to be arbitrarily arrested or detained.

23 Rights of persons arrested or detained

(1) Everyone who is arrested or who is detained under any enactment—

…

(c) Shall have the right to have the validity of the arrest or detention determined without delay by way of habeas corpus and to be released if the arrest or detention is not lawful.

75. One would consider that 'everyone' must include a mental health patient, even accepting that according to the COA in **Sestan**,[33] a patient is detained, but not a proposed patient.

76. The Court of Appeal held that a proposed patient is only entitled to a copy of the certificate which does not outline the reasons for the decision (see s10(4)(a)(i)). The Court further held that Sestan's attempt to depart was not made until after the s8A application had been made and he was given notice of that assessment, at which time the appellant was properly detained. The Court held he was not "detained" until required to undergo a s9 assessment examination. If not detained it is difficult to argue at least under the MHCAT that it is an arbitrary detention to which s22 NZBORA can apply. However there is an argument that it may be a detention at common law on a

[33] **Josko Sestan v Director of Area Mental Health Services Waitemata District Health Board** CA254/06 [12 December 2006] As the case is under appeal and a further hearing occurs in the Supreme Court on 14 February 2007 I have limited my criticism as this stage, and may wish to elaborate after that hearing in the final version of this opinion.

due process argument founded on the Magna Carta 1297.[34]

77. In the context of the NZBORA White Paper, the Butlers have useful comment:[35]

> It should be noted that the application of s22 of BORA to detentions unrelated to law enforcement activities appears to have been assumed and has never been the focus of substantial argument. The wider view, that is that s22 would apply beyond the law enforcement field, is supported by the White Paper commentary which expressly accepted that detention in the draft art 15 would extend to "such areas as those under the Mental Health Act 1969 and the Alcoholism and Drug Addiction Act 1966." Certainly, the High Court has taken the view that in respect of both Acts, s22 of BORA is engaged. The wider view would also appear to be consistent with the approach of the Human Rights Committee to art 9 of the ICCPR, and the approach of the Privy Council in Ramsarran v Attorney-General (Trinidad and Tobago).

78. Also see the European Court of Human Rights in **Gajcsi v Hungary**:[36]

> ...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.

79. Significantly The Court of Appeal was silent on the submission that s16 reviews required reasons in **Sestan**.[37] So this issue remains open.

80. Whether the Court of Appeal was constrained as to how far it could discuss the lawfulness of the s16 reviews as they were not in issue in the High Court is a question as to the scope of habeas and article 9(4). In my opinion an appellate court is not constrained by the lack of evidence and a rights centred approach would be to call for that evidence. Further discussion of this issue is beyond the scope of the paper.

81. Equally the failure to properly consider (if at all) the NZBORA on an s16 review is not merely a breach of the liberty right, but is also discriminatory. Criminal bail applications consider the NZBORA, why are not mental health patients accorded the same right? Section

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34 In force in New Zealand by virtue of the Imperial Laws Application Act 1988 Schedule 1.

35 Andrew Butler and Petra Butler, *The New Zealand Bill of Rights Act, A Commentary*, Wellington 2005, LexisNexis, page 640.

36 Application No. 34503/03, 3 October 2006.

37 **Josko Sestan v Director of Area Mental Health Services Waitemata District Health Board** CA254/06 [12 December 2006]

23(1) applies to anyone detained under any enactment. One law for those detained under criminal law and another for those under Mental Health law is wrong in principle.

82. Baroness Hale in her article observes at p 27—The Convention can protect against forcible interferences with liberty and self-determination.

83. International commentary is of assistance here. See for example the 2004 UN Report of the Working Group on Arbitrary Detention Chairperson-Rapporteur: Leïla Zerrougui[38] in the context of the right to a fair trial.

84. In the revised draft General Comment[39] on Article 14[40] of the ICCPR:

> II. Equality before courts and tribunals
>
> 6. The first sentence of Article 14, paragraph 1 guarantees in general terms the right to equality before courts and tribunals. This guarantee not only applies to courts and tribunals addressed in the second sentence of this paragraph of Article 14, but must also be respected whenever domestic law entrusts a body with a judicial task, i.e. with the task of deciding a particular legal dispute between parties.[41]
>
> 7. The right to equality before courts and tribunals, in general terms, guarantees, in addition to the principles of competence, impartiality and independence and of fairness mentioned in the second sentence of paragraph 1, those of equal access and equality

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38 E/CN.4/2005/6 1 December 2004

51. The handling of the phenomenon of mental illness is an age-old problem for humanity. Even though the treatment of the mentally ill has undergone considerable improvements, the need to isolate them from the rest of the society seems to remain a permanent element of the treatment. Whether isolation amounts to deprivation of liberty cannot and shall not be decided in the abstract. The Working Group is of the view that the holding against their will of mentally disabled persons in conditions preventing them from leaving may, in principle, amount to deprivation of liberty.

39 CCPR/C/GC/32/CRP.1/Rev.3, 28 November 2006. **Rosenthal** (infra) described General Comments as:

2. Interpretative Guidelines
One of the most important sources of interpretation of human rights conventions is the guidelines, known as General Comments, produced by human rights oversight bodies (also referred to as treaty-based committees) to guide governments in the preparation of their official reports. General comments are non-binding, but they represent the official view as to the proper interpretation of the convention by the human rights oversight body. There have only been very limited General Comments on the rights of people with mental disabilities adopted by treaty base committees.

40 26 November 2006, open for comment until 14 February 2007

41 Communication No. 1015/2001*, Perterer v. Austria,* para. 9.2 (disciplinary proceedings against a civil servant); No. 961/2000, *Everett v. Spain*, para. 6.4.

> of arms, and ensures that parties to judicial proceedings are treated without discrimination. [42]

85. Baroness Hale[43] observes the usefulness of the European Convention in respect of equality of access, and discrimination:

> The Convention is only as much help in resolving inequalities in access as it is in resolving access difficulties generally. But we should also continue to ask some more fundamental questions about discrimination between people with mental disorders and everyone else. Article 14 is capable of extending to discrimination in the enjoyment of Convention rights on the grounds of mental disorder or disability.[43] fn 43 See Lord Hope **in R (Pretty) v Director of Public Prosecutions** [2001] UKHL 61, [2002] AC 800, para 105

86. Rights overlap, and this should be obvious from what her Ladyship says above about access, and discrimination.

87. The effect of sanism is made worse by the failure of leading authors to discuss these issues.

88. Borrowing a sentence from a research project[44] I start with the premise that to produce a quality textbook covering the area of mental health and human rights in New Zealand what is needed is *A thorough knowledge of human rights issues as well as of the respective international and national legal instruments is essential for both researchers and forensic practitioners in view of their implications for managing mentally ill patients, including those admitted under criminal law.* Alternatively a New Zealand Wachenfield project is required.

89. Consulting the three[45] principal New Zealand text books where guidance might be found on the interrelationship between the NZBORA and MHCAT, we find:

    1) Butler and Butler[46] who in over 1100 pages of extensive analysis of NZBORA issues devotes some **4 paragraphs** to mentally ill persons under the heading medical treatment, and a similar number under the MHCAT Act.

    2) Rishworth[47] is generally useful as an authoritative text. However, in the Mental Health area, it has little value. In 850

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42 Communication No. 202/1986, Ato del Avellanal v. Peru, paras. 10.1 and 10.2.

43 Hale, ibid p27

44 *Placement and treatment of Mentally ill offenders Legislation and Practice in EU Member States*, Final Report, Central Institute of Mental Health, Manheim, Germany, February 15, 2005 pp1-247, 29

45 *Medical Law in New Zealand***,** General Editors, Skegg and Paterson, Brookers, Wellington, 2006 is in the same vein

46 Andrew Butler and Petra Butler, *The New Zealand Bill of Rights Act: A Commentary*, LexisNexis, Wellington, 2005.

47 *The New Zealand Bill of Rights Act, OUP, 2003.*

pages, the authors appear to have one paragraph devoted to mental health but given the poor index, there will undoubtedly be a few more paragraphs elsewhere.

3) Bell and Brookbanks[48] are of course the mental health specialists. But they are not NZBORA specialists. Their well-written and informative text is helpful, but with respect it does not approach mental health from a rights centred approach. A NZBORA lawyer would and should do. In Part 4 of their book, they canvass the various rights, but any effective marriage must widely incorporate various international principles and comparative law, with rights under NZBORA and the MHCAT. E.g. at Para 16.5 they say in somewhat circular fashion:

16.5 Written acknowledgement of rights

> Under s 64 every person has to receive a statement in writing of his or her rights. The rights include not only those in Part 6 but also the rights conferred under other sections such as the right in s 63 to withdraw consent. The right applies to people from their first contact with the mental health system even though it may not always be appropriate if they are acutely unwell.

90. Recognising the scarcity of human rights lawyers, and even more so with an international and comparative approach, it is not surprising that like most commentators Bell and Brookbanks devote little space to international instruments. Rosenthal[49] comments:

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[48] *Mental Health Law in New Zealand*, 2" ed, Wellington, Brookers, 2005.

[49] Rosenthal Page 11 fn22 Despite the historical lack of attention to people with disabilities, a recent review by the UN High Commissioner on Human Rights finds that treaty monitoring bodies are open including people with disabilities and have established a few limited models of good practice. The authors of the study, Professors Gerard Quinn and Theresia Degener, found that existing human rights conventions and "United Nations human rights treaty bodies have considerable potential in this field but have generally been underused so far in advancing the rights of persons with disabilities." See Human rights of persons with disabilities, Note by the Office of the United Nations High Commissioner for Human Rights, Report of the United Nations High Commissioner for Human Rights and Follow-up to the World Conference on Human Rights, U.N. Doc. E/CN.4/2002/18/Add.1, 12 February 2002 (the Executive Summary of the report is attached as an Annex). The full report is "Human Rights are for All: A Study on the Current Use and Future Potential of the United Nations Human Rights Instrument s in the Context of Disability" (Gerard Quinn & Theresia Degener eds., Office of the UN High Commissioner for Human Rights, February, Geneva 2002) (hereinafter the "Quinn & Degener report"). Philip Alston, a member of the UN Committee on Economic, Social, and Cultural Rights mandated by the ICESCR to oversee the implementation of the convention, has stated that:

> "[i]nternational human rights forums have been generally unresponsive to the situation and specific needs of persons with disabilities." Philip Alston, Disability and the International Covenant on Economic, Social and Cultural Rights, in Theresia Degener, "Disabled Persons and Human Rights: The Legal Framework"

> While international human rights law has grown tremendously over the last thirty years, the development of international law specifically to protect the rights of people with mental disabilities has been relatively limited. Human rights oversight bodies that monitor the mainstream conventions and establish reporting guidelines have dedicated little attention to the rights of people with mental disabilities.

91. Before **Sestan** in the COA, one would have expected the proposition put by Bell and Brookbanks to be correct—The right applies to people from their first contact with the mental health system even though it may not always be appropriate if they are acutely unwell.

92. In short the current textbooks authors, are either MHCAT or NZBORA experts, but none of them are both. Wishful thinking means we need something like a Bell and Butler, *Mental Health Rights in New Zealand*.

93. It is not surprising, given the academic lacunae that there is also little jurisprudence to assist.

Proposed Patients and Rights—Sections 2A, 8, 10, 63A, and 70

94. Section 2A is important for the definition of proposed patient, and the right to legal advice.

95. In **Sestan** the Court of Appeal observes:

> **Section 70 right to a lawyer**
>
> [34] Mr Ellis submitted that even if the appellant was not detained in accordance with s 23 of the NZBORA when the application process was being conducted, the appellant was entitled to be informed of his right to a lawyer in accordance with s 70 of the MHCAT.
>
> [35] Section 70 provides:
>
> 70 Right to legal advice
>
> Every patient is entitled to request a lawyer to advise the patient on his or her status and rights as a patient, or any other matters on which persons customarily seek legal advice, and, if the lawyer agrees to act for the patient, he or she shall be permitted access to the patient upon request.

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in Human Rights and Disabled Persons: Essays and Relevant Human Rights Instruments (Theresia Degener and Yolan Koster-Dreese, eds. 1995).

> [36] Section 70 states that every "patient" is entitled to request a lawyer. A person does not become a patient until required to undergo further assessment under ss 11 or 13: s 2.
>
> [37] Section 63A states that s 70 also applies to "proposed patients". Proposed patient is defined in s 2A:
>
> > **2A Meaning of "proposed patient**"
> >
> > A person—
> >
> > (a) Starts being a proposed patient when an application is made under section 8A; and
> >
> > (b) Stops being a proposed patient when a medical practitioner records a finding—
> >
> > (i) Under section 10(1)(b)(i), in which case the person does not become a patient; or
> >
> > (ii) Under section 10(1)(b)(ii), in which case the person becomes a patient.
>
> [38] An application under s 8A is deemed to be made when the DAMHS receives a completed application that complies with s 8A: s 8(2). A s 8A application for assessment is not complete unless it is accompanied by a certificate issued under s 8B. Therefore, a person becomes a proposed patient only after the ss 8A and 8B processes are completed. Accordingly, up until that time Mr Sestan had no entitlement to a lawyer.

96. This analysis means that during the initial s8 process a "proposed patient" has no MHCAT or NZBORA right to a lawyer. S/he may of course have a common law right, or a Magna Carta right, or a ICCPR right but this finding of the Court of Appeal is nothing short of appalling.

97. To suggest that a person is not detained during the section 8 processes is to borrow the words of Lord Steyn a fairy tale.[50]

98. To suggest that Parliament in enacting what was supposed to an advance for mental health patients meant to deprive "proposed" mental health patients of the right to a lawyer is nothing short of

[50]See **HL v UK** Para 46, infra and for the original text, In re L [1998] UKHL 24; [1999] AC 458; [1998] 3 All ER 289; [1998] 3 WLR 107; [1998] 2 FLR 550; [1998] 2 FCR 501; [1998] Fam Law 592 (25th June, 1998) …Counsel for the Trust and the Secretary of State argued that [the applicant] was in truth always free not to go to the hospital and subsequently to leave the hospital. This argument stretches credulity to breaking point. The truth is that for entirely bona fide reasons, conceived in the best interests of [the applicant], any possible resistance by him was overcome by sedation, by taking him to hospital and by close supervision of him in hospital. And if [the applicant] had shown any sign of wanting to leave, he would have been firmly discouraged by staff and, if necessary, physically prevented from doing so. The suggestion that [the applicant] was free to go is a fairy tale... In my view [the applicant] was detained because the health care professionals intentionally assumed control over him to such a degree as to amount to complete deprivation of his liberty.

ludicrous. See Second Reading of Mental Health (Compulsory Assessment and Treatment) Amendment Bill, Parliamentary Debates, Hansard, 17 November 1998 13211, address by Georgina Te Heuheu, Associate Minister of Health,:

> …One of the principal themes-…is the refinement and extension of the protections offered by the Mental Health (Compulsory Assessment and Treatment) Act to mental health consumers, mental health professionals, and to those who come into contact with them in the course of administering the Act. This Bill provides for the refinement and extension of those protections in a number of ways. As the principal Act is presently worded, not all patients who a medical practitioner reasonably believes may be mentally disordered, but who are not yet under a compulsory treatment order, are entitled to the protection and subject to the status known in the Act as "proposed patients". This amendment Bill seeks to rectify this matter and will ensure that all such people are dealt with in terms of the principal Act, and in terms of the relevant guidelines.

99. This is a clear form of discrimination completely alien to the new UN Convention.

100. It does of course create a second-class detainee, reminiscent of the South Africa apartheid regime and pass laws; those possibly mental ill and detainee have no right to a lawyer.

101. Equally it reduced the rights of the believed to be mentally ill to a similar status as the modern terrorist. See Lord Bingham in **A v Secretary of State** [2004] UKHL 56, para12**:**

> *The 2001 Act*
>
> 12. The 2001 Act is a long and comprehensive statute. Only Part 4 ("Immigration and Asylum") has featured in argument in these appeals, because only Part 4 contains the power to detain indefinitely on reasonable suspicion without charge or trial of which the appellants complain, and only Part 4 is the subject of the United Kingdom derogation. Section 21 provides for certification of a person by the Secretary of State:
>
> "21 Suspected international terrorist: certification
>
> (1) The Secretary of State may issue a certificate under this section in respect of a person if the Secretary of State reasonably -
>
> (a) believes that the person's presence in the United Kingdom is a risk to national security, and
>
> (b) suspects that the person is a terrorist.

102. In New Zealand on the reasonable belief (**usually**)[51] of a psychiatrist a person can be detained and compulsory medicated for 5 days. One can perhaps understand that suspected terrorists can be detained in airports with suspicious substances but even a terrorist needs a lawyer.

103. The power of a psychiatrist to detain under s 10 is on the basis:

> (ii) there are reasonable grounds for believing that the proposed patient is mentally disordered and that it is desirable that the proposed patient be required to undergo further assessment and treatment.

Is seriously questionable. At least in Victorian times two doctors were required.[52]

104. Whilst medical professionals and psychiatrists are bound by professional, ethical standards, and codes of practice, it is not fanciful to suggest that well meaning psychiatrics can abuse power, and it dangerous to repose such power in **any** one person. Especially so given the absence of effective judicial control and no appeal right.

105. The danger of relying on medical professionals and psychiatrists is illustrated in the interdisciplinary book[53] by Prof Taylor, Emeritus Prof of Psychology at Victoria University.

> Then in 1933, when the National Socialists assumed power in Germany they passed a law enabling psychiatrists formally to initiate a programme for the compulsory sterilization of over 200,000 of the mentally ill and their relatives.7 Soon the Nazis brought Jews, gypsies,

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[51] Under section 10(1)(b)(ii) of MHCAT where a medical practitioner in a certificate of preliminary assessment considers there are reasonable grounds for believing that the proposed patient is mentally disordered and that it is desirable that the proposed patient be required to undergo further assessment and treatment:
(a) The medical practitioner must give the patient written notice of this requirement (section 11(1) MHCAT)
(b) At any time during the first period, the responsible clinician considers that a patient who is an inpatient can continue to be assessed and treated adequately as an out patient the clinical must give a written notice to put this into effect (s11(4)(a) and (b) MHCAT)
(c) At any time the responsible clinician considers an inpatient is fit to be granted leave (of absence) from the hospital. This can occur on such terms and conditions as the clinician thinks fit (s11(5) MHCAT)
(d) At any time, the responsible clinician considers that a patient is fit to be released from compulsory status, written notice must be given to the patient and the patient is to be released from that status immediately (s11(6) MHCAT)
(e) During the first period the patient may apply to the Court to have the patient's condition reviewed under s16 (11(7) MHCAT.

[52] Under s30 of the Madhouse Act 1828 and s28 of the Madhouse Act 1832, for entry into a madhouse, a certificate had to be signed by 2 doctors. This applied to non-paupers only: "No person, not a pauper, was to be received into a house without a medical certificate." This position continued until the 1890 Lunacy Act which provided for a Judicial Reception Order from JPs specialising in such orders. Paupers have less protection and could be 'received' by two Justices of the Peace.

[53] Palmer Reg Orovwuje and Prof A.J W. Taylor, Ch 9, *MENTAL HEALTH CONSUMERS, SOCIAL JUSTICE AND THE HISTORICAL ANTECEDENTS OF OPPRESSION*, pp8-*9* In— *Justice As A Basic Human Need,* Ed, Prof Taylor, Nova Books, 2006

> and Slavonic people under a policy of racial hygiene and political conformity, and, with the cooperation of the medical profession, they established extermination camps in which an estimated number of six millions were killed through starvation, disease, medical experiments, and asphyxiation.
>
> > Fn 7 Porter (2002, pp. 186/7) reported that between January 1940 and September 1942, 'in what might be seen as a trial run for the 'final solution', 70,723 mental patients were gassed. The patients were chosen from lists of those whose lives were not considered 'worth living' that were drawn up by nine leading professors of psychiatry and thirty-nine top physicians.
>
> To continue the saga of injustice against the mentally ill, in the 1930's many countries other than Germany were concerned about the marginal and economically unproductive groups in their industrialized societies. *8*
>
> > …
> >
> > fn 8.
> >
> > New Zealand can claim to be a rare exception to the trend, because in 1928 its Parliament rejected a Bill to sterilize the mentally and morally defective that the Government, the Judiciary, the whole psychiatric fraternity, prison administrators, and educational staff had all promoted. However for whatever reason, the country's leading historians have drawn a discreet veil of silence over the extensive debates in which politicians for the affirmative and their advisers paid attention to the research and opinions of Cyril Burt, Charles Davenport, Henry Goddard, Henry Laughlin, Cesare Lombroso, William McDougall (cf. Taylor, 2005).

106. Are suspected mental ill persons to be catergorised as similar to blacks in the apartheid era, or modern terrorists. This form of detention has unfortunate similarities to the Nazi regime classifying Jews, Gypsies, and others as undesirables, which in turn was followed by repressive discriminatory laws, and behaviour, which ultimately resulted in massive genocide.

107. Consider the Anti-Semitic legislation of 7 April 1933, issued under the hand of the Reichs-Chancellor, Adolf Hitler.

108. Persons of Non-Aryan descent could no longer be admitted to the bar (Article 1), and persons involved in communistic activities were likewise excluded (Article 3). However Article I did not apply if lawyers had fought on the WW1 front, or lost sons or fathers in that war.

109. As Thomas J correctly stated in **Quilter v Attorney-General**[54], discrimination and democracy are inherently antithetical. Discrimination is indeed odious for whatever reason.

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54 [1998] 1 NZLR 523

110. Also see Baroness Hale in **A v Secretary of State:**[55]

> Democracy values each person equally. In most respects, this means that the will of the majority must prevail. **But valuing each person equally also means that the will of the majority cannot prevail if it is inconsistent with the equal rights of the minorities.** As Thomas Jefferson said in his inaugural address:
>
> > "Though the will of the majority is in all cases to prevail, that will to be rightful must be reasonable….The minority possess their equal rights, which equal law must protect, and to violate would be oppression."
>
> No one has the right to be an international terrorist. But substitute "black", "disabled", "female", "gay", or any other similar objective for "foreign" before "suspected international terrorist" and ask whether it would be justifiable to take power to lock up that group but not the "white", "able-bodied", "male", or "straight" suspected terrorist international terrorists. The answer is clear.[56]

111. Mental patients similarly a modern discriminated group and once potential patients in the Mental Health system their rights are inadequately protected, at least according to the Court of Appeal in **Sestan**.

112. Section 23 clearly refers to the right to counsel when detained under any enactment:

> **23 Rights of persons arrested or detained**
>
> (1) Everyone who is arrested or who is detained under any enactment—
>
> (a) Shall be informed at the time of the arrest or detention of the reason for it; and
>
> (b) Shall have the right to consult and instruct a lawyer without delay and to be informed of that right; and
>
> (c) Shall have the right to have the validity of the arrest or detention determined without delay by way of habeas corpus and to be released if the arrest or detention is not lawful.

113. Likewise the new draft General Comment on Article 14 of the ICCPR referred to above reminds us from a Covenant perspective all persons detained whether for criminal or mental health purposes have the same Covenant rights.

114. Whatever the Court of Appeal may think as to whether someone is

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55 A v Secretary of State **[2004] UKHL 56**

56 Ibid Para 237-238

detained under s8 or not, how is that someone in danger of criminal process under the evidentiary breath testing regime is entitled to a lawyer when presumably they have been drinking and may have their judgment impaired, but a mental health (detainee) is not? See **Rae v The Police** [2000] 3 NZLR 452.

115. Contrast this with the Montana Supreme Court **in KGF:**

> 48 That these fundamental constitutional rights are at issue during all phases of the involuntary commitment process, including prior to a hearing when counsel is either appointed or obtained, is **self evident**. Thus, we agree that the "[q]uality counsel provides the most likely way--perhaps the *only* likely way" to ensure the due process protection of dignity and privacy interests in cases such as the one at bar. *See Perlin*, at 47.
>
> [**Bold added**]

Section 8 is it a Detention?

116. The Court of Appeal's finding that **Sestan** was not *detained* under s8 MHCAT in my opinion needs challenge and will be subject to a judicial review, hopefully later in 2007.

117. The better approach is set out by a 2006 judgment from Strasbourg. See **HL v UK**[57] where The European Court of Human Rights state:

> 89. It is not disputed that in order to determine whether there has been a deprivation of liberty, the starting-point must be the concrete situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and a restriction upon, liberty is merely one of degree or intensity and not one of nature or substance (see *Guzzardi v. Italy*, judgment of 6 November 1980, Series A no. 39, p. 33, § 92, and *Ashingdane*, cited above, p. 19, § 41).

118. The HL decision confirms the **Winterwerp** approach, the leading European Court of Human Rights decision, i.e. that three minimum conditions must be satisfied: (i) he must reliably be shown to be of unsound mind; (ii) the mental disorder must be of a kind or degree warranting compulsory confinement; and (iii) the validity of continued confinement depends upon the persistence of such a disorder (see *Winterwerp*, pp. 17-18, § 39).

119. In my view, this is the better approach.

120. Likewise the US Courts take a realistic view of the detention of the

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[57] *(Application no. 45508/99),* 5 January 2005

mentally ill. See **In Conservatorship of Roulet** (Cal. 1979), 23 Cal. 3d 219;; 590 P.2d 1; 152 Cal. Rptr. 425; 1979 Cal. LEXIS 195, where the Supreme Court of California stated that it had "*explicitly recognized that civil commitment to a mental hospital, despite its civil label, threatens a person's liberty and dignity on as massive a scale as that traditionally associated with criminal prosecutions*."

121. The Court observed that commitment is a deprivation of liberty and that it is incarceration against one's will, whether it is called 'criminal' or 'civil.'

122. This in my opinion is the reality of the situation for any mental health "detainee". A 'massive scale' of liberty interests is in issue.

123. The questions as to whether or not it is a detention is a question for further legal analysis. In my opinion, what I should have argued in **Sestan**[58] but did not, was the availability of legal aid to obtain a lawyer.

124. Clearly the legislature envisaged lawyer involvement when a proposed patient is detained under s8 MHCAT. Section 15 Legal Services Act provides one of the three rare exceptions where no refunds of civil legal are required.

> [15 Conditions on grant of legal aid
>
> (1) A grant of legal aid may be subject to a condition that the aided person must pay to the Agency an interim repayment of a specified amount calculated in accordance with section 17.
>
> (6) This section does not apply to--
>
> applications for legal aid under section 42 in respect of certain proceedings before the Waitangi Tribunal; or
>
> applications for legal aid by the proposed patient in proceedings under the Mental Health (Compulsory Assessment and Treatment) Act 1992; or
>
> applications for legal aid by the proposed care recipient in proceedings under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.]

125. However, the Legal Services Act does not go far enough. Those **questioned or detained** under criminal law can access legal services under the Police Detention Legal Assistance Scheme.

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58 **Josko Sestan v Director of Area Mental Health Services Waitemata District Health Board** CA254/06 [12 December 2006]

Whereas there is no Mental Health Hospital Detention Scheme for those **questioned or detained** under the MHCAT. This plainly discriminises against mental health patients.

Section 4

126. Bell and Brookbanks correctly put the position on the potential misuse of this section. See their pages 28-30 which state:

> The procedures prescribed by Parts I and II of this Act shall not be invoked in respect of any person by reason only of—
>
> (a) That person's political, religious, or cultural beliefs; or
>
> (b) That person's sexual preferences; or
>
> (c) That person's criminal or delinquent behaviour; or
>
> (d) Substance abuse; or
>
> (e) Intellectual disability.
>
> Section 4 is similar to the requirements in principle 4 of the United Nations Improvement of Mental Health Care. The Principles do not attempt to define Improvement of Mental Health Care …
>
> As the Ministry's guidelines note, psychiatry's ethical position in the treatment of the mentally ill is undermined if it becomes an agent of State control for groups of people who society may find irksome.; This approach is reinforced by the comments of the Court of Appeal in Waitemata Health v A-G described s 4 as:
>
> > A significant pointer to the interpretation of the whole Act … [itj makes explicit what is clear from the long title … it is concerned with the assessment and treatment of those suffering from mental disorder. It is not a vehicle tor compulsory detention of those who are socially deviant or inadequate but not mentally disordered.
>
> It is accepted therefore that although a person cannot be detained for any one of the listed qualifications alone, the fact that he or she has an abnormal state of mind, together with one of those conditions, will not exclude the Act's operation.

127. There is probably room for concern that the Act in respect of drug offenders, whose criminal or delinquent offending, may be seized upon by the medical profession for detention for their own good. This was submitted to the High Court in an application for habeas corpus in **Chu v District Court at Wellington** [2006] NZAR 707 (HC).[59]

128. Equally, the question of intellectual disability, another s4 sole prohibited use, and the topic of warehousing comes to mind. In

[59] A writ of Habeas Corpus was successfully issued in this case, but on section 9(2)(d) rather than section 4 grounds.

Conservatorship of Roulet the Supreme Court of California observed**—***In many cases the "promise of treatment has served only to bring an illusion of benevolence to what is essentially a warehousing operation for social misfits*."

129. In more modern times Baroness Hale[60] surmises:

> Viewed from the point of view of the patient or even the objective outsider, a great deal of what goes on in psychiatric hospitals has the potential to be inhuman or degrading. But the Strasbourg court has imported a concept of medical necessity into its assessment of what amounts to inhuman or degrading treatment. In **Herczegfalvy v Austria**, 30 the Court started well:
>
> > "82. The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with…

130. Intense scrutiny to the decisions should be applied otherwise detention becomes warehousing.

131. The topic is likely to be a major issue in a forthcoming judicial review in respect of special patients outside the scope of this current analysis.

Sections 8, 9 and 10

132. Given the various aspects of these sections addressed above, I do not propose to address these sections further other than to say an analysis of the legislation of various Members of the European Union shows that in the context of involuntary commitment 4 countries have one expert involved in psychiatric certification, 11 have two, and Finland has more than 2. Additional 4 countries have psychiatric decision making for involuntary placement, whereas 10 have non-medical decision-makers. Our section 10 providing for one doctor normally a psychiatrist, is out of step. See tables in Appendix B.

133. Also see the tables in Appendix B for the results of a European Union study which provides an indication of where the Europeans are moving towards in terms of the approach to individual autonomy.

134. Further research would have to be undertaken in a far more detailed way to make full use of the report in New Zealand, but it supports the underlying theme that constraint on the basis of a single psychiatric opinion does not appear to be a mainstream position.

135. The tables illustrate that the time of an initial NZ detention 5 days, is long. Only one EU state has longer Belgium. Only one EU state

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60 Hale, Ibid pp 23-24

Denmark relies like NZ on a single psychiatric opinion on which to base a civil commitment.

Sections 16

136. In my opinion the statement in the European Union research project that the *most crucial patient right concerns mechanisms of appeal.*[61] is correct.

137. Yet we do not have an appeal right merely a totally flawed (in practice) right to a s16 review where the lawfulness of detention cannot be challenged. Alternatively rarely used are a s84 inquiry, or a habeas application, or the albeit even (slower) judicial review.

138. In my opinion none of these mechanisms would satisfy Article 9(4) of the ICCPR the international habeas provision, and if the working group[62] is correct and that is part of Customary International Law neither roes it satisfy our common law.

139. In the context of the ICCPR the UN Human Rights Committee has made one decision in respect of New Zealand of note. Bell and Brookbanks however make mention of **A v New Zealand**[63] without mention of the dissenting views.

140. The dissenting views of members of the Human Rights Committee Fausto Pocar, and Martin Scheinin, widely respected international human rights jurists partly dissenting, are however useful for an overview of international thinking on the topic, they can be usefully canvassed here:

> "Our concern lies in the fact that although there was periodic expert review of the author's status, his continued detention was not subject to effective and regular judicial review. In order for the author's treatment to meet the requirements of article 9, paragraph 4, not only the psychiatric review but also its judicial control should have been regular.
>
> We find a violation of article 9, paragraph 4, in the case. Various mechanisms of judicial review on the lawfulness of the author's continued detention were provided by the law of New Zealand, but none of them was effective enough to provide for judicial review "without delay". Although there were several instances of judicial review, they were too irregular and too slow to meet the requirements of the Covenant. As the following account of the various instances of judicial review will show, this conclusion does not depend on the position one takes on the effect of the entry into force of the Optional Protocol in respect of New Zealand on 26 August 1989.

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61 *Placement and treatment of Mentally ill offenders Legislation and Practice in EU Member States*, Final Report, Central Institute of Mental Health, Manheim, Germany, February 15, 2005 pp1-247, 29

62 E/CN.4/2005/6 1 December 2004

63 CCPR/C/D/754/1997**.** P7

> Between the original committal to compulsory psychiatric treatment in November 1984 and the decision by the Medical Health Review Tribunal, in February 1993 to discharge the author from compulsory status (before which decision he had already been released from a closed institution), there appears not to have been a single instance of judicial review that would have met the standards of article 9, paragraph 4, of the Covenant.
>
> On 9 August 1985, the author submitted a writ of habeas corpus. Instead of resulting in a decision without delay, this writ was incorporated into another procedure of judicial review that ended in the judicial determination of the author's continued detention as late as 21 April 1986.
>
> Another set of judicial proceedings to review the author's detention was initiated by the author in early December 1987. Although the author himself contributed to the delay by, inter alia, escaping from an institution, he was rearrested on 9 August 1989, after which date it took still until 15 August 1990 before the proceedings ended in a judicial determination by the High Court.
>
> A third set of judicial proceedings were completed by a High Court Decision on 24 April 1991. It is unclear from the file when the proceedings in question were initiated, but from the decision itself it transpires that the review was based on "an urgent enquiry" by the author and that a hearing had been conducted on 22 February 1991, i.e. a little more than two months prior to the decision.
>
> Further judicial decisions on the author's compulsory status were made on 5 August 1992 and 19 February 1993. As the author at the time of these decisions had already been released into his community on a temporary basis, they are not of direct relevance for the legal issue under article 9 of the Covenant. It deserves, however, to be mentioned that the last-mentioned decision by the Medical Health Review Tribunal was based on the Mental Health (Compulsory Assessment and Treatment) Act of 1992 and that it was initiated by an application by the author received on 9 February 1993. This appears to us as the only set of proceedings in the author's case that complies with the requirement of a judicial decision "without delay", prescribed in article 9, paragraph 4, of the Covenant.
>
> Our conclusion of a violation by New Zealand of the author's rights under article 9, paragraph 4, is based on the fact that prior to the author's provisional release in April 1992, the author's requests for a judicial determination of the lawfulness of his detention were not decided without delay. Consequently, the author has a right to compensation under article 9, paragraph 5.

141. The dissenting views just set out in **A v New Zealand** as to the adequacy of protection, are leant support from the European Court of Human Rights given that neither habeas, or judicial review are adequate protection in International Human Rights terms, then

neither is s84 likely to be. See for example **Weeks v UK** (1987).[64] Where the European Court of Human Rights said,

> In the Court's view, having regard to the nature of the control it allows, the remedy of judicial review can neither itself provide the proceedings required by Article 5 para. 4 (art. 5-4) nor serve to remedy the inadequacy, for the purposes of that provision, of the procedure before the Parole Board.

142. The adequacy of habeas corpus and judicial review proceedings under Article 5(4) of the European Convention (which is similar to Article 9(4) of the ICCPR) has been considered in a number of cases. In **X v United Kingdom**[65] habeas corpus was inadequate because it did not enable a challenge on medical grounds to detaining an individual on mental health grounds. In **Chahal v United Kingdom**[66] neither judicial review nor habeas corpus provided an adequate basis for challenging a deportation on national security grounds.

143. A s16 review is not comparable to a habeas corpus application according to Bell and Brookbanks.[67] They say:

> The review itself cannot, therefore, be likened to a habeas corpus hearing into the legality of the detention because its statutory purpose is to determine the necessity of further assessment and treatment.
>
> This approach to the legislation has been accepted by the courts. In **Re BWA [mental health]** (1994) 12 FRNZ 510; [1994] NZFLR 321. Judge Donovan held that the power of a District Court judge to make a finding that a patient is "fit to be released from compulsory status" is limited and relates solely to the patient's state of health. It does not extend to permitting a consideration of the legality of the patient's detention in a hospital. The judge also observed that the express provision of a remedy in s 84(3), giving a High Court judge the power to consider the legality of a patient's detention in a hospital, signaled the legislature's intention that only a High Court judge should have that power. In **Re G (mental health)** Judge Boshier agreed that the High Court was the proper forum for determining whether a patient was being illegally held as a result of non-compliance of mental health officials with the statutory procedure.

144. Bell and Brookbanks also suggest an interim application for judicial review under the Judicature Amendment Act 1972, may be possible.[68] They also make brief mention of **MM v Director-General of Mental Health Services** [1998] NZFLR 900 (CA) as to the

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64 10 EHRR 293 para 61.
65 (1981) 4 EHRR 188 paras 58-61
66 (1996) 23 EHRR413 para 130.
67 p262-266
68 p264

availability of habeas corpus, this early case of mine has been overtaken by later cases of **Chu**[69]**, Keenan**[70] and **Sestan**[71], occurring after the Bell and Brookbanks publication.

145. I have already canvassed the proposition that the s16 review must include a NZBORA analysis, and following **Gajcsi v Hungary**[72] **and Lewis v Wilson & Horton**[73] there must be reasons that meet a sufficiency test.

146. The required test must satisfy both criteria laid down in **Winterwerp** and **Gajcsi** ie (a) that three minimum conditions must be satisfied: (i) he must reliably be shown to be of unsound mind; (ii) the mental disorder must be of a kind or degree warranting compulsory confinement; and (iii) the validity of continued confinement depends upon the persistence of such a disorder (see *Winterwerp*, pp. 17-18, § 39) and (b) any deprivation of liberty must not only have been effected in conformity with the substantive and procedural rules of national law but must equally be in keeping with the very purpose of Article 5, namely to protect the individual from arbitrariness. (**Gajcsi**, paragraph 20)

147. There is clearly room for a challenge here that the s16 process is inconsistent with international and domestic rights in that there is no practical method to effectively challenge in a speedy fashion whether a detention is arbitrary.

148. In my opinion a s16 review as operated will not meet international standards (this may or may not be assisted by the UN Human Rights Committee views in **Manuel v New Zealand 1385/2006**, where the Committee are considering a major challenge to the adequacy of habeas corpus and judicial review. The Committee I am advised will consider the case in July 2007 so any meaningful discussion is premature).

149. In **Sestan**, as the s16 review was not raised in the High Court, the Court of Appeal sidestepped the issue. **Sestan** appeared to have had a 10-minute review, which is hardly a meaningful and intense scrutiny and which is not going to meet the required international standard in **Winterwerp** and **Wilkinson**.

150. The proposition that a Family Court Judge cannot look at the reasons for the detention (as illustrated in **Re BWA [mental health]** (1994) 12 FRNZ 510; [1994] NZFLR 321) is an effective ousting of the jurisdiction of the Family Court of NZBORA. It is with respect wrong

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69 **Chu v The Director of Mental Health Services** [2006] NZAR 707 (HC)

70 **Keenan v The Director of Mental Health Services** (High Court, Dunedin, CIV 2006-412- 000494 30 June 2006)

71 **Josko Sestan v Director of Area Mental Health Services Waitemata District Health Board** CA254/06 [12 December 2006]

72 Application no. 34503/03, 3 October 2006

73 [2000] 3 NZLR 546 (CA)

that the Family Court cannot consider the NZBORA, in an s16 application, or indeed any application before it. It is bound to by ss 3 and 6 of the NZBORA.[74]

151. It is extremely worrying is that no one has seen fit to challenge this proposition since1994, and highly indicative of the absence of human rights lawyers practicing in this field.

152. Butler and Mckenzie correctly states in their peer review that s22 NZBORA is relevant to the task to be performed by a Judge on a section 16 review, in that a Judge is required to apply an NZBORA informed analysis under the provision in respect of those matters that legitimately fall within the Court's jurisdiction on a section 16 review.

153. Family Court Judges need to incorporate this approach into section 16 reviews to give effect to the NZBORA protections which they are bound to apply by s3 NZBORA.

154. See **Hansen v The Queen** [2007] NZSC 7, 22 February 2007, paragraphs 90-91, for discussion on the relationship between ss4,5, 6 of NZBORA . Tipping J states:

> [90] I consider the latter is the appropriate course. The court does not moves traight from an apparently inconsistent meaning to look for another meaning. The court first examines the apparently inconsistent meaning to see whether it constitutes a justified limit on the right or freedom in question. If it does not constitute a justified limit, the court goes back to s 6 to see if a consistent or more consistent meaning is reasonably possible. If, however, the apparently inconsistent meaning does constitute a justified limit, the apparent inconsistency is overtaken by the justification afforded by s 5. In effect, s 5 has legitimised the inconsistency. If this sequence were not followed, there would be the potential for subversion of a deliberate policy choice by Parliament and its (at least implicit) view that the ensuing limitation of a right or freedom was justified. This would occur if there was a reasonably possible but unintended meaning which could be given to the statutory words. Such would be the consequence of going straight from Parliament's intended but apparently inconsistent meaning to another meaning which was reasonably possible but unintended.
>
> [91] To approach the matter in this way would give the limitation involved in Parliament's intended meaning no chance of being justified under s 5, if there was a tenable and more consistent meaning. If

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[74] Section 3 NZBORA reads:

3 Application

This Bill of Rights applies only to acts done—

(a) By the legislative, executive, or judicial branches of the government of New Zealand; or

> Parliament's intended meaning is not justified under s 5 then, and only then, should the court look for a reasonably possible alternative meaning under s 6. This is not to subvert s 6 but rather to say that if a meaning which is apparently inconsistent is nevertheless justified under s 5, it is no longer inconsistent for the purposes of s 6. Section 5 makes the inconsistency legitimate. This construction recognises Parliament's ability to legislate in terms which constitute a justified limit without having its purpose frustrated by a tenable but unintended s 6 interpretation. Section 4 comes into play only if Parliament's intended meaning constitutes an unjustified limit and no other tenable meaning can be given to the words in issue. This approach, which I regard as principled rather than prescriptive, best reflects the interrelationship between ss 4, 5 and 6. It is consistent with Parliament's plenary law making powers as emphasized by s 4. It also gives s 5 an appropriate role in the interpretation exercise entrusted to the courts.

155. There should be in my opinion a proper statutory right of appeal that fully canvasses the NZBORA provision and secondly, there should be periodic reviews by right every 6 months.

156. It is of concern that an automatic right of appeal, rather than an elective right of review is provided; a patient must *elect* to seek a s16 review and given the circumstances they are detained under they may not be in the best position to make that election. Such reviews are in my opinion a black hole where the NZBORA by virtue of current practice has disappeared without trace.

157. This is illustrated by the approach adopted in **Re BWA [mental health]** (1994) 12 FRNZ 510; [1994] NZFLR 321.

158. On the basis of **Thwaites** and the above it is certainly possible to seek a Declaration of Inconsistency, and one should be sought. Win, or lose, the position of mental health patients would no doubt improve given the courts being forced to consider and construct a Bill of Rights consistent meanings to the legislation, a medical necessity test (See **Wilkinson** discussion below) for commitment under s10, and a meaningful s16 review.

159. The entire legislative scheme is not only inconsistent with a rights approach, but creates arbitrary detention because of the absence of reasons which in practice are inadequate. This is probably connected with the perception that arbitrariness of the detention is not in issue, therefore reasons are not required. It is therefore further arbitrary relying on the need to give meaningful reasons in **Lewis v Wilson & Horton** [2000] 3 NZLR 546 (CA), and **Gajcsi v Hungary**, Application no. 34503/03, 3 October 2006.

> ...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.

160. In R (on the application of Wilkinson) v The Responsible Medical Officer Broadmoor Hospital[75] As already stated the Court quoted Herczegfalvy v Austria [76] at para 82:

> The Court considers that the position of inferiority and powerlesness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with…. The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is [a] therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist...

161. Bartlett[77] says of this:

> Effectively, this is to change the important question, from one of procedure to one of substance; and attach a very high burden of proof to the requirement to show that the treatment in question is a 'therapeutic' or 'medical' necessity.

162. Bartlett further says:[78]

> It can be cautiously concluded that treatment of doubtful benefit, which is strongly opposed by the patient, and which will, if administered, entail the use of force with possible detrimental effects to the overall health of the patient, is in breach of art 3 of the Convention.

163. In NZ terms, despite the lawfulness under the MHCAT, doubtful treatment, may be a breach of s9 NZBORA as degrading, or s23(5) by breaching the dignity right, and if the rights can be read consistently s6 of the NZBORA will apply, and why can they not be read consistently on a medical necessity test?

164. Whereas Bell and Brookbanks[79] recognising the importance of **Wilkinson** say it has *significant implications for the development of New Zealand law*.

165. This is plainly correct. They also say:[80]

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75 [2001] EWCA Civ 1545.

76 1992 ECHR 437

77 Peter Bartlett and Ralph Sandland, *Mental Health Law Policy and Practice*, 2nd ed, O.U.P. 2003, p363

78. Ibid p365

79 **Bell and Brookbanks**, p245

80 p244

> Wilkinson raised a serious question as to whether the forced psychiatric treatment of a competent patient against his or her will can ever be permissible, save in the most "tightly circumscribed circumstances" (Wilkinson) or "clearly and strictly defined exceptional circumstances"."
>
> What is driving this quite momentous change in English law, is not the "right to refuse-treatment" movement that emerged in the United States in the 1970s, but, rather, generic changes to human rights jurisprudence arising from decisions of the European Court and the adoption, in England, of the European Convention on Human Rights (ECHR) in the Human Rights Act 1998.

166. In my opinion the NZBORA, The Convention, and our international obligations can also drive such *momentous change.*

167. I am also of the opinion that there may be in the **Wilkinson** context circumstances when such forced medications may become medical experimentation, and a breach of Article 7 ICCPR, and s10 NZBORA.[81]

168. Bell and Brookbanks summary of the case law is this[82]:

> (1) Medical "necessity" must be "convincingly" shown to exist before any patient can be treated against his or her will.
>
> (2) Where proposed forced psychiatric treatment has the potential to threaten a person's life and is per se degrading, it must be capable of being justified as both necessary and proportionate.
>
> (3) Every psychiatric patient, but especially competent patients, should be given the opportunity to refuse treatment or other medical interventions. Derogation from that basic rule should be legally based and relate to clearly and stricdy denned exceptional circumstances.
>
> (4) A "precise equivalence" between incompetent and competent nonconsenting patients for the purposes of certifying that treatment is needed is increasingly difficult to justify.
>
> (5) The impact on a patient's autonomy and bodily integrity arising from compulsory treatment is "immense". Where a patient has the capacity to refuse treatment and strongly objects to it and where the prospective benefits of it are speculative, he or she should not be forcibly subjected to it.

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81 **10 Right not to be subjected to medical or scientific experimentation**
Every person has the right not to be subjected to medical or scientific experimentation without that person's consent.

82 p 245

169. Translate that into practice and change is overdue here.

170. Add to that a requirement to analyse serious danger (a definitional and s10 test to detain) into the five elements **Bell and Brookbanks** describe:[83]

> The nature and magnitude of the harm involved
>
> Its imminence
>
> Its frequency
>
> Situational circumstances and conditions that affect the likelihood of harm occurring and imminence
>
> Balancing the alleged harm on the one hand and the nature of society's nature of society's intervention on the other
>
> Then a significant reduction of detention would be expected. Why has this not happened?

171. Baroness Hale's comment on **Wilkinson** include:[84]

> For patients, detention is not, or should not be, an end in itself but merely the means to an end, which is treatment and care. Hospitals are there to look after people, contain their symptoms and hopefully make them better. They are not there simply to imprison and keep people off the streets. Standards that might be acceptable in a prison, therefore, may not be acceptable in a hospital.
>
> > On the other hand, forcible medical treatment, which would not be permitted in a prison, is permitted in hospital. The forcible administration of medication to a protesting patient is surely inherently degrading, unless it can be justified by the Herczegfalvy concept of 'medical necessity', which must be 'convincingly shown'.
>
> …
> How far is this concept of medical necessity linked to the patient's Incapacity? It was argued in Wilkinson that to impose breach of his Convention rights, either under Article 3 or Article 8 (of which more later). Under the MHA, however, the criteria for detention do not depend on incapacity and most forms of medical treatment for their mental disorder may be imposed upon a detained patient against their will, albeit some only with a second opinion. What did the Strasbourg court mean in Herczegfalvy by 'patients who are entirely incapable of deciding for themselves'? Was it referring to a legal or a mental disability? I see difficulties in using

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83 p151-152

84 Rt Hon The Baroness Hale of Richmond. DBE. PC. A Lord of Appeal in Ordinary. *Justice and equality in mental health law: The European experience*, International Journal of Law and Psychiatry 30 (2007) 18-28 (Available online), page 23.

incapacity as a dividing line. It would be discriminatory under Article 14 (see later) unless there was a rational and proportionate justification. Why should it be acceptable to treat an incapacitated person in a way which would be degrading if done to a capacitated? This obviously would not do with, say, living conditions, food, and general care. What makes medical treatment different? In Wilkinson, I said that:

> "79... I would hesitate to say which was worse: the degradation of an incapacitated person shames us all even if that person is unable to appreciate it, but in fact most people are able to appreciate that they are being forced to do something against their will even if they are not able to make the decision that it should or should not be done."

Compulsory Treatment—In or Out Patient

172. Given the discussion above and the immense philosophical problems associated both with In and Out patients orders, fundamental principles, only are touched upon, any further comment requires a study of its own.

173. As far as I can establish no superior court in the common law world has addressed the problem of whether a community treatment order is a 'detention'. There is clearly some scope for considering it might be, for example, see **Sec of State v JJ and Ors** [2006] EWCA Civ 1141 where an extremely strong court consisting of the Lord Chief Justice, the Master of the Rolls, and the President of the Queens Bench Division sat as a Court of Appeal on a terrorism case where "control orders" were made. These orders required:

> 4. The obligations imposed by the control orders are set out in Annex 1 to Sullivan J's judgment. They are essentially identical. Each respondent is required to remain within his 'residence' at all times, save for a period of 6 hours between 10 am and 4 pm. In the case of GG the specified residence is a one bedroom flat provided by the local authority in which he lived before his detention. In the case of the other five applicants the specified residences are one bedroom flats provided by NASS. During the curfew period the respondents are confined in their small flats and are not even allowed into the common parts of the buildings in which these flats are situated. Visitors must be authorised by the Home Office, to which name, address, date of birth and photographic identity must be supplied. The residences are subject to spot searches by the police. During the six hours when they are permitted to leave their residences, the respondents are confined to restricted urban areas, the largest of which is 72 square kilometres. These deliberately do not extend, save in the case of GG, to any area in which they lived before. Each area contains a mosque, a hospital, primary health care facilities, shops and entertainment and sporting facilities. The respondents are prohibited from meeting anyone by pre-

arrangement who has not been given the same Home Office clearance as a visitor to the residence.

6. There is a degree of common ground between the parties:

i) The concept of 'deprivation of liberty' is autonomous.

ii) The best guidance in relation to the nature of 'deprivation of liberty' is provided by the decision of the Strasbourg Court in *Guzzardi v Italy* (1980) 3 EHRR 333.

iii) The difference between deprivation of liberty, contrary to Article 5, and restrictions upon liberty of movement, contrary to Article 2 to Protocol No 4, is one of degree or intensity.

9. In paragraph 92 of *Guzzardi* the ECtHR said:

> "The Court recalls that in proclaiming the 'right to liberty' paragraph 1 of Article 5 is contemplating the physical liberty of the person; its aim is to ensure that no one should be dispossessed of this liberty in an arbitrary fashion. As was pointed out by those appearing before the Court, the paragraph is not concerned with mere restrictions on liberty of movement; such restrictions are covered by Article 2 of Protocol No 4… In order to determine whether someone has been 'deprived of his liberty' within the meaning of Article 5, the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question."

23. The judge's conclusion in paragraph 73 was as follows:

> "I do not consider that this is a borderline case. The collective impact of the obligations in Annex 1 could not sensibly be described as mere restrictions upon the respondents' liberty of movement. In terms of the length of the curfew period (18 hours), the extent of the obligations and their intrusive impact on the respondents' ability to lead a normal life, whether inside their residences within the curfew period, or for the six hour period outside it, these control orders go far beyond the restrictions in those cases where the European Court of Human Rights has concluded that there has been a restriction upon but not a deprivation of liberty."

We agree that the facts of this case fall clearly on the wrong side of the dividing line. The orders amounted to a deprivation of liberty contrary to Article 5. For that reason the appeal against the decision of the judge on the first issue is unsuccessful.

174. It all comes down to a question of fact and degree in each case. But is certainly worthy of more consideration at a later date.

175. Compulsory treatment raises with it a question of where that treatment is given. Questions of freedom of movement under s18 NZBORA come into play, as does the UN Convention Article 19:

> 18 Freedom of movement
>
> (1) Everyone lawfully in New Zealand has the right to freedom of movement and residence in New Zealand.

UN Convention on the Rights of Persons with Disabilities

Article 19 - Living independently and being included in the community

States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

a Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

b Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

c. Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

176. Attempting to restrict residence for mental health patients for example to a particular DHB catchment area would be fraught with difficulties and may well be discriminatory, as for example those with a broken leg are not required to live in any particular place, whereas liver transplants (it we did them rather than send patients to Australia) might justifiably be only performed in Auckland.

177. The policy issues behind In and Out patients and the whole topic of voluntaries are perhaps canvassed well in the WHO Mental Health and Legislation Guide 2003.[85] That study is extensive, it is sufficient for current purposes to quote part of the executive summary:

> P4

[85] Mental Health Legislation and Human Rights, Mental Health Policy and Service Guidance Package, World Health Organisation, 2003

> The principle of free and informed consent to treatment should be enshrined in the legislation. Treatment without consent (involuntary treatment) should be permitted only under exceptional circumstances (which must be outlined). The legislation should incorporate adequate procedural mechanisms that protect the rights of persons with mental disorders who are being treated involuntarily, and should permit clinical and research trials only if patients have given free and informed consent. This applies equally to patients admitted involuntarily to mental health facilities and to voluntary patients. Involuntary admission to hospital should be the exception and should happen only in very specific circumstances. The legislation should outline these exceptional circumstances and lay down the procedures to be followed for involuntary admission. The legislation should give patients who are admitted involuntarily the right of appeal against their admission to a review body…

178. The summary also provides that legislation should ensure that all treatments are provided on the basis of free and informed consent except in rare circumstances. Consent cannot be lawful if accompanied by a threat or implied threat of compulsion.

179. The legislation should also make provisions for the automatic reviewing of all instances of involuntary admission and involuntary treatment, which should involve an independent review body with legal or quasi-legal status enabling it to act as a regulatory authority.

Section 84

180. Section 84 is a judicial inquiry by a High Court Judge which can occur whenever the Judge thinks fit, whether of the Judge's own motion or on the application of any person. Under s84(3)(a) the Judge can examine whether the person is detained illegally, and on its face the inquiry power can be wide ranging.

181. Bell and Brookbanks, describe the s 84 review as:

> The judicial inquiry under s 84 is the ultimate review power conferred by the Act. The power of review under this section is potentially very broad, in that the judge may direct the writing of a report on any matter pertaining to a person detained as a patient "as the Judge thinks fit". The purpose of the s 84 inquiry procedure is to provide an additional protection and an additional safeguard for persons detained compulsorily in a hospital. Section 84 is an important watchdog provision providing an important means of redress for patients who consider that they should not be detained in a hospital…It is a commonly exercised jurisdiction.

182. I respectfully disagree. In my opinion, this hybrid type of statutory habeas, and judicial review is remarkably **unsuccessful** as an *important watchdog*.

183. I base my opinion that it is remarkably unsuccessful on the results; I have not found a single successful reported case in 15 years of its operation.

184. The reader may decide for her/himself.

185. However, I accept that there is an alternative hypothesis that the absence of successful cases could have the opposite meaning i.e. that the effectiveness of the section 84 should not necessarily stand or fall on the number of times that it has led to an order for release by a High Court Judge.

Other Human Rights not in NZBORA or MHCAT

186. In addition, even if the right is not one accorded in NZBORA, it might be a right valid under a different Statute e.g. Magna Carta, and the provisions of due process,[86] or common law (such as natural justice, or the right to reasons), a right may become a common law right not merely by domestic interpretation but also by virtue of customary international law (Whole books have been written on the topic of what customary international law is). Lawyers commonly refer to the Statute of the International Court of Justice for the standard enumeration of the "sources" of international law. The Statute of the International Court of Justice (ICJ) recognizes international custom as a source of international law. Article 38(1)(b) of the Statute of the ICJ defines international custom as "evidence of a general practice accepted by the law**"**. Rosenthal describes Customary International law as:[87]

> Customary international law is made up of legal principles so widely accepted by governments and legal scholars as binding that they need not even be written legal practice[88]

> In the human rights field widespread acceptance of treaties, declarations, resolutions, and other instruments has become a key source of evidence of state practice as well as opinion juris (the The view that a state's treatment of its own citizens is beyond the purview

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86 **Zaoui v Attorney-General** [2005] 1 NZLR 577 may be a good example.

87 International Legal Materials Judicial and Similar Proceedings May, 1980 United States: Memorandum for the United States submitted to the Court of Appeals for the Second Circuit in *Filartiga v. Pena-irala* —The view that a state's treatment of its own citizens is beyond the purview of international law was once widely held and is reflected in traditional works on the subject. [FN4] However, as we have stated, customary international law evolves with the changing customs and standards of behavior in the international community. Early in this century, as a consequence of those changing customs, an international law of human rights began to develop. This evolutionary process has produced wide recognition that certain fundamental human rights are now guaranteed to individuals as a matter of customary international law.

88 Eric Rosenthal & Clarence J. Sundram, *The Role of International Human Rights in National Mental Health Legislation* Department of Mental Health and Substance Dependence, World Health Organization, 2004 (Rosenthal), p12

> of international law was once widely held and is reflected in traditional works on the subject. accompanying sense of legal obligation) in creating binding law. **Weissbrodt, Fitzpatrick & Newman**, supra n.11 at 22.

187. Customary International Law[89] is just one source of rights beyond the NZBORA, consequently it is dangerous to conclude that simply not being covered under the NZBORA means no right exists.

188. The provisions of Article 9 of the ICCPR are according to the working party quoted above, part of Customary International Law, and therefore part of the common law of New Zealand.

Rights and their Enforceability

189. The question of what rights someone has under the NZBORA cannot be divorced from the question of their enforceability, and the absence of skilled practitioners practicing in the area, and the problems of legal aid.

190. In **KGF** the Montana Supreme Court was primarily concerned not with *sanism* but with the issue of competent counsel, and required a higher standard than that of counsel in a criminal case. That is far from the case in New Zealand.

191. This line of analysis is of particular importance in the instruction given to focus on the right of patients, and *proposed* patients. **KGF** states:

> 48 That these fundamental constitutional rights are at issue **during all phases of the involuntary commitment process, including prior to a hearing when counsel is either appointed or obtained, is self evident.** Thus, we agree that the "[q]uality counsel provides the most likely way--perhaps the *only* likely way" to ensure the due process protection of dignity and privacy interests in cases such as the one at bar. *See Perlin*, at 47.This issue is beyond the scope of the current topic.
>
> [**Bold added**]

KGF also says:

> 74 Therefore, before and after the required meeting with a patient, under § 53-21-121(3), MCA, counsel should conduct a thorough review of all available records. Such inquiry must necessarily involve the patient's prior medical history and treatment, if and to what extent medication has played a role in the petition for commitment, the patient's relationship to family and friends within the community, and the patient's relationship with all relevant medical professionals

> involved prior to and during the petition process. In sum, we conclude that the rights afforded a patient-respondent under § 53-21-115, MCA, **without the assistance of diligent, competent, and well-informed counsel at the commencement of the critical investigatory stage of the involuntary commitment process, would have little meaning.**
>
> [**Bold added**]

The Role of Counsel for Mental Patients or Proposed Patients

192. This subject merits greater attention in a report of its own.

193. Under the heading The Rights Illusion—Perlin[90] notes:

> As long as mentally disabled individuals are not assured of access to adequate, ""regularized," and well-structured counsel, many of the questions to which scholars, clinicians, litigators, and courts devote their time and energy will have little ultimate impact, and all of the "rights talk" and law reform efforts of the past two decades will be little more than an illusion.

194. As Prof Perlin further observes:[91]

> The record of the legal profession in providing meaningful advocacy services to mentally disabled persons has been grossly inadequate.
>
> …
>
> > Traditional, sporadically-appointed counsel. . . were unwilling to pursue necessary investigations, lacked . . . expertise in dealing with mental health problems, and suffered from "rolelessness," stemming from near total capitulation to experts, hazily defined concepts of success/failure, in abilifto genate professional or personal interest in the patient's dilemma, and lack of a clear definition of the proper advocacy function. As a result, counsel. . . functioned "as no more than a clerk, ratifying the events that transpired, rather than influencing them.
>
> Commitment hearings were little more than a ritual, adding only a "falsely reassuring patina of respectability to the proceedings."

195. The absence of a realistic ability to contact counsel even at the belated s9 stage the Court of Appeal found in **Sestan**, is probably financially related.

196. No list of lawyers (and therefore the ability to contact one) is provided to mental detainees until a s16 review.

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90 Perlin p45

91 Ibid, p 43

> Legal rights are not necessarily self-executing. The declaration by a court of a right to a service or a right to be free "from" an intrusion does not *in se* provide that service or guarantee freedom from intrusion. A right is only a paper declaration without an accompanying remedy, and, without counsel (so as to best guarantee enforcement), there is little chance that the rights "victories" that have been won in test case and law reform litigation in this area will have any impact on the mentally disabled population.[92]

197. Compare this derogation of recognition of rights, with the detention of "criminals". Recalling that to be non-discriminatory all detainees should be treated equally (with more scrutiny of the rights of the mentally ill given their vulnerability see **HL v UK** cited below). If suspected criminals only had lawyers provided just before going to Court, and not at the police station, there would be an uproar, why should mental detainees be so blatantly discriminated against. Presumably on the erroneous assumption they are being detained for their own good.[93]

198. It is possible to read **Sestan** as not excluding access to counsel. The interesting question arises as to what would happen if a proposed patient arrived with counsel. Would they be excluded? If not, does this not implicitly mean that the wealthy are entitled to counsel and the poor are not, which is inherently discriminatory. See **R v Taito** [2003] 3 NZLR 577 paragraph 20:

> Thirdly, the practice of the Court of Appeal distinguished in effect between rich and poor inasmuch as a rich appellant, who was represented, always received an oral hearing before the Court of Appeal whereas a poor appellant, who was denied legal aid on paper, was never accorded such a right. It has to be said that in the result the system operated arbitrarily. Certainly, it was contrary to fundamental conceptions of fairness and justice.

199. **R v Alo**[94] considered the entitlement of criminal suspects to be told of the availability of free legal advice when informed of their right to a lawyer under NZBORA, s23(1)(b). The majority of the Court of Appeal found that whilst "*there is no absolute requirement for the police to advise suspects of the existence of the Police Legal Assistance Scheme [scheme offering free legal advice at the Police Station]*" the failure will result in a breach of s23 if the circumstances at the time of the interview provide a "*substantial basis for believing that the suspect may not have appreciated that he or she had a practical ability to obtain legal advice*."[95]

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92 Perlin, Ibid, p 47

93 See **Roule**t, and **Olmstead v. United States,** supra

94 [2007] NZCA 172

95 Overview provided in The Capital Letter, A weekly review of administration, legislation and law, 30 TCL 17 (1393), 15 May 2007.

200. By analogy with the rights jurisprudence of the European Court of human rights, rights do not just materialize:[96]

> The crux, however, is that human rights can only be secured by challenges brought before the Court. People with mental illness for the most part have fewer means and less capacity to undertake this step and are thus at a disadvantage (Findlay, 2003). The rights as set out in this Convention have also been brought into the domestic law of those States which have ratified the Convention. France was one of the first to do so; Great Britain's Human Rights Act of 1998 took effect in 2000. Conclusions about the impact of this act differ. It was initially suggested that the Human Rights Act would be likely to result in "a flood of legal cases", particularly those of patients admitted on a compulsory basis under the Mental Health Act. This would necessitate the re-determination of the balance between the rights of the individual patient and those of the Community (Macgregor-Morris et al., 2001). However, Bindman et al. (2003) noted that during the first year after the Human Rights Act had taken effect, the number of cases dropped rather than increased.

201. In the UK, Mind[97] in its civil admission to a hospital guide says this[98]

> If you want advice from a solicitor who has knowledge of mental health law and issues, contact Mind, which has a directory of mental health solicitors. Alternatively, you could get in touch with the Law Society, which has a list of solicitors who are suitably experienced to advise on the Mental Health Review Tribunal. A booklet containing the list should also be available on the hospital ward. Mental health solicitors are also listed in the Community legal service directory, available in libraries or through the Internet. (For details of this, and the organisations mentioned in this booklet, see Useful organisations).

202. Where do you get similar quality advice in NZ?

203. There is clearly a need for the Commission and/or the Human Rights Commission to discuss this with the Legal Aid authorities, and to intervene in appropriate cases, otherwise the rights of the mentally ill will stay the same with scant regard for discrimination and dignity.

Clinical Reviews, Tribunal Reviews, and Psychiatrists on Review Panels

204. Further concerns arise with clinical reviews, tribunal reviews, and psychiatrists on panels and the status of the review tribunal. The lateness in the process for the "reviews" means that do not qualify as an "appeal" even if conceptually such reviews could be classified as

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[96] *Placement and treatment of Mentally ill offenders Legislation and Practice in EU Member States*, Final Report, Central Institute of Mental Health, Manheim, Germany, February 15, 2005 pp1-247, 27

[97] National Association for Mental Health.

[98] www.mind.org.uk/Information/Booklets/Rights+guide/Mindrightsguide1Civiladmissiontohospital.htm

"appeals". Given the already considerable length of this analysis, this the complex topic it is best left for further analysis in a separate paper.

Practical Examples of a Clash of Rights

205. The set of rights elucidated by Baroness Hale[99], as stated earlier in this opinion, must apply to all people, regardless of any mental health disability. If State action impedes the enjoyment of these rights by specifically mentally disabled people, is this not discrimination?

> (1) People with mental disorders and disabilities should be enabled to receive the treatment and care they need.
>
> (2) This applies equally to all people, without discrimination on grounds such as sex, racial or ethnic origin, religion, membership of a particular religious or social group, or the nature of their disability.
>
> (3) The emphasis is upon enabling not enforcing: a person's right to choose what may be done to his body or his mind remains intact unless and until it is taken away in accordance with proper processes of law.
>
> (4) Enforcing may be part of enabling but should be carefully controlled and apply much more narrowly than the availability of treatment and care. The minimum criteria for an acceptable enforcement process are:
>
> > (i) logical and defensible grounds for intervention;
> >
> > (ii) a fair process which enables the contrary case to be put and heard;
> >
> > (iii) appropriate and humane conditions of treatment and care.
>
> (5) Underlying and overriding all of these is respect for the essential dignity and humanity of all people.

206. In **Thwaites v Health Services Centre Psychiatric Facility** [1988] 3 W.W. R. 217 the Manitoba Court of Appeal on an application for habeas overtaken by events, and also by remedial legislation nevertheless treated the proceedings by consent as if they were for a Declaration.

207. The Manitoba Court of Appeal found the Mental Health Act compulsory detention provisions violated the charter right against arbitrary detention. The absence of a "*dangerousness provision*" was pivotal. The legislative provisions were also found not to be reasonable limits prescribed by law as could be demonstrably

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[99] Hale, Ibid pp 19/20

justified in a free and democratic society.

208. Bell and Brookbanks[100] in the context of restricted patients discuss this case. They conclude that in Canada the courts have the power to strike down legislation, and that the legislation was considered to be unconstitutional. This power they say is not available to New Zealand Judges because of the way in which the New Zealand Bill of Rights Act 1990 was drafted. Whilst that is true, what the authors do not say[101] is that a Declaration of Inconsistency may be possible. See Butler and Butler.[102]

209. There is an opportunity to seek a Declaration of Inconsistency, in respect of discriminatory practices, and lack of recognition of dignity, as well as the entire compulsory treatment system not being justified in a free and democratic society. Having the Manitoba Court of Appeal judgment is a good starting point for such a challenge.

210. Whilst we have a *dangerousness* provision, the wording of our Act, and its implementation in practice mean that the entire detention from s8 onwards to s16 is also arbitrary as the legislative provision contained in s10 MHCAT and its application arrive at the same arbitrary result. S10 provides;

> (b) that, in his or her opinion,— …
>
> (ii) there are reasonable grounds for believing that the proposed patient is mentally disordered and that it is desirable that the proposed patient be required to undergo further assessment and treatment.

211. That is on the certification of a single psychiatrist who considers it *desirable*, (not a medical necessity) a person may be detained, and compulsorily treated as well as "assessed",—this is arbitrary.

212. Justice Fogarty in **Chu,**[103] said for example:

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100 P69

101 There have yet to be any declarations of Inconsistency granted, except on two occasions by Thomas J in a minority in the Court of Appeal

102 At 28.5.15:

In the authors' view, while the arguments are finally balanced, the better approach is to accept that Courts do have the power to make a declaration of inconsistency. The key reasons in support are that the declaration jurisdiction would be consistent with the purposes expressed in the Long Title to BORA, is not inconsistent with the language of s4 of BORA, would complement the Attorney-General's role under s 7 of BORA and, finally, has, in effect, been given the legislative imprimatur through the Human Rights Amendment Act 2001. As is noted in Chapter 26, Parliament effectively delegated to the Courts the task of devising and granting "appropriate" and "effective" remedies for acts that are inconsistent with BORA. While striking down or ignoring a BORA-inconsistent enactment is not a remedy open to the Courts (because of the prohibitions in s 4), a declaration of inconsistency means that those "acts done by the legislative branch of the Government of New Zealand" (to use the language of s 3(a) of BORA) can be subject to meaningful scrutiny and in an appropriate case their incompatibility with human rights laws can be marked.

103 **Chu v District Court at Wellington** [2006] NZAR 707 (HC)

> [15] Mr Ellis appropriately due my attention to numerous authorities discussing the writ of habeas corpus which make the link between this great writ and with the provisions of due process in Magna Carta. The lateness of the hour means I cannot do justice to the detail of his argument, but in many ways I consider it should not be necessary to have to spell out, in any event, the authorities. The writ of habeas corpus has been described on many occasions as probably the most important remedy that the independent Courts have in our common law societies. There is a history so deep and complex associated with the importance of due process and the liberty of person that it has to be kept in mind whenever one is examining a procedural requirement set by Parliament and directly relating to the liberty of a person.

213. That is always the problem with a habeas case, His Honour however also orally said to pursue that line I would expect detailed international comparisons (which of course on 3 days notice one cannot put together).

214. A further example of a clash of rights is illustrated by Court Rules. (See Appendix A for the relevant High Court and Family Court rules)

215. Whether a person on a Compulsory Treatment Order is denied legal status as incompetent raises a **classic** case of discrimination,[104] and one where the NZBORA could be invoked.

216. The question of the vires of the Rule 82 of the High Court Rules (see s17 Judicature Act, and s23(1)(a) NZBORA, and s21 Human Rights Act), and their discriminatory effect are totally contrary to the new UN Convention, and Principle 6 of the MI Principles[105], as well as other international principles. The MI principles articulate the point clearly as Rosenthal states:[106]

> In 1991, the MI Principles established minimum human rights standards of practice in the mental health field. The MI Principles have been recognized as "**the most complete standards for the protection of the rights of persons with mental disability at the international level."**84—Fn 84 *The Case of Victor Rosario Congo,* Inter-American Commission on Human Rights Report 29/99, Case 11,427, Ecuador, adopted in Sess. 1424, OEA/Ser/L.V/II.) Doc. 26, March 9, 1999, para. 54. The Inter-American Commission went on to say that "[t]hese Principles serve as a guide to States in the design and or

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104 **82** For the purposes of these rules,—**Incapacitated person** means —
(b) A person who is subject to a compulsory treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992:

105 Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care, G.A. res. 46/119, 46 U.N. GAOR Supp. (No. 49) at 189, U.N. Doc. A/46/49 (1991).(MI Principles).

106 Eric Rosenthal & Clarence J. Sundram, *The Role of International Human Rights in National Mental Health Legislation* Department of Mental Health and Substance Dependence, World Health Organization, 2004, pp 1-77, p26 (Rosenthal) http://bazelon.org/legal/resources/internationallaw.pdf

> reform of mental health systems and are of utmost utility in evaluating the practice of existing systems. Mental Health Principle 23 establishes that each State must adopt the legislative, judicial, administrative, educational and other measures that may be necessary to implement them." *Id.* at note 8, *citing* Rosenthal & Rubenstein, *supra* note 22.

217. MI Principle 1, reads:

> 6. Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.

218. An alternative argument is that a broad definition of incapacitated person appears to be directed at, what we assume to be regarded as, a range of vulnerable people. It may not be particularly directed at the mentally disabled.

219. An "incapacitated person" under the High Court Rules, in particular rule 82, includes:

(a) a minor

(b) a person subject to a Compulsory Treatment Order under the MHCAT,

(c) a person subject to an order under sections 10(1)(i) or 31 of the Protections of Personal Property Rights Act 1988, or

(d) a person whose property is managed by a trustee corporation under sections 32 or 33 of the Protection of Personal Property Rights Act 1988.

220. However, looking at the category of incapacitated persons, it is not in my opinion an alternative argument of any strength. One has to wonder why such important issues are relegated to a mere High

Court rule rather than substantive legislation, as they raise issues of profound importance.

221. The continued use of the wording of s17 Judicature Act 1908 is not helpful:

> 17 Jurisdiction as to mentally disordered persons, etc.
>
> The Court shall also have within New Zealand all the jurisdiction and control over the persons and estates of [ ] idiots, [mentally disordered persons], and persons of unsound mind, and over the [ ] [managers] of such persons and estates respectively, as the Lord Chancellor of England, or any Judge or Judges of [Her Majesty's] High Court of Justice or of [Her Majesty's] Court of Appeal, so far as the same may be applicable to the circumstances of New Zealand, has or have in England under the Sign-manual of [Her Majesty] or otherwise.

> The Court shall also have within New Zealand all the jurisdiction and control over the persons and estates of "*idiots, mentally disordered persons and persons of unsound mind*."

222. Also see Appendix A for Rule 89 of the Family Court Rules 2002 which excludes people who are mentally disordered from self representation. In addition, see the Appendix for s100 of the Judicature Act 1908 which has been applied occasionally in cases since the mid-1980s which involve a report by a psychiatrist or otherwise related to the mental health of a person. One reported cases where such a report was ordered despite the opposition of the party concerned is **Murray v Roman Catholic Archdiocese of Wellington**, Miller J, 17 PRNZ 216.

223. It is time for reconsideration of these rules and legislation, particularly given Article 4(1)(a) of the UN Convention on the Rights of the Disabled.

224. That the question of a person's competence can be subjugated to a generalisation is offensive, and an example of sanism. Obviously such a removal of fundamental rights should be made a by a competent court on an *individual* basis, not on the basis of a class created by secondary legislation. It is plainly a breach of Article 26 of the ICCPR[107], in my view s23(5) NZBORA as it is far from treating someone with inherent dignity and respect, and it surely also breaches s9 NZBORA being degrading. It is a plain example of *sanism*.

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[107] Article 26 of the ICCPR reads:
All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Systemic Misunderstanding and Failure to accord NZBORA rights

225. It is impossible to look statutory sections in isolation. A global overview, and a systemic analysis are needed; otherwise a misleading picture is presented.

226. In my opinion for the reasons detailed above **discrimination** and **inherent dignity** are centrepieces of any understanding of, and protection of the rights of the mentally disabled.

227. From a review of the limited case law, and literature it is apparent that neither discrimination, or dignity, or indeed the NZBORA itself feature as centrepieces in mental health law.

228. In my recent paper *Mental Health Cinderella of the Detention system*,[108] I raised the issue that Mental Health recipients are disadvantaged in the legal process, but on reflection it is far worse. (At least Cinderella had *one* shoe).

229. I adopt the following dicta of the Supreme Court of Montana in The **Matter of the Mental Health of K.G.F**:[109]

> As a starting point, it is safe to say that in purportedly protecting the due process rights of an individual subject to an involuntary commitment proceeding--whereby counsel typically has less than 24 hours to prepare for a hearing on a State petition that seeks to sever or infringe upon the individual's relations with family, friends, physicians, and employment for three months or longer--our legal system of judges, lawyers, and clinicians has seemingly lost its way in vigilantly protecting the fundamental rights of such individuals. *See In re Mental Health of L.C.B*. (1992), 253 Mont. 1, 7, 830 P.2d 1299, 1303 (stating that courts must safeguard the due process rights of the individual involved at every stage of the proceedings); *In re J.B*. (1985), 217 Mont. 504, 511, 705 P.2d 598, 603 (stating that the discharge of judicial responsibility includes rigorous application of statutory mandates) (Morrison, J., dissenting).

230. This US quotation assumes a civil commitment hearing before a judicial officer not a psychiatrist. (The lack of which in NZ is of major philosophical concern). The same criticism can be leveled at our grossly inadequate, and belated s16 MHCAT reviews.

231. Indeed in my opinion a wholesale systemic failure to accord fundamental human rights to the mentally disordered occurs in New

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[108] Tony Ellis, *Mental Health: The Cinderella of the Detention System,* 1st National Nutters Conference, *Napier New Zealand, 26 November 2006,* and Criminal Law Symposium, New Zealand Law Society, Wellington, 27 November 2006.

[109] 2001 MT 140

Zealand. This failure occurs because the NZ Government has failed to incorporate the two main international human rights treaties into domestic law to permit international rights to be challenged in domestic courts,[110] failed to adequately train judges and officials (including medical staff and lawyers either defending or "prosecuting" detainment) on our international and domestic obligations.[111] These failures are assisted by an absence of literature devoted to the human rights and the mentally disabled, a major lack of jurisprudence, and institutional capture at the coal face.

232. As Judge Geoffrey Ellis at a conference in Nov 2006[112] in response to my query of whether s16 reviews took 20 minutes or less, stated in his view s16 reviews rarely took more than 10 minutes. Assuming this is true, how can there be a serious review of someone liberty interests in 10 or even 20 minutes? This is especially so given the massive scale of intrusion of a civil commitment.[113]

233. Any review of individual sections, and their meaning needs to take second place to the overall approach in this country that the Medical and Legal professions (including Courts) take to rights. The current approach needs fundamental reconsideration to take into account **discrimination**, and **dignity**, which currently have little if any application.

234. The situation is reminiscent of **Taito.**[114] Taito and 11 others

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[110] International Covenant on Civil and Political Rights and the Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment. It is not possible to claim a breach of either these treaties in domestic law as of right.

[111] What for example will happen as a result of the awareness training needed to implement Article 8 of the UN Convention on Disabilities, no training budget was allocated to the judiciary on enactment of the NZBORA cf £15 Million pounds for judicial training for the Human Rights Act in England and Wales.

[112] Compulsory Treatment Orders in New Zealand: An Ethical and Legal Consideration, Allen Fraser and Geoff Ellis, "Human Rights in a World of Fear and Diminishing Resources" ANZAPPL (Australian and New Zealand Association of Psychiatry, Psychology and Law) 26th Annual Congress, Lorne, Victoria, 9-12 November 2006.

[113] **People v. Burnick** (1975) 14 Cal.3d 306, 319-322 [121 Cal.Rptr. 488, 535 P.2d 352], **this court explicitly recognized that civil commitment to a mental hospital, despite its civil label, threatens a person's liberty and dignity on as massive a scale** as that traditionally associated with criminal prosecutions…

[114] **R v Taito** - [2003] 3 NZLR 577**.** Part of the Headnote reads:

1 The dismissal by the Court of Appeal of all the appeals under the ex parte procedure had been of no force or effect. The decisions …had been purely formal or mechanical acts relying on the earlier decision that legal aid should not be granted and involving no exercise of judicial judgment … The participation in the decisions to dismiss the appeals of a Judge who had taken part in the decision to decline legal aid would have suggested to a fair-minded and informed observer that the Judge was not independent (see para [14]).

[2003] 3 NZLR 577 page 578

2 … There was no hearing by the three Judges, the appellant was not allowed to be present and the three Judges never met to discuss the cases under consideration. The circulation of papers between Judges without face-to-face discussion or collective decision did not satisfy minimum standards of adjudication by an appellate Court and the applications were dismissed without reasons being given (see Paras [16], [17], [18]).

3 The overall process had failed to meet the requirements of natural justice. The procedural rights of the appellant should have served the instrumental purpose of helping to ensure that

challenged the methods of criminal appeal adopted by the Court of Appeal for legally aided appellants (this in reality affected about 90% of appellants, some approx 1500 people) since the enactment of the NZBORA in 1990. In a strongly worded judgment which included the **discriminatory** effects of the system the Privy Council allowed the appeals, and the system was changed.

235. In particular Lord Steyn giving the judgment said:

> **[**20] Moreover, undoubtedly well intentioned as the practice of the Court of Appeal was, **one is also driven to the conclusion that it had a discriminatory effect.** This can be illustrated by three features of the operation of the system… Certainly, it was contrary to fundamental conceptions of fairness and justice. The appellants were entitled to the observance of the principles of natural justice or fairness. In the landmark case *Ridge v Baldwin* [1964] AC 40 Lord Morris of Borth-y-Gest observed about the principles of natural justice at p 114: "here is something basic to our system: the importance of upholding it far transcends the significance of any particular case". For these further reasons the conclusion that the dismissal of the appeals did not take place in accordance with law is inevitable.
>
> [**Bold added**]

And in respect of

The approach to the right of appeal

> [12] The correct approach to the right of appeal contained in s 25(h) of the Bill of Rights Act, and in s 383 of the Crimes Act, is not in doubt. It is intended to be an effective right of appeal which so far as is reasonably possible will ensure that justice is done in the appeal process. The context is one of access to justice and it calls for what Lord Wilberforce in *Minister of Home Affairs (Bermuda) v Fisher* [1980] AC 319 at p 328, described as "a generous interpretation avoiding what has been called 'the austerity of tabulated legalism'". The substance must match the form. What is required is a collective judicial decision on the merits of the appeal by a division (three members) of the Court of Appeal, sitting together, and arrived at after a hearing in open Court: see s 25(a) of the Bill of Rights Act. So far as the Solicitor-General felt unable unreservedly to embrace these propositions his doubts are not justified. It must be the starting point of the consideration of the present appeals.

236. Whilst there is some Court of Appeal jurisprudence that the starting point is the non-NZBORA statute, for present purposes, the better view is the Taito starting point, i.e. start with the NZBORA.

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correct decisions were made. **The appellants had been denied the information required to perfect their submissions and the system was discriminatory in that an appellant** who was legally represented always received an oral hearing before the Court of Appeal (see paras [19], [20]). [Bold added]
Appeals allowed.

Conclusion

237. Does our legislative scheme measure up?

238. The NZ processes are littered with black holes, and are frankly potentially worse than pre-Victorian and Victorian processes.

239. No doubt the MHCAT on paper has safeguards as the legislators intended, as does the NZBORA**.** In practice these rights are systemically reduced to mere window dressing, and so-called rights come into play far too late.

240. Assistance is needed from the moment an intervention commences, and there is no system in place to ensure this happens, District Inspectors an institutional check are regrettably handicapped by being in the employ of the Ministry of Health which does not permit for true independence, and s16 and s84 reviews have turned out to be paper tigers.

241. A full scale study as was commissioned by the European Union in the Wachenfield paper, in respect to the rights of the mentally ill in Europe is needed to fully understand the inconsistency of rights applied in NZ.

TONY ELLIS
BARRISTER
WELLINGTON
25 May 2007

Appendix A- Legislation and Court Rules

High Court Rules 82-88

82 Incapacitated person and litigation guardian defined

For the purposes of these rules,—

incapacitated person means—

(a) a person who is a minor within the meaning of section 4 of the Age of Majority Act 1970:

(b) a person who is subject to a compulsory treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992:

(c) a person who is subject to an order under section 10(1)(i) or section 31 of the Protection of Personal and Property Rights Act 1988:

(d) a person whose property is managed by a trustee corporation under section 32 or section 33 of the Protection of Personal and Property Rights Act 1988

litigation guardian—

(a) means—

(i) a person who is authorised or who has the power under the Protection of Personal and Property Rights Act 1988 to conduct a proceeding; or

(ii) a person who is appointed under rule 85 to conduct a proceeding; and

(b) has the same meaning as the expression "guardian ad litem".]

83 Representation of incapacitated person by litigation guardian

(1) An incapacitated person must have a litigation guardian as his or her representative in any proceeding.

(2) This rule is subject to rule 84.

84 Incapacitated person who may conduct proceeding in own name

(1) An incapacitated person who is permitted by statute to conduct a proceeding in his or her name may elect to conduct a proceeding in his or her own name or to have a litigation guardian represent him or her.

(2) An incapacitated person who is not permitted by statute to conduct a proceeding in his or her own name, but who wishes to conduct a proceeding in his or her own name, may apply to the Court to conduct the proceeding without a litigation guardian.

(3) On an application under subclause (2), the Court may allow the incapacitated person to conduct the proceeding in his or her own name if it is satisfied that the incapacitated person is capable of making the decisions required, or likely to be required, in that proceeding.

(4) Rules 85 to 94B do not apply to an incapacitated person who elects to conduct a proceeding in his or her own name or is allowed by the Court to conduct a proceeding in his or her own name.

85 Appointment of litigation guardian

(1) This rule applies if no person has been authorised or has the power under the Protection of Personal and Property Rights Act 1988 to conduct the proceeding.

(2) A person may be appointed as a litigation guardian for an incapacitated person if—
(a) the person is able fairly and competently to conduct proceedings on behalf of the incapacitated person; and
(b) the person's interests are not adverse to those of the incapacitated person; and
(c) the person consents to being a litigation guardian.
(3) The Court may, on its own initiative or on an ex parte application made at any time by any person, appoint as a litigation guardian a person who satisfies the conditions in subclause (2).
(4) In deciding whether to appoint a litigation guardian, the Court may have regard to any matters that it considers appropriate, including the views of the incapacitated person.]

86 Notification of appointment
A litigation guardian who is authorised or who has the power under the Protection of Personal and Property Rights Act 1988 to conduct the proceeding must file a copy of the order or other document that empowers the litigation guardian to conduct the proceeding at the same time as the first document relating to the proceeding is filed.

87 Powers of litigation guardian
A litigation guardian may do anything in relation to a proceeding that could be done by the incapacitated person if he or she were not an incapacitated person.]

88 Heading on documents if incapacitated person represented by litigation guardian
The heading of every document filed in a proceeding in which an incapacitated person is represented by a litigation guardian must state the name of the incapacitated person followed by the words “by his/her litigation guardian” and the name of the litigation guardian.]]

Family Court Rules 2002-89

89 Persons who may start, take part in, or defend proceedings only through representatives or managers
(1) In this rule, and rules 91 and 96 to 98, taking part in proceedings includes commencing or defending proceedings.
(2) A person must not take part in proceedings in his or her own name, but must take part in proceedings through a representative if the person is—
(a) a minor; or
(b) mentally disordered within the meaning of section 2(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992; or
(c) a person who a Court, on its own initiative or on an interlocutory application with or without notice for the purpose, orders is a person who needs a representative.

(3) A person must not take part in proceedings in his or her own name, but must take part in proceedings through a manager if—
(a) a manager has been appointed for the person by a property order made under section 31 of the Protection of Personal and Property Rights Act 1988 and—
(i) the order empowers the manager to take part in the proceedings; and
(ii) the proceedings relate to property of the person that is property subject to the property order; or
(b) a trustee corporation is acting as a manager for the person under an application under section 32 or section 33 of the Protection of Personal Property Rights Act 1988 and—
(i) the application empowers the trustee corporation to take part in the proceedings; and
(ii) the proceedings relate to property of the person that is property being managed by the trustee corporation under the application.
(4) Subclause (2) is subject to the following sections and to every other enactment or rule of law that authorises a person referred to in subclause (2) to take part in proceedings without a representative:
(a) section 225 of the Child Support Act 1991:
(b) section 50 of the District Courts Act 1947:
(c) sections 9(4), 10(3), 71, and 72(2) of the Domestic Violence Act 1995:
(d) section 158 of the Family Proceedings Act 1980:
[(e) section 31(2)(e) of the Care of Children Act 2004:]
(f) section 52 of the Property (Relationships) Act 1976.
(5) Nothing in subclause (2) or subclause (3) limits or affects—
(a) any power to appoint a lawyer for a party; or
(b) any requirement that a lawyer be appointed for a party.
Compare: SR 1992/109 r83, r84(1)

Judicature Act 1908-section 100

17 Jurisdiction as to mentally disordered persons, etc.

The Court shall also have within New Zealand all the jurisdiction and control over the persons and estates of [ ] idiots, [mentally disordered persons], and persons of unsound mind, and over the [ ] [managers] of such persons and estates respectively, as the Lord Chancellor of England, or any Judge or Judges of [Her Majesty's] High Court of Justice or of [Her Majesty's] Court of Appeal, so far as the same may be applicable to the circumstances of New Zealand, has or have in England under the Sign-manual of [Her Majesty] or otherwise.

100 Independent medical examination

(1) Where the physical or mental condition of a person who is a party to any civil proceedings is relevant to any matter in question in those proceedings, the High Court may order that that person submit himself to examination at a time and place specified in the order by one or more medical practitioners named in the order.

(2) A person required by an order under subsection (1) of this section to submit to examination may have a medical practitioner chosen by that person attend that person's examination.
(3) The Court may order that the party seeking the order pay to the person to be examined a reasonable sum to meet that person's travelling and other expenses of and incidental to the examination, including the expenses of having a medical practitioner chosen by that person attend that person's examination.
(4) Where an order is made under subsection (1) of this section, the person required by that order to submit to examination shall do all things reasonably requested, and answer all questions reasonably asked of that person, by the medical practitioner for the purposes of the examination.
(5) If a person ordered under subsection (1) of this section to submit to examination fails, without reasonable excuse, to comply with the order, or in any way obstructs the examination, the Court may, on terms, stay the proceedings or strike out the pleading of that person.
(6) This section applies to the Crown and every Department of the public service.
(7) Nothing in this section affects the provisions of the Workers' Compensation Act 1956.]
{ Editorial Note: Workers' Compensation Act 1956 repealed on 1 July 1992 by 1992 No 13, s179(1). }

Appendix B-Tables of European Study

Assessment and Decision Procedures

1.14 Essential expertise for assessing the medical (psychiatric) criteria for involuntary placement

	number	*countries*
trained psychiatrist	7	Aus, Gree, Ire, Neth*, Port, Spa, UK*
any physician	8	Bel, Den, Fin*, Fra*, Ger*, Ita, Lux, Swe

* Finland: preliminary assessment: any physician; hospital assessment: psychiatrist
France: HO-procedure: any physician
Germany: "physician" in some Federal States, "psychiatrist" or "physician experienced in psychiatry" in others
The Netherlands: psychiatrist, any physician only in case of an emergency
United Kingdom: two physicians are required, one must be a psychiatrist

Comment: Seven Member States require that initial psychiatric assessments be made by a psychiatrist. In the remaining eight Members States, however, potentially far-reaching decisions like detaining someone preliminary might be based upon the certificate of physicians not trained in mental health care. However, in all Member States, thorough assessments are performed by psychiatrists as soon as a patient is admitted to a psychiatric facility. This table refers to the initial medical certificate *during the routine procedure*, which may apply for a compulsory admission. Regulations for *emergency procedures* usually differ and might be less strict as to the expertise of initially assessing physicians in most Member States.

1.15 Number of experts involved in the assessment of psychiatric condition

	number	*countries*
one expert	4	Bel, Den, Ger, Neth
two experts	10	Aus, Fra, Gree, Ire, Ital, Lux, Port, Spa, Swe, UK
more than two experts	1	Fin

Comment: Most Member States require the opinion or certificate of more than one expert, which can be seen as a measure of quality assurance.

1.16 Authorities or persons authorised to decide on an involuntary placement

	number	*countries*
medical (psychiatric)	5	Den, Fin, Ire, Lux, Swe
non-medical (judge, prosecutor, mayor)	10	Aus, Bel, Fra, Ger, Gree, Ital, Neth, Port, Spa, UK

Comment: In ten Member States, the decision is made either by a representative of the legal system (judge, prosecutor, mayor), or by other agencies independent from the medical system (e.g. social workers in the UK). In the remaining Member States the decision is left to psychiatrists or other health care professionals.

1.20 Short-term detention (emergency cases)

	max. duration of short-term detention	*decision-making authorities for short-term detention*
Austria	48 hours	psychiatrist
Belgium	10 days	prosecutor
Denmark	Regular procedure applies to emergency cases also	psychiatrist
Finland	Regular procedure applies to emergency cases also	psychiatrist
France	48 hours	mayor (Paris: police)
Germany	24 hours (15 Federal States) 3 days (1 Federal State)	Municipal public affairs office or psychiatrist
Greece	48 hours	prosecutor
Ireland	Regular procedure applies to emergency cases also	psychiatrist
Italy	48 hours	public health department
Luxembourg	24 hours	police or physician or psychiatrist or guardian or social worker
The Netherlands	24 hours	mayor
Portugal	48 hours	psychiatrist
Spain	24 hours	psychiatrist

Sweden	24 hours	psychiatrist
United Kingdom	72 hours	police or physician plus social worker

Comment: Emergency procedures for short-term placement are usually applied at night, at week-ends or whenever immediate action is deemed necessary. Short-term detention is permitted from 24 up to 72 hours (except in Belgium, where it can take 10 days). In some Member States, the decision-making authorities for short-tem placements differ from those deciding upon the regular detention procedures.

Appendix C- Relevant provisions of NZBORA

New Zealand Bill of Rights Act 1990

4 Other enactments not affected
No court shall, in relation to any enactment (whether passed or made before or after the commencement of this Bill of Rights),—
(a) Hold any provision of the enactment to be impliedly repealed or revoked, or to be in any way invalid or ineffective; or
(b) Decline to apply any provision of the enactment—
by reason only that the provision is inconsistent with any provision of this Bill of Rights.

5 Justified limitations
Subject to section 4 of this Bill of Rights, the rights and freedoms contained in this Bill of Rights may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

6 Interpretation consistent with Bill of Rights to be preferred
Wherever an enactment can be given a meaning that is consistent with the rights and freedoms contained in this Bill of Rights, that meaning shall be preferred to any other meaning.

9 Right not to be subjected to torture or cruel treatment
Everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment.

10 Right not to be subjected to medical or scientific experimentation
Every person has the right not to be subjected to medical or scientific experimentation without that person's consent.

22 Liberty of the person
Everyone has the right not to be arbitrarily arrested or detained.

23 Rights of persons arrested or detained
(1) Everyone who is arrested or who is detained under any enactment—
(a) Shall be informed at the time of the arrest or detention of the reason for it; and
(b) Shall have the right to consult and instruct a lawyer without delay and to be informed of that right; and
(c) Shall have the right to have the validity of the arrest or detention determined without delay by way of habeas corpus and to be released if the arrest or detention is not lawful.
(2) Everyone who is arrested for an offence has the right to be charged promptly or to be released.
(3) Everyone who is arrested for an offence and is not released shall be brought as soon as possible before a court or competent tribunal.
(4) Everyone who is—
(a) Arrested; or

(b) Detained under any enactment—
for any offence or suspected offence shall have the right to refrain from making any statement and to be informed of that right.
(5) Everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person.

Appendix D-Relevant Provisions of MHCAT

2A Meaning of "proposed patient"
A person—
(a) Starts being a proposed patient when an application is made under section 8A; and
(b) Stops being a proposed patient when a medical practitioner records a finding—
(i) Under section 10(1)(b)(i), in which case the person does not become a patient; or
(ii) Under section 10(1)(b)(ii), in which case the person becomes a patient.]

4 General rules relating to liability to assessment or treatment
The procedures prescribed by Parts 1 and 2 of this Act shall not be invoked in respect of any person by reason only of—
(a) That person's political, religious, or cultural beliefs; or
(b) That person's sexual preferences; or
(c) That person's criminal or delinquent behaviour; or
(d) Substance abuse; or
[(e) Intellectual disability.]

8 Any person may fill out application form
(1) Anyone who believes that a person may be suffering from a mental disorder may at any time fill out an application form asking the Director of Area Mental Health Services for an assessment of the person.
(2) An application is made under section 8A when the Director of Area Mental Health Services receives a filled out application form that complies with section 8A.
(3) In sections 8A and 8B,—
(a) The person who fills out the application form is called the applicant; and
(b) The person who is the subject of the application is called the person.]

8A Application for assessment
An application is made under this section when the Director of Area Mental Health Services receives a filled out application form that complies with the following:
(a) It is accompanied by a certificate issued under section 8B relating to the person that states a date of examination within the 3 days immediately before the date of the application; and
(b) It states that the applicant is 18 years or over; and
(c) It states that the applicant has personally seen the person within the 3 days immediately before the date of the application; and
(d) It states the relationship or association of the applicant with the person; and

(e) It states the grounds on which the applicant believes the person to be suffering from a mental disorder.]
Status Compendium
8B Medical practitioner's certificate to accompany application for assessment
(1) This section applies when—
(a) A medical practitioner is asked, by an applicant, to issue a certificate to accompany the application form; or
(b) A medical practitioner is the applicant and wishes to issue a certificate to accompany his or her application form.
(2) A medical practitioner to whom subsection (1)(a) applies must not issue a certificate if he or she is related to the applicant or to the person.
(3) A medical practitioner to whom subsection (1)(b) applies must not issue a certificate if he or she is related to the person.
(4) The medical practitioner must—
(a) Examine the person; and
(b) If he or she considers that there are reasonable grounds for believing that the person may be suffering from a mental disorder, issue the certificate.
(5) The certificate must—
(a) State that the medical practitioner has examined the person:
(b) State the date of the examination:
(c) State that the medical practitioner considers that there are reasonable grounds for believing that the person may be suffering from a mental disorder:
(d) Set out full particulars of the reasons for that opinion, explaining in what way the medical practitioner believes that the person's condition may come within the statutory definition of mental disorder:
(e) State that the medical practitioner is not related to the person or to the applicant (except when the medical practitioner is the applicant).]

9 Assessment examination to be arranged and conducted
(1) Where an application is made under [section 8A], the Director of Area Mental Health Services, or a duly authorised officer acting with the authority of that Director, shall make the necessary arrangements for the proposed patient to undergo an assessment examination forthwith.
(2) The arrangements required by subsection (1) of this section shall include the following:
(a) Nominating, in accordance with subsection (3) of this section, the person by whom the assessment examination is to be conducted:
(b) Determining, in consultation with the person by whom the assessment examination is to be conducted, the time and place at which it is to be conducted:
(c) Giving to the proposed patient a written notice—
(i) Requiring the proposed patient to attend at the specified place and time for the purposes of the assessment examination; and
(ii) Explaining the purpose of the assessment examination; and
(iii) Stating the name of the person who is to conduct the assessment examination:
(d) Ensuring that the purpose of the assessment examination and the requirements of the notice given under paragraph (c) of this subsection are explained to the proposed patient in the presence of a member of the

proposed patient's family, or a caregiver in relation to the proposed patient or other person concerned with the welfare of the proposed patient:
(e) Ensuring, where necessary, that appropriate arrangements are made to convey the [proposed] patient at the required time to the place where the assessment examination is to be conducted, and, where it is necessary or desirable that the proposed patient be accompanied on the journey, ensuring that an appropriate person is available to do so.
(3) Every assessment examination shall be conducted by a medical practitioner ([ ] but not being the medical practitioner who [issued] the certificate [under section 8B(4)(b)]), being—
(a) A psychiatrist approved by the Director of Area Mental Health Services for the purposes of the assessment examination or of assessment examinations generally; or
(b) If no such psychiatrist is reasonably available, some other medical practitioner who, in the opinion of the Director of Area Mental Health Services, is suitably qualified to conduct the assessment examination or assessment examinations generally.
[(4) For the purposes of subsection (1), an application under section 8A is deemed to have been made if the Director of Area Mental Health Services or a duly authorised officer receives notice of it from the medical practitioner who issued the certificate relating to the person under section 8B(4)(b). The medical practitioner may give notice by any means, including by telephone. The assessment examination must not take place until the Director of Area Mental Health Services, or a duly authorised officer, or the medical practitioner who is to conduct the examination receives an application relating to the person and complying with section 8A.]

10 Certificate of preliminary assessment
(1) After completing the assessment examination, the medical practitioner shall record his or her findings in a certificate of preliminary assessment, stating—
(a) That he or she has carefully considered the statutory definition of mental disorder and the proposed patient's condition in relation to that definition; and
[(b) That, in his or her opinion,—
(i) The proposed patient is not mentally disordered; or
(ii) There are reasonable grounds for believing that the proposed patient is mentally disordered and that it is desirable that the proposed patient be required to undergo further assessment and treatment.]
(2) The medical practitioner shall send to the Director of Area Mental Health Services—
(a) The certificate of preliminary assessment; and
(b) Full particulars of the reasons for his or her opinion of the proposed patient's condition, and any relevant reports from other health professionals involved in the case; and
(c) A copy of any notice given to the [ ] patient under section 11(1) of this Act; and
(d) The application for assessment made under [section 8A, if it is] in the possession of the medical practitioner.

[(3) If the medical practitioner is of the opinion that the proposed patient is not mentally disordered, that person is free from further assessment and treatment under this Part (without prejudice to the making of a further application under section 8A in respect of the person at some time in the future).]
(4) Where the medical practitioner considers that there are reasonable grounds for believing that the proposed patient is mentally disordered and that it is desirable that the proposed patient be required to undergo further assessment and treatment, the medical practitioner shall—
(a) Give or send a copy of the certificate of preliminary assessment to each of the following:
(i) The patient:
(ii) Any welfare guardian of the patient:
(iii) The applicant for assessment:
(iv) The patient's principal caregiver:
(v) The medical practitioner who usually attends the patient; and
(b) Give or send, to each of the persons specified in paragraph (a) of this subsection, a statement of the legal consequences of the finding set out in the certificate of preliminary assessment, and of the recipient's right to apply to the Court for a review of the patient's condition; and
(c) Otherwise deal with the case in accordance with section 11 of this Act.

16 Review of patient's condition by Judge
[(1) When an application is made to the Court under section 11(7) or section 12(7) or section 12(12) for a review of the patient's condition,—
(a) Subsection (1B) applies if the application is the only application that has been made for a review of the patient's condition during the first and second periods:
(b) Subsection (1C) applies if the application is the second or subsequent application that has been made for a review of the patient's condition during the first and second periods.
(1A) When an application is made under section 29(4) for a review of the patient's condition, subsection (1B) applies.
(1B) When this subsection applies,—
(a) The Court must grant the application; and
(b) A Judge must examine the patient as soon as practicable; and
(c) Subsections (2) to (7) apply.
(1C) When this subsection applies, a Judge must decide whether or not to grant the application. In making this decision, the Judge must have regard to any evidence before the Judge that indicates that the patient's condition has not changed since the last review.]
(2) The examination shall be conducted—
(a) At the patient's place of residence, the hospital, or the other place where the patient is undergoing assessment and treatment; or
(b) Where that is not practicable, at the nearest practicable place.
[(3) The Judge must do the following things before and during the examination, as appropriate and practicable:
(a) Identify himself or herself to the patient; and
(b) Explain to the patient the purpose of the visit; and

(c) Discuss with the patient the patient's situation, the proposed course of assessment and treatment, and the patient's views on these matters.]
(4) As well as examining the patient, the Judge shall consult with the responsible clinician, and with at least 1 other health professional involved in the case, and may consult with such other persons as the Judge thinks fit, concerning the patient's condition.
(5) If the Judge is satisfied that the patient is fit to be released from compulsory status, the Judge shall order that the patient be released from that status forthwith.
(6) Every review under this section of a patient's condition shall, wherever practicable, having regard to the time in which that review is required to be conducted, and to the availability of Judges and other personnel and resources, be conducted by a Family Court Judge.
(7) Where it is not practicable for a review under this section of a patient's condition to be conducted by a Family Court Judge, that review may be conducted by any District Court Judge.

63A Rights of proposed patients

In sections 64(1), 64(2)(a), 65 to 72, and 75, patient includes a proposed patient.]

70 Right to legal advice

Every patient is entitled to request a lawyer to advise the patient on his or her status and rights as a patient, or any other matters on which persons customarily seek legal advice, and, if the lawyer agrees to act for the patient, he or she shall be permitted access to the patient upon request.

84 Judicial inquiry

(1) A Judge of the High Court may whenever the Judge thinks fit, whether of the Judge's own motion or on the application of any person, make an order directing a district inspector or any one or more persons whom the Judge may select in that behalf to visit and examine any person who the Judge has reason to believe is being detained in a hospital as a patient and to inquire into and report on such matters relating to that person as the Judge thinks fit.
(2) A Judge of the High Court may whenever the Judge thinks fit, whether of the Judge's own motion or on the application of any person, and whether any order under subsection (1) of this section has been made or not, make an order directing the responsible clinician to bring any person who is being detained as a patient in the hospital before the Judge in open Court or in Chambers, for examination at a time to be specified in the order.
(3) If, on the examination of the person so ordered to be brought before the Judge, and on the evidence of any medical or other witnesses, the Judge is satisfied—
(a) That the person is detained illegally in the hospital as a patient; or
(b) That the person is fit to be discharged from the hospital,—

the Judge shall, unless the person is a special patient or is legally detained for some other cause, order that the person be discharged from the hospital forthwith.
[(4) If the person has been found to be unfit to stand trial and is detained as a special patient under section 24 of the Criminal Procedure (Mentally

Impaired Persons) Act 2003, and it appears to the satisfaction of the Judge that the person is capable of being tried or committed for trial on the charge or indictment against him or her, the Judge has (without prejudice to subsection (5)) the same powers as the Attorney-General has under section 31 of that Act to direct that the person be brought before a court under that section.
(5) If the person has been found unfit to stand trial and is detained as a special patient by virtue of section 24 of the Criminal Procedure (Mentally Impaired Persons) Act 2003, the Judge may, if in the circumstances of the case the Judge considers it proper to do so and if the interests of justice so permit (whether or not the person is capable of being tried or committed for trial), direct that the charge or indictment be dismissed.]
(6) On giving any direction under subsection (5) of this section, the Judge may order that the person be released from compulsory status; but if it appears to the Judge that the person is not fit to be released from that status, the Judge shall order that the person be further detained in a hospital under this Act, and the last-mentioned order shall have effect as an inpatient order made under Part 2 of this Act.
(7) For the purposes of any examination under this section, the Judge shall have power—
(a) To summon any medical or other witnesses to testify on oath in respect of any matter involved in the examination, and to produce any relevant documents; and
(b) To call for any report on the person's condition by the Review Tribunal.
(8) The Judge may in any case, if the Judge thinks fit, report his or her opinion to the Minister, with such comments and recommendations as the Judge thinks fit.
(9) Nothing in this section shall prevent the exercise of any other remedy or proceeding available by or on behalf of any person who is or is alleged to be unlawfully detained, confined, or imprisoned.