

Mental Health Legislation in New Zealand

A Balancing Act?

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INTRODUCTION

Three principles form the basis on which every doctor-patient relationship should ideally be built- beneficence, non-maleficence, autonomy.¹ In New Zealand, the third guiding principle, autonomy, is fraught with tension when considered alongside the legislation laid out in the Mental Health (Compulsory Assessment and Treatment) Act 1992 ("the Act").² There are a raft of reasons which can explain why the Act should be used to enforce treatment upon a patient.³ These include a patient's lack of competency to make decisions, the potential for societal harm, the maintenance of patients' rights,² and the recent changes to the Privacy Act 1993,⁴ which is used in conjunction with the Act. However, there are several flaws with these arguments and, therefore, reasons against using the Act to impose treatment. These include some ambiguity regarding the definitions provided in section 2 of the Act,⁵ the lack of the maintenance of the fundamental right to refuse medical treatment,² the potential for patients to experience harm as result of enforced treatment,⁶ and lastly, systemic issues regarding compliance to the Act.⁷ When these reasons, both for and against the use of the Act, are juxtaposed, it becomes clear that the Act should be imposed, but only when very specific criteria are met.

REASONS FOR THE USE OF THE ACT

The first is simply that a patient may not be mentally competent, in terms of their mental health, to make a decision for themselves. Section 2 of the Act² defines the condition a patient would need to be in before they can be forced to undergo treatment in a fairly wide manner; the extent of which includes some patients who have not been clinically diagnosed as suffering from a mental illness.⁵ For example, some patients with a severe personality disorder (which is not clinically defined as a mental illness) may qualify for compulsory treatment under the Act.^{5,8}

This definition is discussed in the judge's ruling in *Waitemata Health v Attorney-General*⁹ which concluded that it was a patient's presenting symptoms or their behaviour; and not necessarily a clinical diagnosis which would indicate whether that particular patient required treatment under the Act. However, because the focus of the case was not on this specific matter, the decision in *Waitemata Health* is not binding for future decisions and this description remains contentious.⁵ The statute states the reasons

why the patients who fit the above definition, are required to undergo compulsory treatment – posing danger to themselves or others or having a diminished capacity to care for themselves,² therefore clearly demonstrating one of the prime benefits of using the Act.

The second indicator that the Act should be used to provide compulsory care closely relates to the first. It is that there is a social good in ensuring these patients are required to undergo treatment and therefore limiting this particular patient's ability to harm others.² The factors that are considered when looking at the potential for societal harm are wide-ranging and include the potential severity and frequency of future harm inflicted.⁵ For example, in the case *Re IC*,¹⁰ treatment was enforced under the Act despite the fact the patient had not threatened physical violence. In this case, the victim was stalked by the patient which caused the victim great anxiety and psychological trauma (although no physical trauma). The Southern Review Tribunal found "there is clear and unequivocal evidence to show that [the] behaviour poses and continues to pose a serious danger to the psychological health of the victim and her family".¹⁰

Thirdly, many patient rights are maintained through the use of the Act. This provides patients with good legislative security when decisions are made about their health, therefore supporting the use of the Act.² A right to information, respect for cultural identity, the right to treatment, the right to be informed about treatment, and the right to advice (medical and legal) are included. In addition, patients maintain the right to make a complaint should one of the above rights be jeopardised.² In stark contrast to the usual adversarial procedure followed in the New Zealand legal system, the complaints process is fairly inquisitorial in nature, with all stakeholders' views being considered.¹¹ Furthermore, the Health and Disability Commissioner Act 1994 specifies all patients, inclusive of those treated under the Act, have the right to complain upon breach of any one, or more, of the ten fundamental patient rights.¹²

Although New Zealand does not have one single constitutional document,^{11,13} the New Zealand Bill of Rights Act 1990 ("NZBORA") provides for a number of rights,¹⁴ which are mostly upheld for patients undergoing treatment under the Act. The rights outlined in NZBORA should be considered in conjunction with the Code of Health and Disability Consumers' Rights¹⁵ and the Act, as well as helping to reaffirm those rights set out in the International Covenant on Civil and Political Rights ("ICCPR").¹⁶ One of the key principles stated in the NZBORA, which must be considered in relation to the Act, is that those involved with treating a patient under the Act must do so with compassion and respect for the intrinsic dignity of that person.^{5,14} The maintenance of these rights and the provision for numerous methods of appeal help to ensure that patients' best interests remain at the heart of all decisions made using the Act.

However, the relationship between NZBORA and the Act is certainly a contentious one.¹⁷ Section 11 of NZBORA provides that all persons have the right to refuse to undergo medical treatment.¹⁴ However, the Mental Health (Compulsory Assessment and Treatment) Act 1992 includes a

provision which can override section 11 of NZBORA. Those patients who may cause harm (to themselves or others) may be forced to undergo medical treatment. These statutes collectively state that a person's rights and mana must be upheld throughout this process.^{2,14} Despite the conflict between these different pieces of legislation, the general protection of rights that is provided for patients treated under the Act, delivers another definitive reason for careful, calculated use of the Act, given the appropriate circumstances.

Lastly, in the past, health professionals, coroners, and eventually the Law Commission,¹⁸ have struggled with the fact that even though patients may be in grave danger of injuring themselves or others, the threat of harm was not defined as "imminent", meaning breaching confidentiality would be unlawful.¹⁹ This has meant health professionals were not able to speak to family members, potentially against the patient's will, without the threat being defined as both "serious" and "imminent". For example, on March 18, 2008, Mrs. S committed suicide whilst being treated under the Act. Her husband of 28 years had not been told that she was at risk of suicide.¹⁹

Following this, and as a result of increased pressure, the Government made changes to the Privacy Act 1993, using the Privacy Amendment Act 2013, to provide health practitioners with a more clearly defined outline of when it is appropriate to breach patient confidentiality when treating a patient under the Act.²⁰ These changes mean the Privacy Act 1993 now states that the threat of harm must only meet the requirement of being "serious".²⁰ These changes resulted in the Privacy Act 1993 being further aligned with article 17 of the ICCPR.²¹ Although not yet fully proven, it is hoped that these changes will help to improve the utilisation of the Act,¹⁸ in conjunction with the Privacy Act 1993, and provide for better outcomes for patients and their families.

REASONS AGAINST THE USE OF THE ACT

Firstly, although section 2 of the Act does define the characteristics of a patient who will be required to undergo treatment under the Act, a number of sources acknowledge problems around the specificities of this definition, especially the definition's interpretation in case law.^{5,8,9,22} Despite the Court of Appeal's attempts at clarification of this definition in *Waitemata Health v Attorney General*, the Ministry of Health acknowledges there is remaining vagueness⁵ regarding the definition of the characteristics of a patient which would justify treatment under the Act.

To some extent, the definition seems open-ended, as it is the actions and state of the patient that are assessed, rather than specific clinical diagnoses.⁵ In addition, treatment may even be carried out on a person who is currently considered well but fits other criteria, such as repeated episodes of illness.^{5,23} Recently, this occurred in B 12/14822 where an adult female patient (the applicant), the mother of the patient (who was her legal guardian), the patient's father, and two doctors, had differing opinions in regards to the best possible treatment. Although the patient had recently been maintaining a reasonable level of self-care, previous evidence was indicative of a high chance of relapse, and thus the applicant was not released from compulsory treatment under the Act.²² The ambiguity of this definition provides little support or certainty for patients, their families, or health professionals involved in the care of patients, and thus must be considered a concern in regard to the use of the Act.

Secondly, all patients have a fundamental right to consent to, or refuse, medical treatment.¹⁴ However, there is an inherent conflict, in that the Act can enforce medical treatment on patients who have declined treatment.² Further evidence of the right to refuse medical treatment is seen through New Zealand's adoption and ratification of the ICCPR, especially in Articles 7 and 10.²¹ Moreover, New Zealand's signature to the post-World War II Universal Declaration of Human Rights and International Covenant on Economic, Social and Cultural Rights gave further effect to this right.^{24,25} Although many rights of patients are maintained, this is one salient right which is not upheld when patients are treated under the Act. Obviously, the aim of the Act is to ensure that those who are likely to harm themselves or others are protected, and this is seen to be best done by enforcing medical treatment upon these select patients.²

However, there are examples of less-than-perfect decisions being made, which may have some negative repercussions on those patients treated.^{26,27} For example, Gibbs, Dawson, and Mullen state that Community Treatment Orders (an order for compulsory treatment in the community rather than in an inpatient facility) may result in patients, who do have the mental capacity to agree or disagree to treatment, still being forced to undergo treatment.²⁸ It is clear that the impact, both in the short and longer term, of compulsory treatment needs to be further taken into account when considering whether compulsory treatment under the Act is necessarily the best decision.²⁶

Thirdly, enforced treatment under the Act may cause some patients harm, most likely psychological harm, rather than the intended good outcomes. One Latin maxim that forms a guiding principle for doctors to practice by is *primum non nocere*, or "above all, do no harm".²⁹ In addition, the Hippocratic Oath states that a health professional must work to best treat, but not over treat, a patient.³⁰ Therefore, health professionals are faced with a degree of conflict when considering treating a patient against the patient's will, especially as it may be difficult to foresee the potential future effects on that particular patient's health and well-being.

A publication released by the Mental Health Foundation of New Zealand outlined a range of situations in which some patients, who were under compulsory treatment orders, were negatively affected as a result of their treatment.³¹ For example, one patient stated that they believed they had been "discriminated against because of being held under a compulsory treatment order"¹⁶ which would, if proven, constitute a breach of the Human Rights Act 1993³² and section 26 of the ICCPR.²¹ In an example from 2008, Mr. P committed suicide whilst being treated under the Act. The Coroner stated the side effects of the medication provided were not explained thoroughly to Mr. P's family.¹⁹ Therefore, it is vital that health professionals consider the wider repercussions as a result of prescribing compulsory treatment under the Act.

Lastly, for the Act to work effectively and efficiently, there must be complete compliance with its provisions, and this has not always been the case. A number of articles in the media have raised concerns regarding health professionals' and District Health Boards' (DHBs) acquiescence to the Act.^{7,33,34} In some situations this has led to patients being denied rights that are strictly maintained in the Act.^{33,35} For example, Mr. B died after systemic administrative failures within a North Island DHB led to him being consulted and assessed by a second year trainee student, rather than a consultant psychiatrist,⁷ a clear breach of section 7A of the Act.² This poor compliance with the Act is yet another reason which highlights there are valid concerns regarding both the Act in itself, and implementation of the Act.

CONCLUSION

In summary, although there are some issues that arise from the Act and corresponding case law, it is clear these are overridden by the underlying purpose of the Act. Without this Act in place, it is likely that many patients would suffer unnecessarily at their own hands and that family members, friends, and colleagues of patients would be affected negatively. In addition, although there are allowances for some subjectivity, the Act provides fairly strict guiding criteria to allow consultant psychiatrists to make informed, reasonable, and objective decisions. With further consideration of the flaws raised above, it may be possible for judges and Parliamentarians to make decisions in the courts, or minor changes to Statute, which would provide an improved legislative structure for all stakeholders involved in the implementation of this Act.

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