REVIEWS OF THE
MENTAL HEALTH ACT 1969

discussion papers

Mental Health Act Review Working Party
Department of Health
Wellington

December 1984
PREFACE

It is with great pleasure that I invite your comments on the attached copy of 'A Review of the Mental Health Act 1969: Discussion Papers'. I regard this review as one of the more important legislative initiatives developed by my department in recent years, and I am aware that it has already aroused a considerable degree of interest.

Because legislation of this kind expresses basic values and assumptions of the society we live in, I welcome the fact that groups outside my department are being given the opportunity to participate in the legislative process. Many organisations and individuals have already responded to the department's initial proposals. The attached papers are more comprehensive in scope and incorporate considerable detail. It should, however, be emphasised that the purpose of circulating these papers is to receive informed comment, and that the proposals as outlined do not in any way represent a draft bill. It may well be necessary and appropriate for my department to revise their proposals in the light of comments received, and the consequent further development of its own thinking.

With any new legislative proposal the first questions that must be asked are: what is the legislation intended to do? will it be an improvement on the existing situation? and will it be able to do what it sets out to do? I hope that you will examine the proposals with these questions in mind, and that you will be conscious of what I believe is our paramount goal: that of providing the best possible service, with due recognition of the rights to which we are all ordinarily entitled. The ultimate test of a good health service is that it should be one which we would all willingly utilise as consumers, should the need arise. The establishment of legislation consonant with the prevailing values of society is one important component of such a service for the mentally ill.

These papers will generate discussion and a degree of controversy. If their only achievement is that of general education and 'consciousness-raising' that alone will have been worthwhile. I am convinced however they will also be an essential step in obtaining consensus on what our society believes to be good and effective mental health legislation.

Michael Bassett
Minister of Health
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The process of reviewing mental health legislation is an exciting one, touching as it does on fundamental human values and diverse matters of social philosophy. But it is also in one particular regard a daunting task, knowing that whatever the outcome it will not please everybody!

Recipients of the latest working papers will have had previous opportunities to identify and comment on the relevant issues, and many will recognise their own views in the new documents. The papers are presented in the main as a series of proposals, preceded by a summary of the present situation and the reasoning behind any changes proposed. As such, they form the consensus view of those who have constituted the Working Party, taking into account the submissions received and recognising sometimes the need for compromise. The Working Party has attempted to address not only the practical realities which confront the clinician faced with a psychiatrically ill person, but has also considered the wider ethical issues. It is hoped that those who respond will similarly attempt to view each issue as having more than one perspective.

The proposals are not at all the last word, and any further submissions, supplemented where appropriate by personal discussion, will receive every consideration. The proposals should certainly not be seen at this stage as representing an official departmental intention. The papers are viewed by the working group as their own 'provocations' in the sense that we hope they will sharpen the focus of debate and assist in the formulation of the final proposals which will be presented to the Minister in the latter part of 1985.

We have greatly valued your comments to date, and await your further responses.

Basil James
Director of Mental Health
Mental health legislation directly affects the lives of thousands of people in New Zealand and is a significant measure of the values and attitudes of our community. The present review was therefore initiated in order to examine the Mental Health Act 1969 in relation to social, medical and philosophical developments that have occurred in recent years. It is helpful to see this review in the context of changes in mental health legislation in this country and in other countries.

Mental Health Act 1969

The 1969 Mental Health Act was passed 58 years after the Mental Defectives Act (1911). In the intervening years many changes had occurred, both in methods of treatment, and in the public's perception of mental illness. Although many legislative amendments were made to the 1911 Act, by the 1960s consolidation and reform of existing provisions was well due.

The 1969 Act, substantially revised existing legislation. New definitions were introduced, such as 'mentally disordered persons' while the term 'inmate' was replaced by 'patient'. Formalities surrounding the admission of informal patients to hospitals were relaxed to make these procedures closer to those in general hospitals and new provisions were introduced for regular reviews of the case of each committed patient. In line with moves towards an integrated health service, the Act empowered the Minister of Health to transfer existing hospitals to local hospital boards. The 1969 Act made possible, therefore, the present situation whereby the majority of patients in psychiatric hospitals are informal; and all hospitals but one are administered by hospital boards.

Mental Health Legislation Overseas

Legislation in other countries has also been extensively revised in the light of changes in psychiatric practice and an increased emphasis on the need to safeguard civil rights. States in Australia, Canada and the United States have recently revised their legislation, and in the United Kingdom a new Mental Health Act was passed in 1983.

Certain themes, which are reflected in recent legislative changes, run through modern psychiatry internationally. It is generally accepted that:
- psychiatric patients should be treated as much like other patients as possible, and wherever appropriate, mental health services should be integrated with general medical services.

- treatment should always be provided in the 'least restrictive' environment; in other words treatment in the community is considered preferable to hospital admissions, and treatment on a voluntary basis is favoured over compulsory admissions.

- patients' rights should be protected, efforts should be made to ensure that patients are aware of their entitlements, and review and appeal procedures should be established. The importance of independent patient representatives is also generally recognised.

- multidisciplinary participation in decisions regarding the care and treatment of patients is most important.

Review of the Mental Health Act 1969

With the above considerations in mind, a decision was made to review the Mental Health Act 1969. A Working Party was established within the Department of Health in 1982 for this purpose. The department's first proposals were circulated in a Position Paper in February 1983 (Appendix 1). These proposals created considerable interest, and the Working Party was very pleased to receive comments from over ninety organisations and individuals (a list is attached in Appendix 2). Thereafter the comments made an important contribution to the Working Party's deliberations. In addition to examining these comments, the Working Party has considered the present Act section by section, reviewing concepts in other legislation, and further considering the practical implementation of its original proposals. The Working Party has prepared a number of papers, which form the basis of this document, representing its current thinking on the major aspects of mental health legislation relevant to the New Zealand situation.

Relationship of Legislation and Other Aspects of Mental Health Services

Many of the proposals and background issues are closely inter-related, and also have implications for other legislation. One salient factor is the relationship of mental health legislation to mental health services. The Mental Health Act 1969 does not provide for the establishment of services, as this is covered by the Hospitals and Area Health Boards. The relationship between legislation, services and standards of care will be established principally by the following:

- the Mental Health Bill will include a list of objectives
an explanatory handbook to the Act will be produced in order to explain in clear language the provisions of the Act and to indicate how it should be implemented. The Bill will include a clause providing for an Advisory Committee to be set up with the responsibility of establishing Guidelines for Standards of Care.

A general assumption in the Working Party's approach is that effective and relevant legislation should be flexible and capable of application in a variety of administrative structures. The legislative framework proposed is, therefore, broad, and many details of medical and administrative procedures will be set out in 'Standards of Care' rather than being laid down by statute. Such standards will be subject to regular revision.

In addition to our legislative proposals, therefore, information has been included in these papers which will not find statutory expression. This information is included so that the wider context within which the Act will be implemented and the reasoning of the Working Party, will be apparent. It is anticipated that much of this information will be used in the preparation of the Guidelines for Standards of Care. Each paper, therefore, contains a body of discussion, and a summary of proposals for the new Bill.

Preparation of the Mental Health Bill

It should be made clear that these legislative proposals are not final, and that resource implications must be further considered. The comments of all recipients of these discussion papers will be welcome. Responses are required by no later than 1 March, 1985. You are invited to send them to:

The Secretary
Mental Health Act Review Working Party
Department of Health
Box 5013
WELLINGTON

It is further intended to hold a number of discussions in 1985 on some of the most significant issues with representatives of a number of organisations. The drafting of the new Bill will then begin and it is expected that the Bill will be included in the Parliamentary legislative programme for 1986.
PAPER TWO

OBJECTIVES

It is proposed that the new Bill should contain a set of objectives which should reflect intentions of the Bill and guide those responsible for its implementation.

Mental health legislation in New Zealand does not provide for the establishment and inspection of services and facilities - as does, for example, the Hospitals Act - and the objectives listed below are not therefore identical with service goals.

Clearly, however, both legislation and services should be compatible and mutually reinforcing. It is intended that the guidelines to the Act and Standards of Care will specify in more detail how services and legislation should be implemented so as to meet the objectives, which will be as follows:

'The objectives of this Act are, consistently with the principle of facilitating the provision of the highest possible standards of mental health services in New Zealand,-

(a) to enable mental health services to be as available, accessible and comprehensive as possible;

(b) to enable the highest possible standards of mental health services to be established and monitored;

(c) to ensure that mental health services are, where appropriate, integrated with other health services;

(d) to enable patients to receive the best possible care and treatment;

(e) to ensure that individual rights and freedoms are respected in the provision of services, and to ensure that treatment and care involves the least necessary disruption of, an restrictions to, the person's ordinary life;

(f) to ensure that both the providers of mental health services, and the community, accept their responsibilities in maintaining a high level of service;

(g) to ensure that mental health services are oriented as far as possible to the community, recognising that the nature of New Zealand society is heterogenous and multicultural;

(h) to ensure that mental health services are delivered by a range of health professionals in a range of health settings.'
PAPER 3

COMPULSORY ADMISSIONS : CRITERIA AND PROCEDURES

SECTION ONE : BACKGROUND

1. Introduction

An important concept of any mental health legislation relates to provisions for the compulsory admission to hospital and treatment of people with psychiatric illnesses. The new Mental Health Bill will be no exception, although it will also incorporate a wide range of concepts and proposals unrelated to this area.

The question has been raised whether this should be the only matter dealt with by the new Bill. It has also been suggested that, if there is only one key issue to be considered, then this could be appropriately addressed in a general piece of legislation, in conjunction with the compulsory admission, care and treatment provisions as they pertain throughout the health services. The need for separate mental health legislation would thus be negated.

This approach was rejected by the department for a number of reasons. Firstly, compulsory admission has by far the largest application in the mental health area, even though it is not unique to it. Compulsory admission in the psychiatric area affects a large group of people, and has particular implications and ramifications.

It was further considered that to incorporate legislation for compulsory admission in other statutes would be impractical for those people with the responsibility of implementing it.

2. Present Situation

There are two main procedures in present legislation whereby a person may be compulsorily admitted to a psychiatric hospital. Section 19, provides for a person to be admitted on application, with 2 medical certificates, for up to 21 days. This person must be alleged to be mentally disordered and is considered to need the care and treatment of a hospital in his/her or the public's interest. There is also a provision whereby a person may be admitted with only one medical certificate for a maximum of 72 hours. If it is considered that a person should stay in hospital beyond the 21 day period, a district court judge must sign a reception order. The second main provision for compulsory admission is Section 21, pursuant to which a person can be admitted directly to hospital upon a reception order made by a Judge.
'Mentally disordered' is defined in the 1969 Act as 'suffering from a psychiatric or other disorder, whether continuous or episodic, that substantially impairs mental health, so that the person belongs to one or more of the following classes, namely:

(a) mentally ill - that is, requiring care and treatment for a mental illness;

(b) mentally infirm - that is, requiring care and treatment by reason of mental infirmity arising from age or deterioration of an injury to the brain;

(c) mentally subnormal - that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of mind.'

SECTION TWO : ISSUES DISCUSSED

1. General Proposals

The Working Party considers that there should be a number of different stages in the process of compulsory admission and detention, and believes that for each there should be different criteria and time periods, and specification of personnel involved. This process will provide for a flexible approach in meeting the needs of people with psychiatric illness, in ensuring that there is a thorough screening process, and that people are treated in the setting which is the 'least restrictive alternative'. At the same time no unnecessary impediments should be placed in the way of obtaining effective help for people who need it quickly. The Working Party also believes that further options than presently exist should be available when considering the question of compulsory treatment, and has therefore proposed the concept of compulsory treatment in the community. The compulsory stages envisaged are: a compulsory assessment interview, a 3 day order, a 21 day order, an in-patient order, and a compulsory treatment order.

The Working Party does not propose, as has been suggested by some of the organisations who have provided comments, to incorporate a definition of the term 'mental illness' in the Bill. It is considered that an attempt at a definition of this kind would be neither successful nor particularly helpful, as it would be either under or over inclusive. It is therefore considered that it is more important to concentrate on specifying more clearly those grounds whereby a person may be compulsorily admitted and/or treated.
2. **Criteria for Compulsory Admission/Treatment: Mental Disorder**

One of the criteria for compulsory admission/treatment will continue to be that the person is, or may be, mentally disordered. The Working Party spent a considerable amount of time debating whether the term 'mental disorder' should be replaced by the narrower concept of mental illness. However, on balance, it decided to retain the term 'mental disorder' because the term 'mental illness' would exclude persons suffering from intellectual handicap, or mental impairment resulting from old age.

The Working Party supports and encourages the trend against compulsory admission of such people, but believes that the legislative power for compulsory admission should remain, for that very small number of cases for whom it is necessary; that is, where the mental impairment results in fulfilling the second criterion for compulsory admission as outlined below.

The new Bill will differ from the present Act in making it clear that 'mental disorder' in itself, will be insufficient to enable a person to be compulsorily admitted or treated. A person must also fulfil one of the other criteria as follows.

3. **Criteria for Compulsory Admission/Treatment: Additional criteria.**

In addition to being, or appearing to be, mentally disordered, the person must also be in a state whereby:

Either: the health or safety of self or others is endangered

Or: the person is gravely disabled so as not to be capable of ensuring his or her reasonable physical or social survival.

The grounds for committal therefore, in the new Mental Health Bill will be stricter and clearer than those in the present Act in that two criteria must be satisfied before a person can be compulsorily admitted/treated.

**SECTION THREE: STAGES IN COMPULSORY ADMISSION AND TREATMENT**

1. **Compulsory Assessment Interview**

It is proposed that the initial stage in considering the possibility of compulsorily admitting or treating any person will be to ensure that he undergoes a compulsory assessment interview. A request for a person to be compulsorily assessed may be made by any person of 18
years or over. The request, or application, must state the reasons for seeking the assessment, and the nature of the applicant's relationship to the prospective subject of the compulsory interview. The request must be accompanied by one medical certificate, where possible to be provided by the person's general practitioner.

Criteria for seeking compulsory assessment interview: the medical practitioner will state that

(1) the person appears to be mentally disordered

and

(2) (a) it is considered that the health or safety of others is in danger, or

(b) the person is considered to be gravely disabled so as not to be capable of ensuring his or her physical or social welfare.

There will also be a place on the form which the medical practitioner fills out, to indicate if other health professionals have been involved in the decision to seek an interview.

The compulsory assessment interview would be conducted by a specialist, or a medical practitioner to whom the Medical Superintendent has delegated his powers. The matter is discussed more fully in Paper 10 on Health Professionals. The compulsory assessment could be conducted at any place considered appropriate by the assessing doctor, and by other health professionals to whom the person was referred. This is likely to be a hospital or unit, community house, mental health centre, or outpatient clinic; but there would be nothing to prevent it being the person's own home.

(a) Powers of the Police

The legislation would make it clear that the police would have authority to transport a person to hospital for the purpose of the assessment interview. This would be a last resort provision where the person was completely unwilling to participate in a compulsory assessment interview. Preferably a medical certificate would be obtained, before police involvement is initiated, but where the person is not willing to be interviewed by his general practitioner, the police must be empowered to take the person directly to hospital where 2 certificates would be completed. These certificates could be completed by the person's
general practitioner, if he/she accompanied the
patient to hospital, and/or by hospital doctors.
The purpose of this provision is to assist the
Police in the clarification of their powers, and to
avoid the necessity for a mentally ill person to be
held in a police cell, as now sometimes occurs,
pending examination by medical practitioners and
the district court judge.

(b) Attempted Suicides

The Working Party proposes the repeal of section 126A of the Health Act which provides a general
power to a district court judge to commit any
person who 'has attempted to commit suicide' to
'any hospital, any hospital board institution, any
appropriate place'; or under the supervision of a
relative, a MOH, or probation officer'. Such
persons need not be mentally disordered. Orders
under this section are very rare. The department
believes that this provision could be
satisfactorily integrated with other forms of
compulsory admission procedures in the Mental
Health Bill. The Working Party considers that
where any person attempts suicide, the assumption
may be made that the person 'appears to be mentally
disordered', for the purpose of ensuring that the
person undergoes a compulsory assessment
interview. The Working Party recognises that
whilst suicidal people are not necessarily mentally
ill, examination of mental status is considered
appropriate. The Report of the Legal Information
Service/Mental Health Foundation Task Force on
Revisin of Mental Health Legislation, 'Towards
Mental Health Law Reform',* proposes a short term
tower of detention for attempted suicides. The
Working Party considers that rather than have
specific and separate provisions for attempted
suicides, people in this category will be
satisfactorily assisted by the general graduated
system of compulsory assessment, admission and
treatment procedures proposed.

(c) Completion of assessment interview

The purpose of the assessment interview is to
obtain a second more specialised opinion on the
person's mental state and its consequences; and on

*This report, which was released in December 1983, has been of
particular importance to the Working Party in its
consideration of aspects of mental health legislation. It
will henceforth be referred to in these discussion papers as
'The legal information Service/Mental Health Foundation
Report'.

the most appropriate services and facilities to meet the person's needs. After the assessment interview is completed, the medical practitioner will fill out a second medical certificate (the first being that provided by the person's general practitioner) which will involve a number of options:

1. He/she does not consider that the person has a significant degree of mental illness/disorder.

2. Although the person has a significant degree of mental illness/disorder, this is not considered to be of an extent which endangers the health or safety of self or others or renders him/her incapable of ensuring reasonable physical or social survival.

   Decision: Treatment on a voluntary basis, would be recommended.

3. That the person's physical or social/welfare, or the health or safety of another person, is endangered because of mental illness/disorder.

   Decision: Either compulsory treatment care in the community; or, where there is no reasonable alternative available or accepted, compulsory in-patient detention for care and treatment for a maximum period of 72 hours.

This second medical certificate will also incorporate a space for the comments of other health professionals to be recorded, although, again, it will not be obligatory that there be such input.

Time limit  It will be possible to implement the decision for in-patient care, only if the second medical certificate is filled in not more than 7 days after the first medical certificate.

Discharge from the compulsory assessment interview

The obligation for the person to be present for this assessment interview will lapse when the interview is finished and when arrangements have been made for any necessary further care, on the basis of options outlined.

Involvement of hospital doctors in compulsory admission procedures:

The Working Party believes that the above procedures offer the following advantages:
- the fact that an informed opinion will have been involved in the decision to compulsorily admit.

- the fact that the hospital will be involved in the decision regarding which facility the person should be admitted to (psychiatric unit, psychiatric hospital, other facility).

2. Seventy-Two Hour/Three Day Order

A person will be eligible to be placed under this order only if he/she has already had a compulsory assessment interview, except where the person has till then been an informal patient. This order would be for a maximum period of 72 hours. (further discussed in the section on informal patients) This period would begin from the time that the person enters the hospital, following completion of the certificate outlined as above.

The purpose of the order would be to enable assessment over a longer period than would have been possible in the initial interview, to obtain reports from other health professionals as appropriate, and to administer any short term treatment.

At the expiry of the 72 hour period, options are possible (as at the initial assessment). These options are:

1. The person is not found to have a mental disorder for which treatment is desirable, and no further action is taken; the 72 hour order automatically lapses and the person is therefore discharged.

2. The person is found to have a mental disorder for which treatment would be desirable, but not essential, in the sense that the person's health/safety, or that of others is endangered; the 72 hour order automatically lapses but informal treatment, whether as an inpatient or outpatient, is recommended.

3. Where the person has a significant mental disorder, and is either a danger to self/others or gravely disabled, and where there is no reasonable alternative available, or accepted, a further certificate should be provided by a medical practitioner. This medical practitioner may or may not be the same doctor as the one responsible for signing the second medical certificate. This would authorise either that the person be made the subject of a community treatment order or that he or she be held in hospital for a maximum period of another 21 days.
Discharge from 72 hour order

A person will be discharged according to one of the following options:

- automatic lapse of order at expiry of 72 hours, if no other relevant order is made.
- discharge from hospital at an earlier time if found to be by the medical superintendent 'fit to be discharged'.

3. Twenty-One Day Order

The purpose of this order - broadly equivalent to the present section 19 - would be to provide a period of treatment sufficient to stabilise the conditions of most people.

Discharge from 21 day order:

- automatic lapse if no other relevant order.
- discharge from hospital at an earlier time if found by the medical superintendent to be 'fit to be discharged'.
- transfer to 'informal' status should this be appropriate.

Transfer from 21 day order to other order:

- to Community Treatment Order.
- to In-patient Order.

For both these latter options the involvement of a district court judge will be necessary, for the first time, in the compulsory admission/treatment stages. It will be mandatory for the judge to have available to him or her reports prepared not only by the psychiatrists involved, but also by other health professionals responsible for the care and treatment of the patient. These would of course be prepared before the hearing.

The judge will then, if he is satisfied that this is necessary, make out an 'In-patient Order', to 'a hospital or licenced institution' (not a specific institution'). It will be made clear in the legislation that a patient would have the right to seek a district court hearing at any time, on one occasion, before the end of the 21 day period. (This is similar to a provision already in section
conform to the hospital staff's directions regarding the taking of medication, acceptance of follow-up visits from nursing and social work staff, attendance at out-patient appointments, and the acceptance of a certain degree of guidance from hospital staff regarding such matters as employment and accommodation.

The present leave provisions do not however allow for those patients who have never been hospital residents to receive this compulsory community care and treatment. Therefore the Community Treatment Order will largely replace the leave provisions of the present Act, which could be said to place ill-defined legal obligations on staff and patients. The Community Treatment Order will also avoid the present situation whereby 'trial leave' may be revoked at any time, at the discretion of the hospital staff, without consideration of the patients rights.

The treatment order need not be specific as to what treatment should be provided, or where the person should be resident, but would cover compulsory treatment in a variety of settings. The order should be accompanied by the medical certificate indicating the general nature of the treatment required. As with other forms of compulsory treatment, the order would involve not only an obligation on the person to comply with the recommended treatment, but also an obligation on the hospital to ensure that the services of appropriate staff members are provided to the person: in other words there will be legal provisions for the person to have a right to treatment, as well as a right to refuse treatment, in line with the 'consent to treatment' provisions as outlined in Paper 7.

The person subject to the order would have the same rights of review and appeal as an in-patient.

The duration of the order would be identical to that of the In-patient Order:— that is, the force of the order will lapse at the end of 6 months unless, before the end of that period, a hospital review has taken place which has endorsed continuation of the order (see Paper 8 on The Review Process). The person subject to the order will have the same rights of review and appeal as an in-patient.

The patient will be kept informed of any decision by the hospital review regarding the continuation or cessation of his/her community treatment order.
20 of the present Act). If an early hearing occurs, at the patient's request, the judge would have these options available to him/her: of discharging the patient or making an in-patient order, or of simply directing that the 21 day order continue - at the end of which period the patient's case would then have to be reviewed.

4. In-Patient Order

This order will allow a patient to be compulsorily detained for care and treatment on a longer-term basis than the previous order, that is, for up to 6 months at a time, and will be most similar to the present formal committal.

Discharge from In-patient Order

A patient may be discharged at any point during the duration of the in-patient order if found by the medical superintendent to be 'fit to be discharged'.

The order will automatically lapse at the end of 6 months if the 'hospital review' has not taken place during that time. If the hospital review has endorsed the need for the in-patient order to continue, this order would be for another maximum period of 6 months. (The review should be 6 months or less after the patient's admission - see section on the Review Process.)

Transfer from In-patient Order

A patient may at any time be transferred by the Medical Superintendent to a community treatment order.

5. Community Treatment Order

This is a new concept, which the Working Party has arrived at for two major reasons. The most significant of these stems from our recognition that psychiatric care and treatment should be primarily provided in the community. It seems therefore logical, as well as being in accord with the principles of the 'least restrictive alternative', to make possible the option of compulsory care and treatment in the community. This view is given added weight by the present situation where by many patients now receive such 'compulsory treatment' in the community, by means of the so-called trial leave provisions. Approximately half New Zealand's committed patients are out of hospital on leave, and are expected to
Initiation of Community Treatment Orders

A community treatment order can be made at the following points:

- as a result of the compulsory assessment interview
- at the expiry of the 3 day order
- during or at the expiry of the 21 day order (or while having leave during it, as explained below)
- during the in-patient order (or while having leave during it.)

Procedural requirements for Community Treatment Orders:

The Community Treatment Orders contain an element of compulsion lasting up to 6 months, and extendable beyond that. Because of this, the Working Party considers that a District Court Judge must be involved in the making of such an order, in the same way as he/she is involved for in-patient orders. If this involvement means that a judge must make an order before the order can commence, a number of practical problems will result.

The Working Party proposes, therefore, that the community treatment order can take effect from the time at which the medical practitioner fills out an appropriate form, including details of the treatment plan. This must be validated by a District Court Judge hearing, at some time not later than 3 weeks after the date of the completion of the original form. If this validation does not occur the order will lapse. The hearing could take place either in the hospital - in which case the patient would have to come to hospital for the purpose - or in the court.

It would obviously be important that the patient should have the right and the opportunity to attend the hearing, and to make representation to the court. The patient must be informed of the time, venue, and purpose of the hearing, and of his/her rights. In situations where the patient does not attend, the order could still be made in his/her absence.

In the case of a transfer from an 'In-patient Order' to a 'Community Treatment Order' there would
be no need for the involvement of a District Court Judge, as the judge would have been involved already. The transfer would be effected simply by the medical practitioner completing a transfer form.

Criteria for Community Treatment Order

These criteria would be similar to those of the 3 day, 21 day, and in-patient order, namely that the person would be considered to have a mental disorder and would be:

(a) a danger to self or others or

(b) so gravely disabled as to render himself or herself incapable of ensuring reasonable physical or social survival. The order would indicate that, of the options available (in-patient care, etc) a community treatment order would most appropriately meet the person's needs.

Transfer from Community Treatment Order to other Orders

When any health professional with some responsibility for the supervision of a person subject to a community treatment order considers that the person under supervision is not managing successfully in the community, he/she should make out a request for the person to have a compulsory assessment interview. (Such a request could be made by a person other than a health professional, also.) The health professional or other person would then obtain a medical certificate from the person's general practitioner. The criteria and options open will be identical with those for persons who have had no previous contact with the hospital system.

6. Leave

Patients who are the subject of either 21 day orders or in-patient orders may be granted leave from the hospital for a maximum period of one month, (where the patient is subject to the in-patient order) or for a time not more than the remaining time of the 21 day order (where that is the order involved). Beyond that time period, the person will no longer be subject to any order, unless another community treatment order is made.

SECTION FOUR : LEGISLATIVE PROPOSALS

1. That 'mental disorder' alone will not be sufficient ground for compulsory treatment or admission.
2. That the criteria for becoming subject to a compulsory order be:

that the person is mentally disordered and

1. the health or safety of self or others is endangered

or

2. the person is gravely disabled so as not to be capable of ensuring his/her physical or social survival.

3. That there be five compulsory stages:

- a compulsory assessment interview
- a three-day order
- a twenty-one day order
- an in-patient order
- an order for compulsory treatment in the community.

4. **Compulsory Assessment Interview**

That this will be the initial stage in considering a person as subject to a compulsory order

That a request for such an interview may be made by any person 16 years or over

That the request or application should state the reason for seeking the assessment, and the applicant's relationship to the person in respect of whom the application is made

That the request or application be accompanied by one medical certificate

That the compulsory assessment interview will be conducted by a specialist, or a medical practitioner to whom the Medical Superintendent has delegated his/her powers, and that the interview be conducted at the most convenient place for the persons involved.

5. That the police have the power, where a person is completely unwilling to take part in the assessment interview, to take that person directly to hospital.
6. That after the interview, the specialist or medical practitioner to whom the Medical Superintendent has delegated his/her powers, complete a second medical certificate.

7. That the second medical certificate will provide for 3 options. The specialist or medical practitioner to whom the Medical Superintendent has delegated his/her powers will certify one of the following:

(i) that he/she considers the person does not have a significant degree of mental illness/disorder.

(ii) that the person has significant mental illness/disorder, but not of an extent which endangers the health/safety of self or others, or renders him/her incapable of ensuring his/her own physical or social survival.

(iii) that the person's physical or social survival, or the health/safety of self or others, is endangered because of mental illness/disorder.

8. That on the basis of the second medical certificate, a decision will be made for an order or treatment.

- In the case of (ii), treatment on a voluntary or outpatient basis will be suggested.

- In the case of (iii), compulsory treatment in the community, or compulsory in-patient detention for care and treatment for up to 72 hours, will be arranged.

9. That the second medical certificate provide space for input from other health professionals.

10. That a decision for in-patient care may be implemented only if the second medical certificate is completed not later than seven days after the first medical certificate.

11. **Three Day/Seventy-two Hour Order**

that the 72 hour order will be to enable:

- assessment over a longer period than is possible in the interview.

- completion of reports from other health professionals.

- treatment of the person.

that a person will be eligible to be placed under this order only if he/she has:
either already had a compulsory assessment interview
or been a voluntary patient.

that discharge from the 72 hour order will occur:
- automatically at the end of 72 hours, if no other relevant order is made.
- or at any earlier time if the person is found by the superintendent 'fit to be discharged'.

that at the expiry of the 72 hour period, the following options are available:
- the person is not found to have a mental disorder for which treatment is desirable; the 72 hour order automatically lapses.
- the person is found to have a mental disorder for which treatment is desirable, but not essential as the person's health/safety or that of others is not endangered; the 72 hour order automatically lapses, but voluntary treatment is recommended.
- the person has a significant mental disorder, and is a danger to self/others or gravely disabled; an order may be made (where no less restrictive alternative is available), to authorise the person to be made subject of either a community treatment order, or an order for admission for 21 days.

12. Twenty-One Day Order

that the 21 day order will be to provide for a period of treatment, which should be sufficient to stabilise most conditions.

that discharge from the 21 day order will occur
- automatically, if no other order is made
- at an earlier time, if the person is found 'fit to be discharged' by the Medical Superintendent
- if transfer to informal status occurs
that transfer from the 21 day order to another order will occur with the approval of the District Court Judge.

that the District Court Judge for the purpose of transferring a person from one order to another, will hold a hearing, for which reports must be prepared by psychiatrists involved, as well as by any other health professionals responsible for the care and treatment of the patient.

that the Judge will then make either a community treatment order or an in-patient order to a hospital or licensed institution.

that any patient has the right to seek a district court hearing on one occasion at any time before the end of the 21 day period.

that on application by a patient, the Judge will have the further option of directing that the 21 day order continue.

13. In-Patient Order

that this order will allow a patient to be compulsorily detained for care and treatment for up to 6 months.

that the patient may be discharged by the Medical Superintendent at any time during this order, if he/she is found 'fit to be discharged'.

that the order will automatically lapse at the end of 6 months, unless the hospital review has endorsed the need for the in-patient order to continue.

that a patient may at any time be transferred from an in-patient to a community treatment order.

14. Community Treatment Order

that this order will allow for treatment in the community for up to 6 months.

that the order will automatically lapse at the end of 6 months, unless the hospital review endorses the need for the order to continue.

that the order will take effect from the time that the medical practitioner completes the appropriate form.
that the order must be validated by the district court judge not later than 3 weeks after the completion of the form.

that if validation does not take place the order will lapse.

that in validating this order the district court judge will hold a hearing at which the patient will be invited to attend.

that the district court judge is to determine whether this is the most appropriate order to meet the patient's needs.

that when any staff member with responsibility for the patient, considers that the patient is not managing successfully in the community, he/she will make a request for the patient to attend a compulsory assessment interview, and will obtain a medical certificate from the person's general practitioner.

15. Leave

that patients subject to either 21-day or in-patient orders may be granted leave from the hospital for a maximum of one month or - where the 21-day order is concerned - for no longer than the remainder of that order.
COMPULSORY ADMISSIONS: STAGES AND PROCEDURES

Application + One Medical Certificate

- Compulsory Assessment
  - Interview

  2nd medical certificate
  - 2nd medical certificate + judicial order

  judicial order

- 3rd medical certificate

  Community Treatment Order

  Discharge

  no further action

  informal admission

  informal admission

- 72 hour/3 day order

- 21 day order

  3rd medical certificate

  health professional reports + judicial order

  In-patient Order

  Leave

  discharge

  informal

  informal

  discharge
INTRODUCTION

This paper addresses two main issues. The first is concerned with which kinds of hospital facilities should treat which legal categories of psychiatric patients. The second issue is concerned with whether the two sets of legal provisions presently governing the establishment of private psychiatric facilities, should be integrated and/or amended.

SECTION ONE: FACILITIES FOR COMPULSORILY ADMITTED PATIENTS

1 PRESENT SITUATION

At present psychiatric hospitals and licensed institutions are the only facilities which can take compulsorily admitted patients, whereas informal patients can be admitted to psychiatric units attached to general hospitals, and to ordinary wards of general hospitals, as well as to psychiatric hospitals. Psychiatric units can, however, apply to be 'gazetted' as 'hospitals', within the definition of Section 2 of the Mental Health Act 1969; this enables them to take committed people. The only unit in New Zealand which has done this is Cook Hospital, which is known for legal and statistical purposes as a psychiatric hospital, although there are only 14 beds set aside for psychiatric patients.

In addition, the Mental Health Act allows for units and other hospitals to take patients under section 19 (ie for a maximum period of about 3 weeks) pursuant to section 117(4). In order for units to do this, the general or specific approval of the Minister is required. The only hospital which is currently approved under this provision is Princess Margaret Hospital in Christchurch.

2 DISCUSSION

It is proposed that the difference between units and hospitals should be made less distinct in respect of which legal categories of patients may be admitted. This is in line with the desirability of treating patients, as far as possible, according to their clinical needs rather than according to their legal status alone. The proposal also follows from our belief that psychiatric units should attempt to provide a comprehensive service, and that all patients, including those compulsorily admitted, should where possible, be treated in their local community settings.
There are obviously many important practical considerations which would have to be thought through before any changes could be contemplated. Information in this area has been obtained from the only two units which now admit committed patients, that is, Cook Hospital and the Princess Margaret Hospital in Christchurch.

(1) **Cook Hospital**

Although Cook Hospital is gazetted to take committed patients, it does not in fact receive very many. In 1982, out of 155 admissions, only 10 were committed. The hospital has a secure wing which is specially adapted and can take a maximum of 3 people.

Any committed patient who is unmanageable in Cook is transferred to Tokanui Hospital, although the total number of patients from the Cook region admitted to other psychiatric hospitals is small.

(2) **Princess Margaret Hospital**

Princess Margaret Hospital reports that committed patients can present more management difficulties than informal patients, particularly in respect of the need for more 'specialising' (that is, one to one care) and the occasional need for security for brief periods. It does not appear, however, that the presence of committed patients routinely necessitates a higher staff/patient ratio than would be the case if only informal patients were admitted. In general, Princess Margaret Hospital emphasises the need for patients to be admitted only to those facilities which are appropriate to their clinical status. The Canterbury Hospital Board states that Sunnyside Hospital is the receiving hospital for acutely disturbed or potentially severely disturbed patients. Patients who are admitted to the Princess Margaret Hospital, and who are then found to be too disturbed, are transferred to Sunnyside Hospital.

The view is also stated that psychiatric patients should not be admitted to non-psychiatric general hospital wards, and that forensic patients (special and remand patients) in particular should not be admitted to psychiatric units.

(3) **General Proposals**

The Working Party agrees with the view that patients should be admitted and treated only in those facilities appropriate to their clinical condition. We believe that this can be achieved by allowing, but not making obligatory, a range of facilities to receive a range of patients. This proposal should be considered in
conjunction with our proposals regarding a series of committal procedures which would facilitate and make necessary a thorough screening process, during which decisions can be made about the most appropriate placement for the patient concerned.

As already proposed, no patient will be admitted compulsorily to any facility without an assessment interview, which in most cases will involve the participation of a hospital board doctor. He or she will take the major responsibility for deciding where the patient will be placed for the next maximum period of 3 days, should this be the decision. We propose that psychiatric units should be one of the available options. At the end of the 3 day period, it may be decided that the patient should continue to be compulsorily detained; in this case, again the person could continue to be resident in a psychiatric unit, if this was appropriate to his or her psychiatric condition. Equally, however, he or she could be transferred to a hospital at any stage when this was appropriate.

At present, the hospital's first knowledge of a person's admission may be his or her arrival, following an order made pursuant to section 21 by a District Court Judge. This would not now be possible under the scheme proposed: the judge would only become involved at a later stage, and would not participate in the decision about where a person should be detained.

Special and remand patients would fall outside the scheme proposed. Decisions about whether such people should go to a psychiatric hospital, and which one, will be made in a court setting by a judge, as at present. The need, therefore, for a term, such as 'psychiatric hospital' to be legally defined remains; but the practical effect of retaining this definition will only be that the facilities to which special and remand patients can be sent, will be identified. In those sections of the Bill which outline committal procedures, it will be made clear that people held pursuant to the 72 hour or the 21 day order, or the in-patient order will be received and detained in a 'hospital facility'.

The Working Party acknowledges that this proposal will involve a significant change in our use of psychiatric facilities. It is stressed, however, that this change is one of emphasis. It will also be clear that the change proposed will not mean that units will be obliged to take inappropriate admissions; on the contrary, hospital board staff will have greater participation in decisions about whether patients should be admitted, and about which facilities should admit them.
(4) Repeal of Present Provisions

The Working Party proposes the repeal of Sections 38-40, in the 1969 Act, which provide for the detention of 'Single Patients', that is of mentally disordered persons in private homes. This section is anachronistic and not in current use.

Part VI of the present Act, 'Homes for Mentally Subnormal Persons' was repealed by the Disabled Persons Community Welfare Act 1975. According to the latter which the administration of such homes was transferred from the Department of Health to the Department of Social Welfare.

SECTION TWO : PRIVATE PSYCHIATRIC FACILITIES

1 Present Situation

There are currently two sets of legal provisions which govern the establishment of private psychiatric facilities. These are section 9 of the Mental Health Act; and Part V of the Hospitals Act and the 1964 Private Hospital Regulations.

Section 9 of the Mental Health Act provides for the Minister of Health to grant a license to any person or persons to keep an institution for the mentally disordered. This license allows for the 'reception, detention, care, treatment or occupation ... of mentally disordered persons'. The Minister may revoke this license, also, and the First Schedule to the Act details a number of provisions relating to the granting of a license, (for example, plans of the buildings and land, numbers of people to be received, statement of fire protection appliances and precautions).

There is only one private hospital licensed under the Mental Health Act - Ashburn Hall in Dunedin. It was established in 1882 and currently has a 100 bed capacity. The three private hospitals licensed under the Hospitals Act have a total of 45 beds between them; while two of these hospitals accept mainly elderly patients with mental impairment, the third (Calvary Hospital in Christchurch) admits a range of patients with psychiatric illness.

2 Some differences between institutions licensed under the Mental Health Act and private hospitals licensed under the Hospitals Act

(1) Legal category of patients who may be admitted:

Ashburn Hall is empowered to admit warranted patients, while the other private hospitals may accept only informal admissions.
(2) Licensing procedures:

All preliminary work in relation to the licensing of hospitals under the Hospitals Act is carried out at district office level, although the license is granted by the Minister.

(3) Personnel:

An institution licensed under the Mental Health Act must be headed by a medical practitioner, while the manager of a private hospital may be a medical practitioner or a registered nurse.

(4) Staff/Patient ratio:

The Mental Health Act does not cite minimum staff/patient ratios for licensed institutions, while the Private Hospitals Regulations (1964) stipulate that one registered nurse is required for every five patients in a private hospital, with one nurse for any number of patients in excess of all multiples of five.

(5) Inspection:

Staff of the Department of Health district offices have authority to inspect private psychiatric hospitals annually, or more frequently if considered necessary. There is no similar inspectorial provision in relation to licensed institutions.

(6) Building Standards:

The Private Hospitals Regulations and Schedule of Requirements lay down detailed provisions relating to facilities and requirements. This breadth of detail is not reflected in the First Schedule to the Mental Health Act.

(7) Financial Assistance

In Ashburn Hall and also in private hospitals patients may be entitled to social security hospital benefits or daily patient benefits. Ashburn Hall receives a special subsidy of 80% of the cost of medical salaries, while some hospitals operated by religious and welfare organisations also receive salary subsidies.

3 Options and Conclusions

The Working Party reviewed the legislative provisions in the two Acts in order to determine whether to:

- retain the present system of two sets of provisions for private psychiatric care
- integrate the provisions in the Mental Health Act into Part V of the Hospitals Act
- provide for private psychiatric hospitals to be licensed under both Acts
- retain the system of two sets of provisions for private psychiatric hospitals, but amend the present Mental Health Act provisions.

The Working Party decided on the fourth option, that is that the present system should be retained but the Mental Health Act provisions should be developed. The Working Party believes that the service provided at Ashburn Hall is unique and important, and that it would experience severe difficulties in continuing to function if it were to become subject to the Private Hospitals Regulations. A further consideration is that although Ashburn Hall does not accept many committed patients, it is desirable that it continue to be empowered to admit them when appropriate. This would not be possible under the Hospitals Act.

The Working Party considers however that the Department of Health should have a statutorily recognised role in inspecting institutions licensed under the Mental Health Act and ensuring that standards of care are maintained. While the present standards at Ashburn Hall may well be higher in some aspects than many public hospitals, it is important that a mechanism should be in place to ensure that licensed institutions at all times provide a satisfactory service.

The Mental Health Bill will therefore allow for regular inspections of licensed institutions by the Director-General of Health or his delegate. It will also specify that the Standards of Care Guidelines (as established according to the procedures described in Paper 14) will apply to licensed institutions as well as to public hospitals.

SECTION THREE : LEGISLATIVE PROPOSALS

1. That the term psychiatric hospital continue to have a legal definition enabling them to take special patients.

2. That all general hospital facilities be empowered to admit all legal categories of psychiatric patient, except special patients.

3. That sections 38-40, which provide for the detention of 'Single Patients,' be repealed.

4. That a section equivalent to the present section 9, which governs the establishment of private licensed institutions, will be retained.

5. That the Director-General of Health or his deputy, is empowered to inspect such private licensed institutions.
6 That the Standards of Care approved by the Director-General of Health will apply to private psychiatric facilities as well as public hospitals.
SECTION ONE : INTRODUCTION

Many of the new Mental Health Bill's provisions will relate primarily to those psychiatric patients who are compulsorily admitted to hospital; but it must be remembered that these patients will not represent the majority of psychiatric patients. The present situation is that 85% of people admitted to hospital are informal, and that almost all admissions to psychiatric units, (which constitute one third of all first admissions), are informal. For these reasons alone therefore careful consideration needs to be given to what, if indeed any, separate provisions shall be in the new Bill with respect to informal patients.

The first issue to be discussed, albeit one of a fairly minor nature, is the term 'informal'. In general, people outside the psychiatric hospital system do not know what the term means, whereas the word 'voluntary' is self-explanatory. Objections to the word 'voluntary' are largely historical. Both terms have their advantages and disadvantages, and while the working party would on balance prefer the status quo, it would be interested to receive comments on this point. For the remainder of this paper, and in other papers, the term 'informal' will be used.

The general principles that the working party has borne in mind in considering issues relating to informal patients are that:

- the primary consideration which should govern the treatment of all patients in psychiatric hospitals should, as far as possible, be their clinical condition rather than legal status;

- the procedures governing the admission and treatment of informal patients in psychiatric hospitals should, as far as possible, resemble those for patients in general hospitals.

SECTION TWO : ISSUES

The main issues to be discussed concerning informal patients in relation to the Mental Health Bill are -

- procedures for admission and discharge
- procedures for review
- procedures for change of status from informal to other compulsory orders
- applicability of general provisions of the Bill to informal patients.
1 Admission and Discharge

At first sight, it might seem logical to decide simply that admission procedures for informal patients should be identical with those for patients going to general hospitals. However, the present situation is that there are no general legislative provisions relating to general hospital procedures. Procedures relating to the admission and discharge of patients and out-patients in public hospitals are contained in the individual by-laws of each hospital board, as authorised by section 65 of the Hospitals Act 1957. These by-laws vary to some extent from one hospital to another. It should be recognised that these by-laws (although in most cases not framed with the characteristics of psychiatric hospitals in mind) do in fact apply to psychiatric hospitals.

The question therefore is whether we wish to have what would be in effect two sets of provisions applying to informal patients (a section equivalent to the present section 15 and by-laws), or whether the by-laws alone would suffice. It could be argued that having two sets of provisions is unnecessary and inconsistent with the general principle of providing similar admission procedures for informal psychiatric and general patients. On the other hand, it could be said that statutory provision is required for people whose perceptions and judgements may be impaired.

The Working Party proposes that there be no provision in the Mental Health Bill for the admission and discharge of informal patients. These matters will come under the authority of individual hospital board by-laws. The Working Party considers that the present by-laws are, in general, adequate; but also recognises that they could be further improved or that at some future stage it might be considered opportune to have some control over by-laws in relation to psychiatric facilities. The Working Party proposes to address these concerns in the following two ways.

Firstly, in order to improve by-laws in relation to psychiatric facilities, the department should ask hospital boards to review their by-laws in order to ensure their relevance to psychiatric hospitals and services.

Secondly, in place of the present section 15, provision will be made in the new Bill for authority for subordinate legislation. In other words, the Bill could require boards to pass by-laws under the Mental Health Act. The content of these by-laws cannot be dictated by the department, but they must meet with the approval of the department and the Minister of Health.

One example of an area which could be covered by either hospital board by-laws, or guidelines, is the need for thorough assessment of all informal patients on admission.
The Legal Information Service/Mental Health Foundation, in its comments on these issues, considers that there should be more detailed and specific provisions relating to the admission and discharge of informal patients rather than fewer provisions, as we suggest. They propose, for instance, that the law should provide informal patients with a right to discharge themselves at any time. The Working Party does not agree, as informal patients have this right, in the same way as any patient in a general hospital. It may well be that increased attention should be given to ensuring that patients are aware of this right, but the Working Party believes that this would be best achieved by improving the information available to patients, rather than by enacting unnecessary legislation. The Working Party further considers that informal patients should be notified in writing of their discharge.

2 Review

The question of whether there should be any statutory provision for the review of informal patients has been raised for two main reasons. Firstly, it is a matter of good clinical practice that all patients in psychiatric facilities should be reviewed regularly; and this is especially important in view of the fact that some patients, (although certainly not the majority), stay in hospital for long periods, for example some profoundly intellectually handicapped people, or intellectually impaired elderly people.

Secondly, the 'voluntary' nature of informal patients can be queried, as is suggested by the Legal Information Service/Mental Health Foundation. By the very nature of their conditions, some patients (in particular those in the two categories mentioned above) may not be fully capable of appreciating the facts of their situation, and may not be capable of giving or of withholding consent.

The Legal Information Service/Mental Health Foundation proposes that a mechanism should be provided whereby the propriety of an informal admission might be reviewed by an independent body. According to this proposal, each informal patient should be seen within 3 months to decide whether he/she has given informed consent.

The Working Party rejects this proposal, both for clinical and practical reasons. Such a proposal would make the workload of the Review Tribunals completely unmanageable, and the benefit in relation to the cost involved would be negligible.

Nevertheless the Working Party strongly believes that informal patients should be reviewed regularly; this review is needed in order to ascertain the patients' clinical conditions and to decide if they are appropriately placed in hospital, or whether there would be any other setting capable of meeting their needs. It is proposed therefore that there be a statutory requirement for reviews to be conducted regularly at
hospital level in relation to all patients, whether admitted informally or compulsorily (see Paper 8, the Review Process). The time periods and personnel involved will be the same for both groups of patients. The form to be completed in respect of informal patients would, however, differ in some details, and would contain references to checking the patients, understanding of their informal legal status. It is anticipated however that samples of these review forms will be seen by both the district inspector/official visitor, and any external review personnel, such as members of the Department of Health. If the district inspector/official visitor were dissatisfied with any individual case, he could take it up with the doctor, ward team, or medical superintendent; and a departmental adviser could, if he found a review form to be unsatisfactory or inadequate in any way, make this point in his hospital report. As with many proposals in the Working Party's papers, it will be clear that legislative changes will have to go hand in hand with improved education, training and monitoring.

The Working Party acknowledges that there are ethical problems involved with informal patients who, because of severe mental impairment, are not capable of giving or withholding consent. It is possible that the provisions of the Incapacitated Persons Welfare Bill (Paper 13) may apply.

3 Change of Status

The Working Party considers that it will continue to be necessary to have some legislative provision for the change of status of informal admissions to other compulsory orders. At present there are two sections relating to a change of status: section 16 of the Act which allows the superintendent of a hospital to apply for a reception order in respect of any informal patient; and section 117 which provides that any person in a hospital, whether in relation to his mental condition or not, may be detained while an application for a reception order is being made.

As all institutions (except Lake Alice and Ashburn Hall) are now administered by hospital boards, and as it is intended to make it possible for a patient to be compulsorily admitted to any hospital, there will be need for only one mechanism for change of status. It is proposed that legislation will state that, should it be considered that a person fulfils the criteria compulsory treatment/detention as described in Paper 3, two medical certificates should be completed.

Following the completion of two medical certificates, the path of the former informal patient in the psychiatric system will be identical with that of any other patient entering the system compulsorily. The person will be notified in writing of his/her change in status.
4 Application of general provision of the Bill to informal patients

The Working Party proposes that it be made clear in the Bill that, unless specifically stated otherwise, all provisions in the Bill will apply equally to all patients regardless of their status. Examples of such provisions would relate to records, visiting, communications, and offences.

SECTION THREE: LEGISLATIVE PROPOSALS

1 That provision will be made in the Mental Health Bill for authority for subordinate legislation, such as by-laws.

2 That informal patients should be notified in writing of their discharge.

3 That there be statutory provision for the regular review by hospital staff of informal patients.

4 That there will be provision for the change of status from informal to a 72 hour order, which will require two medical certificates.

5 That all provisions in the Bill will apply to all patients regardless of status, unless stated otherwise.
SECTION ONE : BACKGROUND

1 INTRODUCTION

The legislation governing special patients is complicated by the fact that it is incorporated in several Acts - the Criminal Justice Act 1954, the Crimes Act 1961, and the Mental Health Act 1969.

The first two Acts are administered by the Department of Justice, the third by the Department of Health. Changes to one Act relating to special patients frequently have implications for the other legislation and any such changes require co-ordination. It should be noted that a new Criminal Justice Bill is proposed by the Department of Justice for introduction this year.

2 PRESENT LEGISLATION

There are three main categories of special patients, and two main Acts which deal with them.

(1) Sentenced prisoners

If such prisoners become psychiatrically ill during their sentence, they may be transferred to hospital. They may or may not be transferred back to prison before their sentences expire. The provisions relating to such patients are contained in the Mental Health Act, that is, section 42 which relates to the compulsory transfer of prisoners who would, if not in prison, qualify for committal; and section 43 which relates to the voluntary transfer of convicted prisoners who would benefit from psychiatric care and treatment.

(2) Remand patients

Persons may be sent by Courts to psychiatric hospitals in order that a psychiatric examination may be undertaken pursuant to sections 47A(2)(c) or 39B of the Criminal Justice Act. In addition, a person who has already been remanded to prison, but not yet brought to court, may, pursuant to section 42(4) of the Mental Health Act be transferred to hospital if he/she is considered to be mentally disordered and hence committable.
(3) Court ordered patients

There are two main classes of patients resulting from Court decisions, which are provided for in the Criminal Justice Act. These are:

(a) patients found under disability (unfit to plead, unable to instruct counsel etc); 39G (l)(a)

(b) patients acquitted on the grounds of insanity—that is, persons whom the judge or jury finds are suffering from disease of the mind, and who did not know what they were doing, or did not know it was wrong; 39G (l)(b) (see notes on insanity in criminal law in Adams' "Criminal Law and Practice in New Zealand").

Reclassification procedures differ for these last two classes of special patients, and are authorised by either the Minister of Health or the Minister of Justice, or, in cases which carry a maximum sentence of 14 years, by the Governor-General in Council (Criminal Justice Act, Section 39H and 39I).

Special patients differ from committed patients in that there are limitations affecting leave and transfers; most importantly, they cannot be discharged directly from hospital by the medical superintendent (unlike ordinary committed patients), but must first be 'reclassified' to ordinary committed status.

SECTION TWO : GENERAL ISSUES

There are at least six fundamental issues to be considered in relation to the two main Acts affecting special patients, the Criminal Justice Act and the Mental Health Act.

1 Legal and clinical concepts of 'sane' and 'insane'

These two concepts are inadequate to accommodate the wide variety of clinical conditions from which offenders may suffer; they do not convey accurately the extent to which offenders' capacity for understanding or responsibility is impaired. Criteria sufficient to commit a person under the Mental Health Act, may fall short of the legal definition of insanity. Similarly, some accused persons may be found not guilty on account of insanity, and thus become special patients, because it is judged that they suffered a brief—sometimes even momentary—psychosis at the time of the offence, even though subsequently they may be not mentally ill, and thus not in need of hospital care or treatment. It has been suggested, therefore, that there should be a third category of verdict under criminal law: 'guilty but mentally ill' or 'having diminished responsibility'—comparable to some overseas legislation. Such changes have not, to date, found favour in New Zealand.
Particular difficulties attach to this finding, and the reclassification procedures relating to it:

- although the accused person has not undergone trial, and guilt, therefore, has not been judicially established, the verdict may result in detention in hospital for a long period;

- in practice, the periods for which many patients are retained on this status extend well beyond that during which they fulfil the strict criteria for 'under disability' - in other words the term appears sometimes to be interpreted as meaning merely 'psychiatrically unwell'. In support of this practice, it could be argued that some patients, although not 'under disability' in a hospital setting, may rapidly become so on return to court, should this be directed;

- the period of time before which the hospital recommends that a person has become fit to plead, is frequently very prolonged. The law presently provides for the Minister of Justice to require such persons either to return to court to face their original charges, or to be reclassified to committed status. Because of the time period involved, the former option, that of a return to court, may be judged impracticable, meaningless or cruel. However, although rarely used, the option may have value in individual cases, especially those in which the lapse of time has not been great.

Such problems have been addressed to some extent in the new Criminal Justice Bill, prepared by the Department of Justice. This Bill proposes limiting the duration of 'under disability' status to half the maximum sentence of imprisonment that could have been incurred, had there been a conviction, or seven years where the sentence would have been life imprisonment or preventive detention.

Nevertheless, attention has been drawn to the fact that many other countries limit the period for which 'under disability' status can be maintained, and the fact that recording of evidence relating to the offence as soon as possible after its detection, may assist in later decisions regarding the person's future.

3 Reclassification Procedures

While reclassification procedures differ for the categories 'under disability' and 'acquitted on account of insanity (Sections 39G(1)(a) and (1)(b) of the Criminal Justice Act), they are similar in that decisions regarding reclassification can be made only by either the Minister of Health, or the Minister of Justice, or the Council. It could be argued that it is inappropriate to require Ministers or the Executive Council to make decisions relating to individual patients; and
that 'political' factors may influence decisions which should be determined solely on clinical and legal grounds. Alternatively, it can be maintained that a Minister is an elected representative of the wider community interest, an important factor in decisions concerning offenders who may have committed grave crimes.

Alternatives to ministerial power

At least two alternatives are in use in overseas legislation: 'advisory boards' which make recommendations to Ministers or to departmental officers empowered to make discharge decisions; and 'statutory tribunals', akin to Parole Boards, which are empowered to make discharge decisions.

The Donaldson Report recommended that a 'National Advisory Committee' be established which could advise the Minister in respect of particularly difficult cases of special patients. The Legal Information Service/Mental Health Foundation Report advocates statutory tribunals, possibly subject to ministerial veto. At this stage the Working Party would tend to support the concept of statutory tribunals with multi-disciplinary membership. However, such changes are beyond the scope of the Mental Health Act itself and would involve major changes to the Criminal Justice Act.

4 Protection of the Public

This issue has been extensively discussed in the forum of the Donaldson Commission, and by the committee of officials which arose out of it. Questions arising include whether the public is sufficiently protected from the psychiatrically disturbed dangerous offender; and if not, whether the situation can be improved by means of new legislation, or new services/facilities, or both.

The question of services and facilities is beyond the scope of this paper, but the Donaldson Report made the following recommendations relevant to the protection of the public:

- that all special patients should be reclassified or sent back to prison only following an appropriate recommendation of a 'Review Panel';
- that some special patients, and patients in the Maximum Security Villa of Lake Alice Hospital, could be eligible for 'restricted status', the principal criterion for which would be that of 'dangerousness'.

The category of 'restricted status' would be intended to ensure that extra care and caution was exercised with regards to 'dangerous' patients, and to provide additional means of supervising them, once they were given leave from hospital. The establishment of a National Advisory Committee, composed of psychiatrists, lawyers and lay members, was recommended to advise on decisions relating to 'restricted' people and monitor their progress.
These recommendations, generally supported by the Department of Health, are still being considered by government.

5 Protection of the Rights of the Special Patient

Under present law, special patients have little right of appeal against their status or detention in hospital. The only exception is section 74 of the Mental Health Act, whereby any patient, including a special patient, may ask a Higher Court Judge (who may not agree) to examine his/her case. The judge may report his/her opinion and recommendations to the Minister; in the case of an 'under disability' patient, may direct that the patient be returned to court to face his/her original charges, or he/she may direct that the charge be dismissed. This section is rarely used. It should further be noted that according to the European Convention of Human Rights, the periodic review of a patient's position by a Court is required. British legislation was amended specifically to cover this requirement.

The department considers that special patients should have greater rights of review and appeal than currently exist. It is proposed therefore that:—

(a) special patients should have access to the same 'hospital review process' as will be available for other patients (see Paper 8, Review Process).

(b) they may apply to the local Review Tribunal if they disagree with the findings of the hospital review.

For section 42 and 43 patients (Mental Health Act 1969), this would involve appealing against continued detention in a hospital rather than prison. (They cannot appeal against the special patient status because this must be retained while in hospital and subject to a sentence of imprisonment). Patients subject to 39G (l)(a) and (b) of the Criminal Justice Act could appeal against continued detention as special patients.

The Review Tribunal would not have the authority to transfer, discharge, or reclassify a special patient. In the case of Mental Health Act Section 42 and 43 patients, the Tribunal could recommend to the hospital/prison authorities that a transfer be made.

In the case of section 39G Criminal Justice Act patients, the Tribunal would make appropriate recommendations to whichever authorities were responsible for reclassification (whether the Minister, an Advisory Committee or Statutory Board).

Further more, it is proposed that provisions similar to the present section 74 will be preserved in the new Act, in order to enable a High Court Judge, as appropriate, to:—

- discharge an 'under disability' patient;

- direct that an 'under disability' patient be returned to court;
make recommendations to the reclassification authorities, regarding 'acquitted on account of insanity' patients.

Comprehensive or separate legislation regarding special patients

As previously noted, legislation affecting special patients is principally contained in both the Criminal Justice Act and the Mental Health Act. The question of whether these provisions would be more conveniently integrated in one Act has been raised. The only practical alternative to the status quo, would appear to be incorporation of those provisions presently in the Mental Health Act into a new Criminal Justice Act. It would not be possible to incorporate Criminal Justice provisions into the new Mental Health Act as they deal with the disposition of people charged with offences. The argument against taking the leave/transfer/jurisdiction provision out of the Mental Health Act and into the Criminal Justice Act is that these matters relate almost entirely to hospitals, and would be administered there. On balance it would seem best to recognise the fact that issues relating to psychiatrically disturbed offenders are issues to be dealt with jointly by health and justice legislation and services; in order to minimise the inconvenience involved with having two pieces of legislation, the Working Party recommends that guidelines specific to special patients be produced, in conjunction with the new Acts, explaining the provisions in an integrated and comprehensive way.

SECTION THREE: SPECIFIC ISSUES

In this section it is assumed that provisions for special patients will remain divided between the Mental Health and the Criminal Justice Acts; and that the proposals for change outlined above will be incorporated in one or the other, as appropriate.

In addition to the major issues discussed above, there are a number of specific, though relatively minor issues, stemming from provisions in the present Mental Health Act:

1. Transfer from prison to hospital of inmates considered to meet the criteria for committal (present section 42)

The Working Party does not consider that this section should be modified in substance, except that it agrees with the 1981 Report of the Working Party on Psychiatrically Disturbed Prisoners and Remandees, which recommended that this section which provides for 'temporary reception orders' to psychiatric hospitals for persons remanded in penal institutions, should be transferred from the Mental Health Act to the Criminal Justice Act, where it could be placed with other provisions concerning remandees. The Criminal Justice Bill incorporates this recommendation.
Transfers from prison to hospital of inmates not meeting criteria for committal but capable of benefitting from psychiatric care and treatment (present section 43)

The 1981 Working Party Report recommended that the authority to make such transfers should be vested in the superintendents of the prison and hospital concerned, rather than the Secretary of Justice and the Director of Mental Health; and that these officials should only become involved in cases of disagreement. The Working Party agrees.

Transfer of offender patients from hospital back to prison (section 44)

The 1981 Working Party recommended that such transfers be authorised locally, by the superintendents of the institutions concerned, for both 'section 42' and 'section 43' patients, and the Working Party agrees.

Transfer of special patients between hospitals (section 46)

This section which provides that transfer of special patients between psychiatric hospitals be authorised by the Director of Mental Health, would be retained as is.

Long leave for special patients (section 47 (1)-(3)

These provisions allowing for long leave to be granted to special patients acquitted on account of insanity will be retained, although the persons or body responsible for authorising such leave would be those given responsibility for status reclassification (discussed above). It is proposed however, that these long leave provisions should be available to 39G (1)(a) 'under disability' patients as well as 39G (1)(b)s.

Short leave for special patients Mental Health Act (section 47(4): section 42/43 patients)

The 1981 Working Party Report stated that:-

'It is unjust (and indeed an unwarranted interference with the decision of the court) for prisoners to be given leave and subsequently returned to conditions of medium or maximum security. We recommend that a hospital superintendent should not be permitted to grant a section 42/43 patient leave without the prior consent of the superintendent of the prison from which the patient was transferred. The decision would be based upon accepted penal practice.'

There are clearly arguments for and against this recommendation. On the one hand, section 42/43 patients are convicted offenders and should therefore be subject to the same sanctions as their fellow inmates; on the other hand,
they are in hospital to be treated and the medical superintendent should have the same flexibility to grant leave, which may be therapeutically beneficial, to section 42/43 patients as he/she would to committed patients. On balance however, we support the Working Party's recommendation that leave should not be given to section 42/43 patients without the prior consent of the prison superintendent.

The Working Party also raises the question of such patients being given release to work as they near the end of their sentences, the intention being once again to bring the conditions of their detention in hospital as near as possible to conditions relating to prison inmates. We would support this recommendation.

7 Short leave for special patients (section 47(4) Mental Health Act:Section 39G Criminal Justice Act Patients)

We support the retention of this section as is applicable to 39G patients.

8 Escape of special Patients (section 47(5))

The subsection states that 'a special patient who escapes may be retaken at any time after his escape'. Following a recent court case A W Taylor v Police [1984] BCL 902, it was found that although special patients can be retaken at any time, special patients do not actually commit an offence in escaping. In the court judgement it was considered that this was probably not an accidental omission on the part of those responsible for the 1969 Mental Health Act. It was stated that 'It would not be consonant with the philosophy of an enactment which is primarily concerned with the care and treatment of mentally disordered persons, that they should be subject to prosecution for escaping from the hospital where health care and treatment is being provided for them. Nor would any good purpose be served by a criminal prosecution in such circumstances'. Not everyone would agree with this view, and it has been suggested that the fact that special patients cannot be prosecuted for escaping is an anomaly which should be resolved by legislative change. The department appreciated both points of view, but is inclined to support the Court of Appeal's judgement in this matter - as long as the legislation makes it clear that while a section 42/43 patient is AWOL, his/her sentence ceases to run and therefore the time that he/she is away is taken into account when his/her release date is calculated. Section 39G patients would not be penalised for escaping in any way.

It could be argued that the legislation should make it clear that the section 42 or 43 patient is in the custody of the hospital, while he/she is there. This was recommended by the 1981 report.
9 Security institutions (section 48)

According to this section the Minister of Health may declare any psychiatric hospital to be a security institution. This provision has never been used. It is considered however, that it should be retained.

SECTION FOUR : LEGISLATIVE PROPOSALS

1 that there be statutory provision for the regular review by hospital staff of special patients in the following categories: 39G(1)(9), 39G(1)(6), (Criminal Justice Act) and section 42 and 43 (Mental Health Act).

2 that a special patient in the category listed above has the right to apply to Review Tribunals for a review of his/her case; although the Tribunals would only have the power to recommend and not discharge.

3 that a section equivalent to the present section 74 be retained, i.e. that patients, including special patients, may ask a high court judge to inquire into their cases.

4 that the authority to make transfers between prisons and hospitals of convicted prisons be vested primarily in the superintendents of the institution concerned.

5 that the present provision relating to the transfer of special patients between psychiatric hospitals be retained.

6 that there be provision for long leave to be granted to 'under disability' patients.

7 that short leave should be given to section 42 and 43 special patients only with the consent of the prison superintendents involved.

8 that the present provisions relating to the escape of special patients remain unchanged.

9 that a provision allowing the Minister of Health to declare any psychiatric hospital to be a security institution should be retained.
PAPER 7

CONSENT TO TREATMENT

SECTION ONE : INTRODUCTION

All patients when they seek medical treatment, whether for physical or mental ailments, do so in order to utilize the expertise of the medical practitioner concerned. In most cases, the patient has the right to consider the advice given, and then to reject it or refuse the service offered. Patients are in general legally free, if they so wish, to seek additional medical opinions.

The health team's prime responsibility is to the patient. Members of the team, and particularly doctors and nurses, are trained to analyse critically the evidence from various sources, and to decide on an appropriate course of action for each patient. This does not imply that such professionals cannot make mistakes, or that they are infallible, but their professional training and the associations to which they belong, and by which they are governed, serve to reinforce good practice.

Medical practice relies on the trust established between doctors and their patients. Patients may decide to proceed with a suggested course of treatment although fear and distress may prevent assimilation of the information given, or its rational assessment.

In some cases the agreement to proceed may be verbal or involve an implicit understanding. In others, where, for example, surgical intervention is necessary, the written consent of patients is obtained. Parents or guardians are required to provide written assent for children. Doctors treating patients without consent may be sued for trespass or assault, though in an emergency, the medical superintendent may authorise that the doctor act without the patient's or guardian's consent to save the patient's life, alleviate suffering, or prevent rapid deterioration of condition.

All patients are equally entitled to:

1. the best and most appropriate care and treatment available.

2. information that can be easily understood concerning the proposed treatment, its nature, likely benefits, side effects and risks, and any alternative forms of treatment.

The principles which govern the care and treatment of psychiatric patients should be no different from those for patients who are physically ill. However, there are several ways in which the situation of psychiatric patients can be seen as different.
- The psychiatric patient's judgement may be impaired by his/her illness to an extent to which he/she may not be competent to make a decision about him/herself.

- Some patients are committed for treatment against their will.

- Within some sections of the community there is apprehension concerning the consequences of mental illness and its treatment.

At present, the Mental Health Act 1969, in Section 25 provides that for committed persons a Reception Order is sufficient authority to detain and treat a patient. There are no provisions for discussion or consent. The assumption has been that involuntary detention which includes the detention of special patients, equates with involuntary treatment. Committed and special patients are in this way treated differently from informal patients, who have the right, if they so wish, to refuse treatment, and even to discharge themselves.

The assumption on which the remainder of this paper is based, is that psychiatric patients, regardless of their legal standing, are resident in a hospital or institution for treatment; that measures to improve their health, should be effected as quickly, efficiently and humanely as possible; and that all patients should have the same rights to receive information about that treatment, and to express their willingness or unwillingness to undergo it.

Psychiatric patients do require extra provisions that general patients do not. This paper will address these, including relevant comments received on the department's earlier position paper. Consideration is given to the legal and medical difficulties involved, and to progress in the international arena, and an attempt has been made to confront those issues in the New Zealand setting. As the Working Party considers that this is a particularly important area, the paper will provide a broad discussion, much of which will not be encoded in legislation, but will be a matter for guidelines.

SECTION TWO: ISSUES

(1) The Information Process

It is recognised that patients should always be kept informed about treatment plans and options available to them. Informed consent is particularly necessary for certain categories of treatment, but the giving of information should not be confined to those treatments only. Regular communication should take place between the patient and members of the therapeutic team on all recommended treatment programmes. When a patient has an understanding of the illness and its treatment, active co-operation in his/her own recovery is more likely.
Explanation is required for each new or different course of treatment undertaken. Again this ensures that patients know how they are being treated, and how each course of treatment is expected to benefit them.

Thus the department acknowledges the obligation of the treating professional to explain the purpose, nature and consequences, including potentially adverse results, of any treatment either to the patient, and where necessary, or appropriate to his/her relative, friend or guardian.

The information should be provided by the medical practitioner or his/her delegated representative, with overall responsibility for that patient. Not all health professionals are skilled at such communication process, and two submissions emphasised the need for special training to enable the informant to successfully carry out this function. Such skills would be of value for all health professionals, and are most appropriately taught during under-graduate training, and reinforced during postgraduate training.

As far as possible, the information should be given to the patient at a time and in a setting conducive to the patient's understanding. The doctor should, therefore, choose the most appropriate time according to the patient's mental state, thus avoiding informing the patient when he/she is unduly distressed, or less likely to comprehend.

Such an interview should take place in private, with the attendance of a specified other person if the patient so requests.

Explanations should be made in the patient's native language. Where patients do not respond to explanations in English, or where it is clear from the outset that the patient would not fully understand an explanation in English, an interpreter must be invited to attend the interview. In such cases any written explanations should also be given in the patient's own language.

The importance of full and regular communication will be stressed in guidelines, but legislation will refer to the responsible health professional's role in communicating to all patients, the nature and purpose of the proposed treatment, with its possible side effects, and alternative treatments.

(2) Patient's Understanding

After the patient has been informed of the course of treatment suggested, it may in some cases be useful, with the patient's consent or at his/her request, to inform a relative or friend of the information passed on to the patient.
A person other than the doctor who made the initial explanation should check the patient's comprehension before treatment is given. It is considered desirable that checks by explanations by several professional persons, be given. It would be most practical if the person ensuring understanding has easy contact with the patient, and in that way a person working on the ward, for example a nurse, may be most appropriate. Relatives or friends may also assist in checking comprehension.

Some comments expressed concern that a patient's refusal to give consent to treatment, because he/she is unconvinced by the explanation, may be misconstrued as a sign that he/she is incapable of understanding. If the patient has had the treatment explained by several persons, as suggested above, then a reasonable course to follow in respect of committed and special patients, is that adopted by the British in their Mental Health Act 1983. The British view on this point is that in the case of a refusal, if alternative satisfactory means of treatment are available, they should be offered, and if the patient's condition demands some form of treatment, the one he/she finds least objectionable should be selected. The patient must be informed fully of the efficacy of different choices. Medical professionals may, where applicable, record that a decision for treatment has been made that was not their first choice.

Patients are, therefore, entitled to refuse to give consent at any time. Having given consent to a course of treatment, a patient may later withdraw consent. The issue of patient understanding will be covered in guidelines but not legislation.

(3) Documentation

The Working Party considers that written evidence of consent should be provided for in the regulations. A simple consent form should be prepared which would provide for:

(a) confirmation by the doctor that an explanation has been given of the proposed treatment, its purpose and risks, and that the patient appears to understand;

(b) confirmation by the patient - whether informal or under compulsory order - that he/she has received an explanation of the proposed treatment, that he/she understands, and has given consent;

(c) a broad outline for a treatment plan which would be limited to a course of treatment, and should allow for such revisions as changes of drugs which would require a new explanation, but not necessarily a new consent.
The consent form need be only a very simple one. Details of the explanation, and of the treatment plan itself need not be given on that form. The treatment plan should be a separate document, kept on the patient's file, but copies should be available for the patient and family, if wanted.

It would be most appropriate if the consent form was completed by the doctor after the interview, and by the patient when his/her understanding is checked by the nurse or other health professional. At that later stage the patient could check any misunderstandings, and full comprehension would be ensured.

The Working Party considers that documentation will be required by legislation, and its' exact nature spelled out by regulations.

(4) Informal Patients

An informal, or voluntary, patient enters a psychiatric hospital or institution of his/her own free will. Such a patient is, in the same way as a patient in a general hospital, free to leave the hospital whenever he/she chooses. As a result of this status, informal patients cannot be forced to undertake a specific course of treatment. The voluntary patient can accept, or refuse, any treatment. However, if the patient refuses to accept the treatment which is offered, the consequences of such a refusal will be clearly explained. It may well be that an alternative form of care or treatment may be offered. If the patient refuses all forms of care or treatment, and hospital staff consider, therefore, that there would be little point in the patient remaining in hospital, there are two options:

- the patient may be informed that there is no reason for them to remain in hospital, and he/she will be discharged

- if the patient fulfils the criteria for compulsory admission, such procedures will be instituted (see the papers on 'Compulsory Admission : Criteria and Procedures', and 'Informal Patients'.)

Section 6 of this paper will cover treatments of particular significance. The first category will apply to both informal patients, and those under compulsory orders.

(5) Patients subject to Compulsory Orders

Where a person is considered to be mentally ill, and a danger to self or others, he/she will become subject to a compulsory order (see paper on 'Compulsory Admissions :
Criteria and Procedures'), which may mean either compulsory care and treatment in the community, or in a hospital. While this category of patient becomes subject to an order involuntarily, he/she retains the right to be fully informed, and to be offered alternative forms of treatment, and where certain special treatments are concerned, additional procedures will be provided (see Section 6).

(6) **Special Treatments**

It has been agreed by the Working Party that there are two categories of treatment for which special safeguards should apply and for which there should be a special effort to obtain consent. It is proposed that these treatments be included in a Schedule to the Act.

(a) The first category of treatment, including psychosurgery, will require:

(i) the consent of the patient whose understanding of the nature, purpose and likely effect of treatment has been verified by the regional review tribunal (lack of patient consent would preclude this treatment); and

(ii) a second specialist opinion from an appointed medical practitioner called in by the review tribunal, (see Paper 8), who would be required to consult with the patient, relatives or friends as appropriate, and at least two other health professionals concerned with the patient's management. The written agreement of this second specialist would be required before treatment could occur.

This category of treatment will apply to all legal categories of patient.

(b) The second category of treatment, which includes ECT and certain psychotropic drugs, will require:

(i) the informed and formal consent of a patient, OR

(ii) a second specialist opinion in writing by an appointed medical practitioner called in by the review tribunal, who should consult with the patient, friends or relatives as may seem appropriate, and at least one other health professional concerned with the patient's management.
These procedures will apply to patients under compulsory orders, including special patients; not to informal patients, who have the right to decline all categories of treatment.

Specific treatments which fall into these two categories should be established, and amended from time to time, by a specialist technical committee.

Arrangements for regular reviews of those patients to whom the above procedures have applied, need to be established. Not only should health professionals monitor the patient's progress, but the review tribunal should be empowered to request that the second specialist examine the patient at appropriate intervals.

The whole of the Section on Special Treatments will be included in legislation.

(7) Emergency Treatment

In emergencies, when treatment is considered to be immediately necessary to prevent further physical and/or mental deterioration, serious suffering, excessively violent behaviour, or to save a patient's life, the provisions hitherto mentioned do not apply. This provision will not apply to treatments specified in the first category of special treatments outlined above.

In an emergency, the treating doctor may act without the patient's consent or a second opinion. Where possible, consultation with the patient's family or closest friend should occur. The medical superintendent will authorise the doctor to take immediate action in the patient's best interests.

Thorough documentation will be required in emergencies. Guidelines will recommend that as soon as practical after treatment has begun, the responsible medical officer will obtain a second opinion on the continuance of the emergency treatment already begun.

Legislation will allow for the provision of treatment in emergencies. Guidelines will reinforce good practice.

(8) The Patient's Role

Successful treatment depends upon an alliance between the treating professional and the patient. Recovery depends on the patient's cooperation, and he/she should be encouraged to take part. With the active participation of the patient, benefit will accrue to all involved in the treating process.
SECTION THREE: LEGISLATIVE PROPOSALS

1 That the importance of full and regular communication will be stressed in guidelines, but legislation will refer to the role of the responsible health professional in communicating to all patients the nature, and purpose of the proposed treatment, with its possible side effects, and alternative treatments.

2 That the issue of ensuring a patient understands the information conveyed to him/her will be covered in Guidelines not legislation.

3 That documentation will be required by legislation, and its exact nature spelled out by regulations.

4 That legislation will establish two categories of special treatments, the first of which will require, for all patients, consent of the patient and a second specialist opinion; and the second, for compulsorily admitted patients, consent of the patient or a second specialist opinion. Treatments will be included in a Schedule to the Act.

5 The legislation will allow for the provision of treatment in emergencies.
SECTION ONE : INTRODUCTION

The question of providing adequate safeguards to committed patients through the operation of an ongoing system to review their legal status has been a major part of the comprehensive revision of the existing mental health legislation. This is a broad issue and covers a variety of processes and personnel. An important element - and a new one for New Zealand - is the proposal to set up regional mental health review tribunals, as an extension of current review processes, and to provide an independent review of the legal status of the 'involuntary committed. A discussion of these review tribunals is the focus of concentration in this paper. But it must be seen in the wider context and in relation to the other means of review, in particular, the 'hospital review' which, in the opinion of the Working Party is, and must remain, the most essential form of patient review and of protection against unnecessarily extended committal.

The present proposal is for mental health review tribunals of three people - a lawyer, a psychiatrist and a suitably qualified or experienced third person - with the primary function of considering applications against continued detention by committed patients or by others acting on their behalf. They will also be involved in reviewing the legal status of special patients, but not that of informal patients. Further, it is intended that these tribunals should have a role in the new consent to treatment procedures to be implemented.

The establishment of tribunals so that they operate in an efficient and effective way will be a complex task. Firstly, their terms of reference and areas of responsibility must be designed to ensure that they form part of, and make a contribution to, the overall review process; they must complement other review components. Secondly, it must be seen that the resources required in terms of tribunal and support personnel, and in administrative costs, can be justified in relation to the benefits likely to accrue. The difficulties in estimating these costs are referred to later.

The concept of mental health review tribunals is not new. The United Kingdom Mental Health Act 1959 provided for them. Under the Amendment Act of 1983, tribunals with extended powers, are to exist in every region where regional health authorities are constituted for the purpose of dealing with applications and referrals by, and in respect of, patients under the provisions of the Act. In Canada, all the provincial Mental Health Acts have provisions for appealing against admission as an involuntary patient, and in most
cases, the appeal is to a review board or panel of some sort. The Oakley Committee of Inquiry also recommended such tribunals be established.

EXISTING PROCEDURES FOR REVIEW AND APPEAL

Briefly, these procedures comprise:-

(a) **Sections 20-24 of the Act** - Court proceedings for reception orders. This is the judicial element of the compulsory admission process and it is intended that it should remain.

(b) **Section 34** - This provides for appeals against reception orders which are invalid, incorrect or deficient, and enables The Director of Mental Health or the Attorney-General to call for a fresh inquiry. Section 34 is not relevant in the context of this paper but it is believed that it should be retained, even though it is rarely used.

(c) **Section 55** - Under this section, superintendents are to keep the case of every committed patient (whether in hospital or on leave) under review. The Act states that within 1 month after the expiration of the period of 3 months following the date of a reception order, the superintendent shall have entered in his clinical records a description of the patient's medical condition and a statement why he/she should not cease to be a committed patient. Section 55 also requires that such Reviews be carried out within 1 month before both the first and second anniversary of the date of the reception order.

The Working Party believes that hospital reviews are of the greatest importance and that they should be, and be seen to be, regular, multi-disciplinary and thorough as regards both the clinical state and social situation of the patient and the options available at that time of the least restrictive setting for him/her. With this in mind, it is proposed that more emphasis should be placed on six-monthly reviews for all patients. New forms would be designed to take account of the involvement of health professionals additional to the psychiatrist in charge. Patients would be informed of their right to appeal to a review tribunal, in respect of their continued detention, and of the way in which this could be done.

(d) **Section 73** - This provides that, when a superintendent considers a patient not fit for discharge, a district inspector, official visitor, relative or friend may report the matter to the Minister. The patient himself may apply to the Minister for a hearing and may reapply at regular intervals. If the Minister so decides, a judicial inquiry is held, at which the district judge may order the patient's discharge.
It is not considered necessary to retain this section since appropriate provisions for appeals to review tribunals are to be provided under current proposals. There would be nothing to prevent patients, or others mentioned in the existing section, from writing to the Minister who would, in all probability, direct the applicant to the appropriate review tribunal. An independent multi-disciplinary tribunal rather than a Court would then conduct the hearing.

(e) Section 74 - This section allows for committed and special patients to apply through a judge for an inquiry to be held into their case. Section 74 is still required, even though it is rarely used. Special patients in particular, should be better informed of their rights to apply for an inquiry under this section.

SECTION TWO : REVIEW TRIBUNALS

As mentioned above, proposals for mental health review tribunals need to be seen in broad context and in relation to other processes for review, especially the hospital-level review on which the Working Party places much emphasis. Further, while the concept of review tribunals is based on the important principle that patients committed against their will should have the right to some form of independent review of their legal status, the benefits of its implementation must be balanced against possible costs. There must be an acceptance that review tribunals would be a worthwhile and warranted utilisation of limited resources of finance and suitably qualified personnel.

It has become clear that the Department's original proposals for review tribunals which would have involved regular, automatic review of all committed patients, would be very expensive indeed to implement. Matters requiring clarification include: the number, if any, of committed patients currently overlooked; the workload involved; the cost of each hearing (bearing in mind a British estimate of £250 per hearing, not including administrative costs); whether the considerable expenses involved could be better used elsewhere. These factors have an obvious bearing on the paragraphs below, particularly those relating to functions of tribunals and to the timing and type of tribunal hearing.

Issues discussed in the following sections are:-

1. Number, size and composition of tribunals.
2. Proposals for functions considered but not adopted.
3. Principal functions for New Zealand tribunals.
4. Consent to treatment procedures.
5. The review process - principal issues.
7. Review options.
8. Proposals for review.
9. Applications to tribunals.
10. Tribunal procedures.
11. Legal aid.
13. Appeals.

1. NUMBER, SIZE AND COMPOSITION OF TRIBUNALS

Because of the scattered population of New Zealand and the need for tribunals to meet frequently and rapidly, the department in its initial position paper (see Appendix 1) proposed that review tribunals should be established on a regional basis and that they should consist of three people: a psychiatrist, a lawyer and a lay person. The current view of the Working Party is that the third mentioned member could possibly be another health professional; in any case, such qualifications and experience should certainly not be a bar to membership of a tribunal.

It is now proposed that:—

(1) Official lists of persons (i.e. pools) from which tribunal members can be drawn, should be established in a number of regions to correspond geographically with the location of psychiatric services.

(2) The size of pools should depend on separate estimates of workloads, but should include at least one substitute member in each category. The work should be part-time only, enabling pool members to continue with their own professional work and with their community interests.

(3) Pool members should be appointed by the Minister of Health on the basis of recommendations made by the Director of Mental Health.

(4) A legal member should chair each hearing. Further, there should be a regional chairman, also a lawyer, who would be responsible for selecting pool members for individual hearings. It is considered desirable for membership of tribunals to vary from time to time.

(5) There should be a role for other health professionals. For example, there should be a social worker report where a patient's discharge from committed status is being considered.

(6) In establishing pools, account should be taken of the socio-cultural and sex distribution of committed patients in the region. However, it is appreciated that it might not always be possible to reflect this in respect of individual hearings.
(7) Appointments should be for 3 years but be staggered after the conclusion of the first term to provide the basis for rotation. Members would be eligible for reappointment, provided that their total term of appointment is not for more than six consecutive years.

(8) Members of pools should be adequately prepared for their role and informed of their full powers (e.g. by orientation).

(9) No person should be permitted to hear cases in which he/she has a close personal or professional interest.

(10) Members should be paid fees and travelling expenses in line with comparable statutory bodies.

(11) There should be sufficient administrative resources to ensure the efficient and effective operation of review tribunals. The resources required will vary in relation to the workloads of individual regions, but in each case the location of a base and the appointment of a Secretary to facilitate the smooth functioning of the tribunal will need to be considered. In some instances, additional administrative support will be required. Provision will have to be made for these resources and for continuing monitoring of the tribunal's operations.

In formulating the above proposals, consideration has been given to the various suggestions made for using the Family Court, or establishing a special Mental Health Division within it, for exercising functions considered appropriate for review tribunals. It is felt that, on balance, while such a development would have merit in terms of the nucleus of experienced professional staff which would be developed, it would not offer any greater protection for patients and would introduce an additional legal component, which would not be warranted and would be likely to be time-consuming. It is concluded that the department's present proposals represent the simplest and most effective way of dealing with the issues involved.

2. PROPOSALS FOR FUNCTIONS, CONSIDERED BUT NOT ADOPTED

Various suggestions have been made to the department for tribunal functions additional to those outlined in our original proposals. After serious consideration it is not proposed to proceed with them. The major suggestions examined are as follows:-

(1) Informal Patients

While it is clear that informal patients need to be advised of their rights and protected against the possibility of being kept in hospital in the absence of a real understanding of their circumstances for longer than
is necessary, there is not believed to be a case for including informal patients in the work programme of review tribunals. The Bill will provide for regular and multi-disciplinary hospital review procedures for all patients. Informal patients will also benefit from the improved scheme for Official Visitors and District Inspectors elaborated in Paper 12.

(2) Guardianship

In some overseas legislation — for example, in South Australia — provision is made for appeals to be made to tribunals against guardianship orders. In New Zealand's case, however, guardianship questions are being considered in a wider context, and by the Justice Department in proposed legislation discussed in Paper 13.

(3) Review cases of treatment under emergency procedures without patients' consent

It has been suggested by the Legal Information Service/Mental Health Foundation that a way of avoiding oversights in these areas would be to have a requirement that the use of all emergency procedures should be reported and explained to an independent tribunal which would then review the use of the procedures, and call and examine the doctor if it felt this necessary. Review tribunals will, as explained, have a role in certain aspects of the consent to treatment procedures (set out in Paper 7). However, the broad range of duties envisaged in the above proposals raise questions about the considerable clerical work involved, especially for medical staff, and about the qualifications of tribunals, as constituted, to assess the clinical validity of emergency treatments. Members would, of course, have the right to see clinical records of patients whose cases they reviewed or heard, and to call for relevant documentation. It would also be possible for tribunals in their reports to the Director of Mental Health to comment on the appropriateness of practices relating to patients whose cases they have considered. It should be noted further that district inspectors have access to patients' records and that hospital guidelines should provide for monitoring systems (including district inspectors and official visitors) so that all treatments given without consent are recorded in a readily checkable form. For these reasons, the proposals made for involving review tribunals in this way are not considered appropriate or necessary.

The above comments concern safeguards for patients. A second aspect of the suggestion relates to the actual recording of procedures being followed and to the use of such material in developing or monitoring codes of practice. In New Zealand's case, these matters are being considered in the context of Standards of Care (see Paper 14).
(4) Exercise powers similar to those of the United Kingdom Mental Health Act Commission
The Working Party does not believe it appropriate for tribunals to take on the inspectorial and monitoring functions of the United Kingdom Mental Health Act Commission (outlined in Appendix 3). One major reason is that the Commission has a national jurisdiction while tribunals will operate on a regional basis only. It is intended, however, that the tribunals should have the responsibility (elaborated later), of calling on suitable specialists to give second opinions on the use of treatments causing concern. This is similar to the second major function of the United Kingdom Mental Health Act Commission which has an authority delegated from the Secretary of State to appoint medical practitioners (including the psychiatrist members of the Commission itself). These powers are discussed more fully in Paper 7 on Consent to Treatment.

(5) The protection and vindication of patients' rights
These functions are not considered to be appropriate ones for mental health review tribunals since they can be achieved in the other ways set out in separate papers dealing with patients' rights, the roles of official visitors, and district inspectors, and consent to treatment procedures.

(6) Review of treatment plans
The Legal Information Service/Mental Health Foundation has proposed that all patients should have treatment plans and that these should be reviewed periodically. Review tribunals, it is suggested, should have the right to review and comment on these plans. Another suggestion which has been made is that the primary function of tribunals should be that of appeal, enabling any person to apply for an immediate inquiry, including a specialist review of treatment programmes. The Working Party agrees that the review of treatment plans is important but considers that these reviews should take place in hospital as part of the hospital review process. Tribunals will, of course, have the right to consider treatment alternatives (for example, in-patient or community treatment orders) as an intrinsic part of a patient's review. It is intended, moreover, that all reports of tribunals, including their comments on standards of care, should be sent to the Director of Mental Health.

3. PRINCIPAL FUNCTIONS FOR NEW ZEALAND TRIBUNALS
As outlined in the department's initial proposals, the primary responsibilities of tribunals will relate to reviewing the legal status of committed patients and to certain aspects
involved in appointing medical practitioners to give second opinions under the consent to treatment procedures. The latter function is mentioned first.

4. **CONSENT TO TREATMENT PROCEDURES**

Under current proposals, there are to be two categories of treatment for which special safeguards are required. These will be covered more fully in the context of the paper on Consent to Treatment. However, the proposed role of tribunals should be noted here.

It is intended that tribunals should have the following responsibilities.

1. **Under the first category of special treatment, including psychosurgery**

   a. In respect of consent, to verify the patient's understanding of the nature, purpose and likely effects of the treatment in question;

   b. to appoint a specialist to give a second opinion, who would be required to consult with the patient, relatives and/or friends as appropriate, and at least two other health professionals concerned with the patient's management. The written agreement of a second specialist would be required before treatment could commence.

   These provisions would apply to all patients and, in the absence of the patient's consent, treatment would not occur.

2. **Under the second category of treatment (including ECT and certain psychotropic drugs)**

   In the event that the patient's informed and formal consent cannot reasonably be obtained, to appoint medical practitioners as above. The second specialist called in by the review tribunal would consult with the patient, relatives or friends as may seem appropriate and at least one health professional concerned with the patient's management. These procedures would apply to patients under compulsory orders but not to informed patients.

   In respect of calling on medical practitioners to give second specialist opinions, it is intended that the chairman of each tribunal (or his deputy) should have access to a panel of suitable practitioners and that the department would be responsible for drawing up this list, in consultation with the appropriate professional associations. (See Paper 7, - Consent to Treatment.)
5. **THE REVIEW PROCESS - PRINCIPAL ISSUES**

It is essential that the review process should be seen as a whole. Within this context, several main aspects need to be considered.

1. The respective areas of, and relationship between, tribunal reviews and hospital reviews. It is reiterated that the Working Party sees the hospital-level review as the most important component of the review process, with tribunal reviews providing an additional and independent form of protection to committed patients.

2. Whether existing provisions - sections 20, 34, 73 and 74 of the Act providing for alternative judicial reviews or inquiries - need to be retained or superseded. The Working Party's views on these questions are covered in the earlier section of 'Existing Provisions for Review and Appeal'.

3. Whether in view of the heavy pressure on limited resources of finance and qualified personnel, the original proposal for automatic reviews, as well as hearings on application, can be justified.

4. The time frame for reviews, bearing in mind the additional work which will be placed on professional people as a result of tribunal reviews (for example, documentation required, attendances at hearings and so on). This will inevitably reduce the time available for normal clinical duties.

6. **RESOURCE IMPLICATIONS**

Points raised in (1) and (2) above have already been referred to elsewhere. Before decisions can be taken on (3) and (4) however, it is essential to note some figures relating to patient numbers and to the likely workload of tribunals under different systems.

Unfortunately, it has been extremely difficult to make any statistically acceptable projections even on the basis of numbers of patients who would be entitled to automatic review. The principle problem is that the patient population is not static and that it is not possible to estimate accurate numbers of patients eligible for review on the basis of bed occupancy and "trial leave" statistics at one fixed point. Projections of length of stay are extremely difficult to calculate and would have to allow for differences between regions, hospitals and patient-populations. However, in broad terms it can be seen that:

1. At the time of the bed occupancy survey in 1981, there were almost 4,800 committed patients.
(2) Patient numbers are highest in the early periods (especially the first three months) and decline significantly after one year.

(3) Long-term patients, committed for 4 years and over, amounted to almost one third of the total in 1981.

(4) The number of patients in 1981 who had been committed for over 6 months (and thus would be eligible to at least an annual tribunal review under the Department's original proposals) total almost 3,500.

When these statistics are considered, it is clear that the Department's earlier proposals would, in practical terms, place a considerable burden on review tribunals and those required to service them. The fact also has to be faced that there may not be a sufficient number of suitably qualified people prepared to devote to this work the time and dedication required. Above all, the financial cost of providing for automatic reviews for all committed patients at the time sequences envisaged, would seem to be unacceptably high.

7. REVIEW OPTIONS

In considering various review options, the Working Party has been guided by several relevant factors, viz:

(1) That the principal safeguard preventing patients from being detained in hospital when they are fit for discharge, or for transfer to some less restrictive environment will be the regular, formal, multi-disciplinary hospital review. (These will cover informal and special patients also) Review tribunals are not intended to be a substitute for these reviews but are designed to provide another tier in the process and an opportunity for review independent of the hospital system.

(2) That the concept of community treatment orders will provide committed persons with an alternative with fewer limitations than detention in hospital.

(3) That the interests of all patients, especially those who may not feel confident enough to initiate action themselves, will be better protected than they have been in the past by the increased emphasis to be placed on the roles and responsibilities of Official Visitors and District Inspectors and by improved orientation of, and contact with, such personnel.

(4) That, unlike the situation in the United Kingdom, there is an involvement of the legal process at 21 days.

With these factors in mind, consideration has been given to several alternative schemes - the objective being to provide sufficient safeguards to patients within the bounds of the
restricted resources which are available at the present time. These alternatives have sought to limit the number of possible reviews to a realistic proportion by:-

(1) Restricting numbers of automatic six monthly reviews that a patient may have to two, three or four reviews, with annual reviews thereafter a range of the order of 2,400 - 2,500 reviews every six months. (All figures used are rough estimates only).

(2) Restricting automatic reviews as above, but patients who have been committed for 5 years or longer would not be entitled to automatic reviews (between 1,650 - 1,775 reviews every six months).

(3) Restricting automatic reviews as (1) above, but limiting automatic reviews to hospital in-patients only and excluding patients in the community (about 1,100 - 1,220 reviews every six months).

(4) Limiting the number of six-monthly reviews as in (1) above and excluding both patients in the community, and those committed 5 years or longer (about 450 - 520 every six months).

After serious consideration, the Working Party concluded that the most effective solution is to include all committed patients in the scheme but to forego the idea of automatic reviews, as outlined below.

8. PROPOSALS FOR REVIEW

In coming to its conclusion, the Working Party is confident that the development of its proposals in respect of more regular hospital reviews, and a greater degree of involvement by Official Visitors and District Inspectors, will compensate for the scaling down of its original proposals which appear to represent an unattainable ideal in terms of the extensive resources required. Current proposals are:

(1) that all patients should receive regular six-monthly, formal, multi-disciplinary hospital reviews;

(2) that, while there will not be regular automatic reviews, the Bill will not exclude the possibility of a hospital board setting up additional 'automatic' reviews to test the workload and benefits of such a scheme. It may at some later stage be possible to amend the Act to allow, in the light of such research, automatic reviews;

(3) that where the outcome of hospital reviews is the continuation or renewal of committal orders (either in-patient or community treatment order), patients should be advised not only of their right to apply to a review tribunal for a hearing but also of the way to go about it;
(4) that Official Visitors and District Inspectors should be made aware of these arrangements so that they can advise and assist patients;

(5) that committed patients should be entitled to one appeal to a review tribunal in every six months period (but in the first period only after three months have elapsed).

There is, of course, no way of estimating the number of applications likely to be made. What can be said is that this system should limit the workload of tribunals to cases where, rightly or wrongly, some dissatisfaction is felt about the decision made by the hospital review group. It should also highlight the importance which should be placed by all people concerned on regular and thorough reviews at the hospital level.

9. APPLICATIONS TO TRIBUNALS

It is proposed that applications should be handled in the same way as in the United Kingdom:

(1) Applications from patients or relatives/others should be made in writing to the office of the appropriate Mental Health Review Tribunal for the area. (These addresses will need to be well publicised.)

(2) One application only would be permitted within each authorised period.

(3) An application that has been made but withdrawn in accordance with tribunal rules must be disregarded. (In the United Kingdom revised procedural rules are likely to require the agreement of the Chairman of the Tribunal before an application is withdrawn, to ensure that the withdrawal is not the result of improper influence or has not been decided on without consideration.)

10. TRIBUNAL PROCEDURES

Tribunals would be judicial in their powers and procedures and would be chaired by experienced lawyers.

The Working Party believes that the Act should provide for regulation-making powers as elsewhere, but that it would be preferable for tribunals to have written guidelines which they should all observe. These guidelines would cover such matters as:

- the provision of reasonable notice of hearings;
- the availability of relevant documents and information;
- the categories of people entitled to attend;
- the provision of statements of reasons for decisions made.
11. LEGAL AID

In New Zealand the scope of legal aid provided for under the Legal Aid Act 1969 is specified in Section 15. It may be that paragraph (h) of section 15(1) relating to proceedings in administrative tribunals would be applied; in this instance, legal aid may be given in any case where the District (Legal Aid) Committee considering the application is of the opinion:-

(1) that the case is one that requires legal representation having regard to the nature of proceedings and to the applicant's personal interest;

and

(2) that the applicant would suffer substantial hardship if aid were not granted. A means test is applied.

However, it would put matters beyond doubt if the legislation were to provide that legal aid procedure would apply in respect of mental health review tribunals; this matter will be further explored with the appropriate authorities.

12. POWERS OF TRIBUNALS

While the powers of tribunals will be elaborated in guidelines, it is intended that the revised Act should include a reference to them in a similar way to the South Australian Act where it is stated:-

'Unless the Tribunal is satisfied in proceedings under this section that there is good cause for the continuing detention of the patient (or custody of the protected person - not relevant in New Zealand's case), it shall direct that the order for detention (or custody) be discharged'.

The Bill will provide several options for New Zealand tribunals:

(1) discharge from the compulsory order;
(2) transfer from detention to a community treatment order;
(3) continuation of the order;
(4) adjournment of proceedings pending the receipt of further information or further investigation into alternative accommodation and so on.

13. APPEALS

Since it will be possible for appeals to be made to review tribunals at regular intervals, it is not considered necessary to provide for another appeal authority.
14. SPECIAL PATIENTS

Under the revised legislation, it is intended that Special Patients should have the same right to regular six-monthly hospital reviews as other patients. They would also be entitled to apply for a review of their continued detention in hospital by tribunals which will be independent of the hospital authorities. In the case of Special Patients, however, review tribunals will have recommendatory powers only. They would not have the authority to discharge, transfer or reclassify this group. Further details are included in Paper 6 entitled 'Special Patients'.

CONCLUSIONS

The concept of mental health review tribunals is a complex one and is dealt with at some length in this paper. The main points to be considered are set out in the subsections of the section entitled 'Review Tribunals - Major Issues', especially the Working Party's principal proposals in subsection 8 'Proposals for Review'.

SECTION THREE : LEGISLATIVE PROPOSALS

1. That regular six monthly hospital reviews be conducted for all categories of patient: that is, informal, compulsorily admitted and special patients.

2. That the hospital review be primarily concerned with the patient's clinical condition, but will also involve consideration of social and legal factors.

3. That all health professionals closely involved in the patient's care and treatment should take part in the hospital review.

4. That forms used in documenting such reviews will indicate this multidisciplinary involvement.

5. That if the hospital level review does not occur at the appropriate time, the compulsory order will lapse.

6. That, after the hospital review has taken place, the patient be informed of any decision made concerning his/her legal status, and of his/her right to apply for a hearing by the Review Tribunal, if wanted.

7. That regional Review Tribunals be established.

8. That each tribunal panel consist of a lawyer, who shall be the chairperson, a psychiatrist, and a third person, who could be a health professional or a lay person.

9. That panels be drawn from regional pools, consisting of at least two persons in each of the above categories.
10 That each regional pool have a chairperson, who would be one of the lawyers.

11 That appointments of pool members be for three years, renewable for one further three year term.

12 That no person should be permitted to hear cases in which he/she has a close personal or professional interest.

13 That pool members be paid fees and travelling expenses in line with comparable statutory bodies.

14 That the functions of the Review Tribunal be to review the case of any compulsorily admitted or special patient who applies to the tribunal in his/her region.

15 That patients may apply to the tribunal at intervals of not more than once every six months; but that their first application may be within three months of admission.

16 That persons other than the patient, such as friends or relatives, may apply for a hearing on the patient's behalf, but must state in writing the nature of their relationship to the patient, and their reasons for seeking the review.

17 That a decision to proceed with a hearing, when a person other than the patient has made the application, be at the discretion of the pool chairperson.

18 That the Review Tribunal focus on the legal status of the patient, but will also involve consideration of clinical and social factors.

19 That Review Tribunals have a function in relation to consent to treatment procedures, particularly in relation to obtaining second opinions.

20 That Review Tribunals have the authority to make decisions:

(1) in relation to patients under compulsory orders to:
   - discharge from the compulsory order
   - transfer the patient from detention to a community treatment order
   - continue the order
   - adjourn proceedings;

(2) in relation to special patients, to make recommendations to the appropriate authorities.

21 That the new Bill will contain provisions equivalent to the present section 34 (which provides for appeal against reception orders alleged to be invalid, incorrect or deficient) and Section 74 (which allows committed and special patients to apply to a judge for an inquiry into their case).
22 That section 73 of the 1969 Mental Health Act will be repealed.
Psychiatric Hospitals: Committed Patients by Length of Stay

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<tr>
<th>Length of Stay</th>
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<td>6 - 9 months</td>
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Source - National Health Statistics
SECTION ONE : PRESENT PROVISIONS

(1) Appointment

Every psychiatric hospital or institution is required to have a superintendent, who must be a medical practitioner. The appointing authority is in all cases, with the exception of Lake Alice (administered by the Department of Health), a hospital board.

(2) Responsibilities and Authority

The superintendent can delegate any of his/her responsibilities and powers under the Act to any other medical officer of that hospital (Section 4). Furthermore, any medical officer employed as a psychiatrist in a psychiatric hospital may exercise, without delegation, all or any of the powers conferred on the superintendent by the Act, in respect of any informal or committed patient.

The statutory responsibilities of the superintendent fall into several areas: admission of patients, review of their status, the keeping of records, leave of absence, transfer and discharge.

(a) Admission - Informal Patients: The superintendent is to use his/her discretion in admitting any person expected to benefit from psychiatric care or treatment;

the superintendent may apply for a reception order for any person, who has been admitted informally to the hospital, whether in the hospital at that time or not.

Committed Patients: On receipt of an application for compulsory treatment, and of certificates signed by 2 medical practitioners, the superintendent may, within 7 days, detain the person alleged to be mentally disordered, in that hospital. When the patient's immediate admission is considered necessary, the superintendent may detain that person on the basis of one medical certificate.

The District Court will be notified within 21 days, and shall initiate procedures for issuing a reception order.
(See Paper 3 on Compulsory Admissions; and 5 on Procedures Informal Patients)

(b) Review of Patient Status - It is the superintendent's responsibility to keep under review the case of every committed patient in hospital. (See Paper on the Review Process).

(c) Record-keeping and Reporting (Sections 51-53) - The superintendent is to keep a register of admissions and discharges, and a register of restraint and seclusion. Other records are to be kept as the Director of Mental Health requires.

Superintendents are required to report regularly to the Director of Mental Health. However, section 123(4) also provides that the Director, by written notice, may dispense with the sending of any notices to him/her. As a result, only papers relating to special patients are routinely forwarded.

A copy of any review of patient status is to be sent to the Director (Section 55).

Within 14 days of discharge, transfer, or absence of any patient, the director is to be informed. Notice of death, its apparent cause, and a report from a staff member present, are to be forwarded to the Director if any patient dies.

(d) Transfer - The superintendent may transfer a committed patient to another hospital with the concurrence of the superintendent of that hospital. Special patients may be transferred with the approval of the Director of Mental Health.

(e) Leave of Absence and Discharge - The superintendent may grant patients leave of absence for up to 24 months, and this time period can be extended with the approval of the Director of Mental Health (Section 66). While on leave, a patient may be discharged. Leave may also be cancelled, and the patient returned to hospital by the director or superintendent, or someone acting for them.

(3) Offences

There are 2 offences under the Act which apply to superintendents only:

(a) The wilful omission of any information in notices, statements or entries required under the Act, or the deliberate supply of false or misleading information in those statements (Section 109(1)).
(b) Receiving or detaining in a licensed institution, of which Ashburn Hall is the only example, a greater number of patients than the institution is licensed to take (Section 109(2)).

Other offences, for which the superintendent may be held liable, also apply to any other employee of psychiatric hospitals or institutions. These offences include the neglect or ill-treatment of patients, (section 112), sexual intercourse with a mentally disordered female, (section 113), and supply of liquor to mentally disordered persons (section 114).

SECTION TWO : POINTS CONSIDERED

1  NON-MEDICAL SUPERINTENDENT

It is the policy of the Department of Health that there shall be medical superintendents in New Zealand hospitals. It is interesting to note that other methods of management exist overseas, and some aspects of such management are already utilised in this country. For instance, there is an increasing awareness that other persons than the medical superintendent have a major role to play in the administration of hospitals; it is increasingly the norm that administrative structures will not be limited to the medical superintendent, but will also include the head nurse and administrator. Thus, some hospitals already function in management by a small panel.

Legislation will continue to provide that the superintendent of a psychiatric hospital will be a medical practitioner. In practice it is likely that hospital management will be shared, but this will vary from hospital to hospital.

2  RESPONSIBILITIES AND AUTHORITY

(a) Hospital superintendents, as provided in the Hospitals Act, are responsible for monitoring the quality of care provided by the hospital, and ensuring that the hospital provides a high standard of care. This responsibility, and standards to measure the quality of care, should be covered in greater detail in guidelines.

(b) Superintendents should remain ultimately responsible for the functioning of the hospital. They should also, as is currently provided, be able to delegate any of their powers and responsibilities under the Act to the most appropriate person. The current situation whereby medical officers employed as psychiatrists are able to exercise the superintendent's powers without delegation, will be repealed. In the Superintendent's absence, a Deputy Superintendent will exercise all the Superintendent's powers and responsibilities.
Superintendents should ensure that information on rights has been given to patients, and that the latter understand those rights and provisions. Superintendents should also ensure that when appropriate, the help is enlisted of persons who speak the same language as the patient, or who come from the same cultural background. For further information on this subject, see Paper II on Patients Rights.

The Bill will recognise that all patients have the right to treatment, and superintendents and supervisory staff will have the responsibility of ensuring that an individual treatment plan is being followed.

Superintendents will maintain responsibility for internal hospital reviews. Review Tribunals are also to be set up (see Paper 8 'The Review Process'), and arrangements must be established for referral to tribunals as required.

At present discharge procedures are very informal. These procedures need to be elaborated. Superintendents should be responsible for informing the patient, and, on the patient's request, any other person, when a patient is about to be discharged. If a patient is discharged while on leave, he/she should be informed in writing. Standards for discharge, should be set. While this matter will be largely covered in Guidelines, it is proposed that there be a statutory requirement to inform the patient of his/her discharge.

Written rules on the rights and obligations of hospital staff and administration are already covered by hospital by-laws.

The superintendent's role in monitoring the confidentiality of patient's records, and in providing patients and relatives with such information, is already covered by the Hospitals Act (which also applies to psychiatric hospitals). More details will be covered by Guidelines.

Psychiatric hospital superintendents should be required to liaise with, and periodically report to, the board to which that hospital is responsible, through the medical superintendent-in-chief. This, again, is not a matter for legislation, but is covered by Hospital Board policy and by-laws.

Penalties for failure to discharge duties will be revised. Offences punishable by summary conviction in Court should be provided in the following circumstances:
(i) when without due course a superintendent causes a person to be detained

(ii) the superintendent knowingly permits an offence against the Act or against a patient.

Sections of the Mental Health Act should be amended to provide that sexual intercourse with a psychiatric in-patient, not only a mentally disordered female, is an offence.

SECTION THREE: LEGISLATIVE PROPOSALS

1 That legislation will continue to provide that superintendents of psychiatric hospitals be medical practitioners.

2 That superintendents be ultimately responsible for the functioning of the hospital.

3 That superintendents may delegate any of their powers and responsibilities under the Act to whoever is considered most appropriate.

4 That in the superintendent's absence, a Deputy Superintendent will exercise all the Superintendent's powers and responsibilities.

5 That the section in the 1969 Act which provides that any medical officer may exercise any or all of those powers without specific delegation, shall not be included in the new Act.

6 That superintendents should ensure that an individual treatment plan is drawn up and followed for each patient.

7 That the superintendent should ensure all patients are notified of their discharge, in writing.

8 That offences punishable by summary conviction in Court be provided when:

(1) without due cause the superintendent causes a person to be detained

(2) the superintendent knowingly permits an offence against the Act, or against a patient.

9 That sexual intercourse with a psychiatric in-patient is an offence.
ROLE AND FUNCTIONS OF HEALTH PROFESSIONALS IN THE IMPLEMENTATION OF THE MENTAL HEALTH ACT

INTRODUCTION

Many of the Working Party's thoughts on the role and functions of health professionals in implementing the new Act have been directly or indirectly expressed in the preceding papers, in particular in paper 3 Compulsory Admission: Criteria and Procedures; paper 7 on Consent to Treatment and paper 8 on the Review Process. The purpose of this paper is to summarise those provisions which relate specifically to the functions of health professionals.

SECTION ONE: THE ROLE AND FUNCTIONS OF MEDICAL PRACTITIONERS

In relation to the other groups of health professionals, medical practitioners will continue to take the major statutory responsibility in decisions relating to the admission and treatment of patients to psychiatric facilities.

The Working Party originally proposed that there should be a 'special register' of psychiatrists who alone would be required to sign certificates relating to compulsory admission or treatment. This proposal met with a number of criticisms, both because it was felt by some that the person with most knowledge of the patient, i.e. the general practitioner, was the most appropriate person to be involved in compulsory admission procedures; and also it was believed that it would be impractical to expect a sufficient number of 'special register' psychiatrists to be always available in cases where compulsory admission should be considered.

The Working Party recognises the validity of these points, and both for these reasons and because it had agreed to prepare a more flexible and 'staggered' approach to compulsory admission than had been first envisaged, decided to revise its original proposal. It is instead suggested that as each step in the compulsory admission procedures is taken, (i.e. assessment interview, 3 day order, 21 day order, community treatment order, in-patient order), a corresponding 'higher' degree of specialisation and expertise is required. This concept could be implemented as follows:-

First medical certificate for compulsory assessment interview:
- general practitioner

Second Medical Certificate made on completion of the compulsory assessment interview:
- a specialist or a medical practitioner to whom a Medical Superintendent has delegated his/her powers.
Certificates relating to:
- 21 day orders
- in-patient orders
- community treatment orders

will be completed and signed by a medical practitioner to whom the Medical Superintendent has delegated his/her powers, and should in most cases be a specialist psychiatrist.

Those other statutory functions in relation to the Mental Health Act - discharge of patients, reviews, consent to treatment procedures, - will be vested in the Medical Superintendent. The Superintendent may delegate these powers to a medical practitioner.

SECTION TWO: THE ROLE AND FUNCTIONS OF HEALTH PROFESSIONALS OTHER THAN MEDICAL PRACTITIONERS

An important trend in recent years has been an increased awareness of the role of health professionals other than medical practitioners. The concept of the 'multi-disciplinary' team has been widely accepted and is recognised as a vital aspect of modern psychiatric care.

An important theme in the Working Party's discussions has been therefore the question of whether and how the multi-disciplinary concept and the input of non-medical health professionals should be incorporated in mental health legislation. It has been decided to include a reference to these concepts in the objectives which will be a part of the new Bill, for example, to ensure that mental health services are delivered by a range of health professionals in a range of health settings. It is envisaged that this objective should be borne in mind by all those responsible for implementing the new Act. In the main, however, it is believed that the 'multi-disciplinary' team concept should be fostered by means of a continuing emphasis in training and through the standards and guidelines which will be produced following the enactment of mental health legislation.

One most important role which was, however, envisaged for non-medical health professionals was that of 'mental welfare officer' or 'approved social worker'. In our original proposal it was suggested that 'designated health professionals', who would have special experiences and training would have a role specially related to the Mental Health Act.

The purposes of this proposal were to broaden and improve the quality of advice available to mentally ill people, their families and friends, to ensure that a knowledge of all available treatment options was known to all concerned, to take the responsibility of initiating compulsory admission procedures from relatives and friends, and to ensure that the
rights of mentally ill people were safeguarded and to act as advocates, where appropriate, on their behalf. This proposal received a considerable number of comments, both in favour and against. These comments have been extensively reviewed, and the Working Party has carefully examined some of the implications of its original proposal. As a result of this further review the Working Party has decided not to incorporate the concept of a 'designated health professional/mental health officer' or 'approved social worker' in its proposed Mental Health Bill; the reasons being as follows.

Firstly, the concept of 'approved social worker' in the British legislation involves a recognised statutory group. No such recognised group exists in New Zealand. Furthermore, although the option of approving individual social workers for the purposes of the Mental Health Bill could possibly be considered, the fact remains that there are not enough social workers spread sufficiently both in urban and rural areas in New Zealand to make an adaptation of the English system a practical proposition. Moreover, even in the United Kingdom, a great number of practical problems appear to have been experienced.

Objections to the concept have also been based on more philosophical considerations, namely that it is generally agreed by the profession that social workers are reluctant to accept and exercise statutory power, and that such a power often conflicts with many of the professional attitudes and values of social workers.

However, social workers do already fulfil and should be further encouraged to fulfil many of the functions outlined above for the designated health professional in providing support and advice for patients, relatives and medical practitioners. These functions are also carried out by other groups of health professionals. The Working Party did not consider it a practical proposition to give statutory recognition to a new group - with a title such as mental health officer/worker - drawn from all groups presently working in the community health area; however it was considered that further thought should be given to informally creating a small cadre of persons to assist in the community. Such persons would require additional training.

As we are not proposing that any specific group will be responsible for initiating compulsory assessment/admission procedures, the Bill will state that such applications can be made by any person.

Section 21 of the present Act indicates a preference for a relative to initiate an application for a reception order. The Working Party does not agree that this statutory preference for relatives is necessary and the wording of the Bill will therefore be completely neutral.
There will, however, be some statutory references to the functions of health professionals other than medical practitioners in the new Bill, as follows:-

(1) **Compulsory Orders:** in addition to medical certificates, the District Court Judge will have to have available to him, when considering making an 'in-patient order', a report from at least one health professional, in addition to, a medical practitioner.

(2) **The Review Process:** although the statutory hospital level review will be signed by the medical practitioner as the head of the team responsible for the care of the patient, the involvement of other health professionals will also be required and their signatures will indicate their involvement.

(3) **Consent to Treatment:** As outlined in paper 7, consultations with other health professionals involved with the care of the patient is required in respect of special treatments.

In addition, some of the forms to be used in, for example, compulsory assessment or admission procedures, will require an indication that other health professionals have been involved. The principle means by which broader health professional involvement and responsibilities will be recognised and encouraged will be, however, as previously indicated, by appropriate training, standards of care, and guidelines for use in implementing the Act.

**SECTION THREE : LEGISLATIVE PROPOSALS**

1. **Medical Practitioners**

(1) that the first medical certificate initiating a compulsory assessment interview usually be completed by the persons general practitioner.

(2) that the second medical certificate made at the conclusion of the compulsory assessment interview be completed by a specialist psychiatrist or a medical practitioner to whom a Medical Superintendent has delegated his/her powers.

(3) (a) that certificates relating to - 21 day orders - in-patient orders - community treatment orders; and

(b) documents relating to - discharge - review - consent to treatment - transfer etc.

be completed by a medical practitioner to whom the Medical Superintendent has delegated his/her powers.
2. **Other Health Professionals**

(1) *that any* person may initiate compulsory assessment/admission procedures.

(2) *that health professionals* other than medical practitioners have statutory functions relating to
- compulsory orders
- the review process
- consent to treatment
The issue of patients' rights is one which creates much interest and some dissenting opinion. There can be little disagreement about the need for psychiatric patients to retain as many of their normal rights as are consistent with their state of health and their place of residence, either in hospital or in the community. However, while support can be given to the principle that rights should, as far as possible, be the same for those in general and in psychiatric hospitals, it must be recognised that there is often a basic difference between the two groups relating to mental capacity and impairment of judgement. This adds a complexity to such issues as consent to treatment and the management of property. Another issue which merits attention is the extent to which any difference in the rights accorded to committed, special and informal patients can be justified.

The first part of the paper deals with issues relating to patients' rights; most of these are more relevant to in-patients than to those on community treatment orders. It must be noted that several of the more fundamental safeguards relating to restrictions on liberty and on decision making - that is, appropriate assessment and committal procedures, adequate review processes, consent to treatment procedures and management of property - are covered in other papers.

The second part refers briefly to the ways in which such rights can be reinforced and by whom. There will be differences dependent upon whether the rights are encoded in legislation, are set out in hospital guidelines or a Code of Practice, or are, simply, based on standard hospital practice (adjusted, as appropriate, to local needs). Many hospitals already have written statements of patients' rights displayed for all to see.

Before considering this subject further, several points should be made.

Firstly, as community facilities develop there will be an increasing emphasis on the exercise of rights of committed patients in this environment rather than in hospitals. Secondly, it should not be overlooked that patients also have responsibilities. Finally, and very importantly, in attempting to assess at any moment the correct balance between freedoms and restrictions in the care of patients, it is essential to bear in mind that the best possible treatment should be provided to patients, and that is the objective of health professionals responsible for their care. As has been said 'The physician seeks to liberate the patient from the chains of illness, the judge from the chains of treatment. The way is paved for patients to rot with their rights on.'
SECTION ONE: ISSUES

The paragraphs below are concerned with issues relating to patients' rights and, in some cases, restrictions on those rights. It will be evident that the Working Party has been considerably assisted by the relevant recommendations of the Legal Information Service/Mental Health Foundation in the extensive and helpful report of its Task Force.

It has been suggested that many of the restrictions on in-patients' rights are unnecessarily broad or open to subjective interpretation.

The question has been raised as to whether psychiatric in-patients should be guaranteed by statute a number of enforceable rights. The Working Party considers that it would not be appropriate to encode all these rights in legislation. Some are more suitable for incorporation in hospital guidelines or a Code of Practice; some are good hospital practice. It is intended, however, that references to standards of care and to a Code of Practice will be included in the revised Act and, further, that arrangements will exist for such guidelines to be drawn up by an expert Committee, and kept under review.

1 THE RIGHT TO TREATMENT

The concept of a legally enforced right to treatment is primarily a US development and has been incorporated into the mental health legislation of a number of American States. It has also been included by the American Psychiatric Association in its 'Guidelines for Legislation on the Psychiatric Hospitalisation of Adults'. Some of their guiding principles for legislation are:

(1) that 'treatability' is a criterion governing committal;

(2) that without adequate and appropriate treatment, confinement is no more than preventive detention;

(3) that recognition of a right to treatment does not necessarily place a corresponding duty upon the patient to accept the treatment offered;

(4) that exceptions exist in respect of those who are too gravely incapacitated to survive outside hospital, provided that hospital is the least restrictive placement. Such people can be hospitalised for 'asylum' and, as not-treatable, do not need treatment.

The Working Party has decided to include in the new Mental Health Bill a list of objectives, one of which will be to ensure that patients receive the best possible care and treatment. Any patient who considers that he/she is not receiving active treatment, may if he/she wishes, apply to
have his/her case heard by the Review Tribunal (see Paper 8 on Review Process). The patient could also communicate his/her concerns to Official Visitors or District Inspectors.

2 VISITING

In broad terms, the Working Party believes that the status quo is satisfactory, that is, the policy should be that all patients have the right to be visited, but that in particular circumstances superintendents have the responsibility and discretion to curtail visiting rights, in furtherance of legitimate hospital objectives or where, for example, it would be detrimental to a patient's treatment. These policies are incorporated in hospital board by-laws - a general reference to which will be made in the new Bill.

3 COMMUNICATION

The Working Party believes, and the Bill will state, that all patients have a general right to communication with persons and organisations outside the hospital. Communication is to be understood in a broad sense, but principally by post and by telephone. Legislation will not specifically allow for, for example, right to access to telephones, but guidelines and standards will make clear that patients have reasonable and private access to telephones. The only legislative restrictions in the new Bill will relate to mail.

CENSORSHIP OF MAIL

The Working Party believes that, in practice, provisions in the Mental Health Act 1969 concerning the censorship of mail are not often exercised. It proposes that procedures in this area should be revised as follows:-

(1) as at present, mail to, or by, an informal patient should not be read or withheld;

(2) mail sent by a compulsorily admitted or special patient should be withheld only if the person to whom it is addressed has requested that communication to him or her by the patient should be withheld;

(3) mail sent to a committed patient should not be read or withheld;

(4) mail sent to a special patient may be opened and withheld if the superintendent believes this is necessary to prevent the patient being a danger to self or others;

(5) all patients should have, in a provision similar to that in the present Mental Health Act, an absolute right to correspond with certain listed persons. These would include:-
a Minister or MP;
- the Ombudsman;
- any Court or Tribunal;
- the Director of Mental Health;
- the District Inspector and Official Visitors;
- the Medical Superintendent;
- any legally qualified person instructed by the person;
- the person's usual medical practitioner;
- the person's usual religious or spiritual adviser
- any mental health professional in relation to proceedings or proposed proceedings;
- the person's advisor or mentor (pursuant to the Incapacitated Persons Welfare Bill);
- the person's manager (pursuant to the Incapacitated Persons Property Bill).

The Working party believes that details of procedures relating to censorship of mail should be contained in guidelines.

(1) Where, in the case of special patients, Superintendents have opened and inspected incoming correspondence, a record must be placed in the postal article before it is resealed. This should include the name of the person who opened it, and, if an item is not passed on, the grounds on which it was withheld. The district inspector or official visitor should be entitled to view such withheld correspondence.

(2) Complaints about the withholding of mail should be addressed to Official Visitors or District Inspectors.

(3) When mail sent by a patient is withheld the patient must be notified within 7 days. When mail is withheld from a special patient the person who sent it (if known) must be notified within 7 days. The notification must include information concerning access to review of the decision.

4 VOTING

There are no restrictions in New Zealand on the normal voting rights of informal or committed patients. Prisoners and some patients entering hospital via the criminal justice system are disenfranchised. There are a number of anomalies. For example, persons detained under section 39G (2) as committed patients following an acquittal on account of insanity retain the vote; persons detained as committed patients under section 39J following a conviction are disqualified. Further, the disqualification applies only to national and not municipal or local body elections.

The voting rights of prisoners were considered by the Penal Policy Review Committee which reported:
'The right to vote has nothing to do with the loss of personal liberty and accordingly should remain as one of the attributes of a citizen ... A majority of the committee recommends that all prisoners should be entitled to vote.'

The Legal Information Service/Mental Health Foundation notes that these comments apply even more strongly to psychiatric patients and recommends that S 42(1)(c) of the Electoral Act 1956 should be repealed accordingly. The Working Party agrees, and intends to consult with the Justice Department with a view to amending the legislation to bring it into line with current philosophy on civil rights in this area.

5 DRIVERS' LICENCES

At present, section 26 of the Transport Amendment Act 1983 prohibits any special or committed patient from using his/her driver's licence. The licence is considered to be suspended, and should be retained by the Medical Superintendent, who may, on discharge, return the licence, or forward it to the Ministry of Transport.

The Working Party considers that:-

(1) there should be no automatic link between committability and the right to hold a driving licence, particularly now that the intention is to have different types of committal (eg community treatment orders). The Transport Act would, therefore, need to be amended.

(2) those patients whose illness or medication would make them unsafe to drive should have their licences suspended until such time as they are considered safe to drive. This would apply to all patients, and will be covered by guidelines.

(3) people involved with the assessment of patients' ability to drive safely should be, firstly, the admitting doctor and, later, the doctor and/or other health professionals responsible for the patients' care and treatment. Guidelines for doctors should identify particular types of treatment and forms of illness which would be contraindicative for driving. Admission forms should include space for doctors to note patients' suitability to drive.

(4) superintendents certifying that patients are unfit to drive on discharge should be obliged to provide written reasons for their decisions, and the length of time for which it is considered that revocation should apply. Patients should be informed of this, and of their right to appeal the revocation. This would be a matter for guidelines.
patients should have the right to apply for a review of an adverse decision, the review taking the form of a second medical opinion, and a decision made by the Ministry of Transport's medical personnel. This would bring procedures for psychiatric patients into line with those of other groups considered unfit to drive for medical reasons. This would again require amendment to the Transport Act.

persons making a new application should be included under the same provisions as other persons whose licences have been revoked on medical grounds. At present there appears to be nothing to prevent psychiatric patients, whose licences have been revoked, from applying for a new licence. This should be drawn to the attention of the Ministry of Transport.

6 FIREARMS LICENCES

The Arms Act provides in section 24 for the issue of firearms licences, in section 27 for the revocation and surrender of licences, and in section 62 for appeal to the District Court against refusal or revocation of a licence. While the Act does not specify persons who are not 'fit and proper' persons to hold licences, guidelines list certain groups considered unsuitable; this would include psychiatric patients.

The position relating to firearms is far less specific than in the case of drivers' licences, and while revocation applies to all psychiatric patients regardless of their status, the mechanics of policy notification is not so clear cut. The Police suggest that superintendents should be required to notify them of admissions of patients holding firearms licences. The Working Party agrees with this suggestion, and that these licences should be temporarily withdrawn by the Medical Superintendent while patients are undergoing treatment. It also seems reasonable, however, that a discharged patient should be able to reapply for a licence and that, as long as medical certificates support the application, it should not be impossible for him/her to acquire a licence again. While caution is clearly essential, procedures which automatically associate psychiatric treatment with the need to permanently prevent ex-patients from possessing firearms licences, serve to reinforce in the public mind a connection between psychiatric illness and dangerousness which is not warranted.

7 ACCESS TO RECORDS

Section 29 of the 1969 Act permits persons to inspect records relating to their detention in hospital. It should also be noted that the Official Information Act is the main piece of legislation dealing with issues such as access to records. This Act does not, at present, apply to psychiatric and general hospitals, except Lake Alice.
The Working Party proposes that a section similar to the present section 29 should remain and will apply to all compulsory orders.

While the Working Party agrees it is often reasonable that patients should have information about themselves, the decision to provide such information should remain as at present, at the discretion of hospital staff concerned. If further legal expression is required, this should be incorporated in an amendment to the Official Information Act.

8 MARRIAGE

The Working Party has given some thought to the proposal by the Legal Information Service/Mental Health Foundation that the right of psychiatric patients to marry unless they are 'unable to appreciate and understand the nature of obligations of the marriage contract' should be included in any list of enforceable rights. At present there is no statutory ban to marriage by mentally disordered persons.

The Working Party does not believe there is any need to change existing legislation. However, since people may be uncertain about it, it is proposed that a clear statement about the right of mentally ill people to marry should be incorporated in some easily accessible, easily readable guide for the use of staff, patients, relatives and friends.

9 PATIENT LABOUR

In the Legal Information Service/Mental Health Foundation's report, it is recommended that no patient should be required to perform non-therapeutic labour, that those who perform such labour voluntarily should be compensated accordingly, and that regulations governing patient labour should be passed under the Mental Health Act.

In discussing this question, the Working Party notes that work is often a very important element of treatment and rehabilitation programme, but that it is difficult to say in every instance whether it is therapeutic or not. Although sections 126 (e) and (i) of the Act provide for the making of regulations relating to the employment of patients and to the carrying on of agricultural, industrial or commercial pursuits, guidelines are considered to be more suited to this purpose, and should include reference to payment.

10 THE USE OF SECLUSION AND RESTRAINTS

The provisions in the 1969 Act requiring documentation of restraint and seclusion will be retained. Although it has been suggested that procedures should be more clearly laid down by means of regulations under the Mental Health Bill, the Working Party believes that details of procedures, purpose, time periods and personnel involved would most appropriately be dealt with by guidelines.
11 REMOVAL FROM NEW ZEALAND

Attention has been drawn to section 72(1) of the Act which provides the Minister of Health with a power to remove a committed patient to any place outside New Zealand under certain circumstances. A patient removed in this way is deemed to have been discharged. With the agreement of the Minister of Justice, this power may also be exercised in respect of a special patient. The Legal Information Service/Mental Health Foundation claims that this is a drastic power and very little guidance is given to the Minister as to its exercise. It is recommended that the Minister's power should be structured in a similar way to that of the Home Secretary in the United Kingdom.

The Working Party considers that although the powers provided under section 72(1) do not appear to be much used, it would be harmful to remove the section. It is proposed that the section should:

(1) apply to committed patients only;
(2) be on the basis of professional opinion and in the best interests of the patients;
(3) be consequent upon the existence of relatives or friends willing to undertake care in the receiving country;
(4) depend on satisfactory evidence that appropriate treatment is available and arranged;
(5) not be restricted to aliens only (eg New Zealanders with families abroad would be included).

It is further proposed that the Minister should act on the recommendation of professional opinion, and that the question of allowing a right of appeal to a Mental Health Review Tribunal should be debated. The ultimate decision should, however, rest with the Minister.

SECTION TWO : ENFORCEMENT

The Working Party has spent much time considering how patient rights should best be enforced and safeguarded. Several suggestions have been made - the establishment of a Mental Health Act Commission, Mental Health Review Tribunals, Patients' Advocates and the repeal of section 124 of the 1969 Act. (This section protects any person 'acting in pursuance or intended pursuance of the Act' against legal proceedings, unless the person has acted in bad faith or without reasonable care.)
Our conclusions on these suggestions are:-

- that a Mental Health Act Commission is not considered necessary, nor a practicable proposition in New Zealand as its functions will be fulfilled by other means (see Appendix 3);

- that the function of Mental Health Review Tribunals will be primarily to review legal status (see Paper 8 on Review Process);

- that because of the roles of Official Visitors and District Inspectors, there is no need for an additional system of independent advocacy (see Paper 12);

- that Section 124 'Protection of Persons Acting Under Authority of Act' should remain in the new Bill, as this does not act as a barrier to patients initiating legal action against health professionals, and it is strongly believed that these professions should not be inhibited in the exercise of their powers in the best interests of patients.

Safeguards already exist, though ways of improving them and making them better known should be considered. The Working Party believes that patients' rights will be safeguarded in the following ways:-

1. Avenues for complaint including official visitors, district inspectors, social workers, hospital boards; the Director of Mental Health and the Minister will continue to be available;

2. Psychiatric patients will be provided with more information on their rights, and the avenues of complaint available to them;

3. Guidelines and a Code of Practice will establish standards of care, and ensure that staff are aware of their responsibilities in relation to patients' rights (see Paper 14);

4. Individual hospitals will be responsible for drawing up their own statements of rights, and ensuring that a summary is displayed, in easily readable form, in every ward. A health professional will be responsible for ensuring that all patients are aware of their entitlements - perhaps there should be a person assigned on each ward to do this;

5. The Hospitals Act 1957 provides that Department of Health staff have a statutory role in inspecting hospitals and ensuring high standards of care are maintained.

SECTION THREE : LEGISLATIVE PROPOSALS

1. that one of the objectives of the Mental Health Bill will be to ensure that patients receive the 'best possible care and treatment'.
that a provision similar to that in the 1969 Act, relating to the right of patients to be visited, be retained.

3 that all patients have a general right to communication with persons and organisations outside the hospital.

4 that, as at present, mail to, or by an informal patient should not be read or withheld.

5 that mail sent by a compulsorily admitted or special patient be withheld only if the person to whom it is addressed has requested that communication to him/her by the patient should be withheld.

6 that mail sent to a committed patient should not be read or withheld.

7 that mail sent to a special patient may be opened and withheld if the Superintendent believes this is necessary to prevent the patient being a danger to self or others.

8 that all patients have an absolute right to correspond with the following persons:-

- a Minister or MP;
- the Ombudsman;
- any Court or tribunal;
- the Director of Mental Health;
- the district inspector and official visitor;
- the Medical Superintendent;
- any legally qualified person instructed by the patient;
- the person's usual medical practitioner;
- the person's usual religious or spiritual adviser;
- any mental health professional in relation to proceedings or proposed proceedings;
- the person's mentor/adviser, pursuant to the Incapacitated Persons Welfare Bill;
- the person's manager, pursuant to the Incapacitated Persons Property Bill.

9 that superintendents have the responsibility of notifying the Police of admissions of patients holding firearms licences.

10 that patients retain the right (as in Section 29 of the 1969 Act) to ask to inspect records relating to their detention.

11 that sections which provide for the making of regulations in relation to the employment of patients (Section 126(e) and (i) be retained.

12 that documentation of Restraint and Seclusion practices be retained (as in the 1969 Act).

13 that provisions relating to the removal of patients from New Zealand be retained (Section 72, 1969 Act) and modified as follows:-
(1) on the basis of professional opinion and in the best interest of the patient;

(2) consequent upon the existence of relatives or friends willing to undertake care in the receiving country;

(3) depend on satisfactory evidence that appropriate treatment is available and arranged;

(4) not restricted to aliens only, and New Zealanders with families abroad would be included.
SECTION ONE : PRESENT SITUATION

OFFICIAL VISITORS

1  APPOINTMENT

Section 5 of the 1969 Mental Health Act makes provision for the Minister of Health to appoint official visitors to psychiatric hospitals. When hospital boards took over responsibility for these hospitals from the Division of Mental Health, it was considered that the position of official visitor would no longer be necessary, as it was thought that their role could be performed by officials from the local board. So when, in 1974, the Department of Health sought local opinion on the continuation of this position, all hospitals with the exception of Sunnyside, agreed to allow the position to lapse. In 1982, however, the system received a new lease of life following an increased awareness of the need to safeguard patients' rights. By September 1984, 23 official visitors had been appointed.

Any person, except an employee of the Public Service, may be appointed as an official visitor. The term is a five year one, which is renewable. The hospital board concerned makes nominations of persons considered suitable and in most cases appointments are made by the Minister from these nominees. Official visitors are unpaid.

2  RESPONSIBILITIES

(1) General Responsibilities

The Act does not clearly specify the official visitor's role, and it is likely that there is much individual variation in the carrying out of their allotted tasks. The Department of Health has interpreted the role as acting as a 'patient's friend' or an outsider from the community who can represent the patient's point of view. In this capacity, the department would like to see the official visitor informing and advising patients of their rights, ensuring patient care standards are maintained, and on occasion acting as a mediator between patients and staff. In serious cases, where mediation does not resolve the matter, the official visitor may refer disagreements or problems on to the Principal Nurse, Medical Superintendent or District Inspector.

In contrast to District Inspectors, official visitors are not people with legal training, and are therefore not empowered to conduct formal inquiries.
The official visitor is seen as having a lay approach to the health system, and as acting as an advocate for patients in such a way as to complement the district inspector's role.

(2) Responsibilities Specified in the Act

The Act requires that each official visitor should visit the hospital for which he/she is responsible at least once in every three months. The hospital may be visited at any time of day, and for whatever length of time the official visitor considers necessary. Visitors are allowed access to every part of the hospital buildings and grounds, and to all people within them. All documents relating to patients may be inspected.

A written report should be made on every visit, either by entering into the visitation book the fact of his/her visit, and any observations on it, or by reporting to the superintendent within 14 days of the visit. When a particular issue has arisen, the official visitor is at liberty to present a report on that alone. He/she may also be called to report on specific issues.

The official visitor has the statutory responsibility to inspect all mail to or from patients that has been withheld by the medical superintendent.

The last authority allocated in the Act relates to the discharge of patients. The official visitor may dispute the superintendent's decision not to discharge a patient by referring the matter on for an inquiry.

DISTRICT INSPECTORS

1 APPOINTMENT

The district inspector's position has some similarities to that of the official visitor, but there are several important differences. The district inspector is also appointed for a renewable five year term, and may not be a public servant. However, the inspector must be a barrister or solicitor, and in recent years the practice has been for the District Law Society to nominate a suitable candidate, who, if no objection is raised, will be confirmed in the position by the Minister. Whereas the official visitor is unpaid, the district inspector is paid for any formal or semi-formal inquiries undertaken.

2 RESPONSIBILITIES

(1) General Responsibilities

The district inspector is regarded as a 'watchdog' for patients' legal and civil rights in relation to both hospital conditions, and welfare and detention of patients. Their job is to protect patients by:
(a) making information available on matters such as legal status, complaint and appeal proceedings and rights;

(b) investigating complaints by discussing problems with staff or in serious cases referring matters to the police.

(2) Responsibilities Specified in the Act

Inspectors are empowered to:

(a) if the Director of Mental Health requires, inquire into any breach of regulations or duty of persons employed in the hospital;

(b) inquire into any other matters, concerning patients or hospital management, at the request of the Director of Mental Health;

(c) When the superintendent believes a person is not fit to be discharged, but the inspector disagrees, the inspector shall report on the matter to the Minister;

(d) a judge of the High Court may direct inspectors to visit and examine any person detained as mentally ill, and to report as the judge sees fit.

They are given the authority to summon witnesses and receive evidence, and at the end of an inquiry, the responsibility of reporting fully to the Director.

In the same way as official visitors, district inspectors are required to visit the hospital for which they have responsibility at least once every three months, and they have the same rights to visit at any time, to have free access to all patients, all parts of the hospital and grounds, and documents relating to patients.

The inspector is also required to enter his/her visit into the Visitation Book, along with any necessary comments, or to report to the Superintendent. In addition, the inspector is to maintain an 'inspector's case book' into which he/she is to comment on patients as seen fit. With the official visitor, the inspector shares responsibility for inspecting withheld mail.

SECTION TWO : POINTS CONSIDERED

1 PATIENTS' ADVOCATE

One group has suggested that the system of official visitors and district inspectors is deficient, and has pressed for 'paid advocates' who would be involved in pressing for transfer, release on leave and discharge.
The Working Party's view is that the positions of official visitor and district inspector should be retained and strengthened. The role of the official visitor, in particular, needs to be better articulated but there is considered to be no requirement for the appointment of a patient's advocate, who would duplicate the functions of the visitor and inspector, and may do this in an unnecessarily adverserial way. The role of patient's advocate is established in places where such persons as official visitors and district inspectors do not exist. Visitors, inspectors and Review Tribunals in New Zealand will provide comprehensive safeguards, so that a patient's advocate is not necessary.

It has also been suggested that there could be a medical ombudsman to investigate patient complaints about institutional treatment. In view of the fact that there are already several avenues for complaints, and that the official visitor's role is to be expanded, the Working Party does not see there is a need for such an ombudsman. Should a Medical Ombudsman position be created for general health matters, psychiatric patients, equally with others, could have the right of appeal to such an Ombudsman on matters falling outside the scope of Review Tribunals.

2 TITLES

After some discussion, it has been proposed that the titles of Official Visitor and District Inspector should be retained. It is considered that there would be merit in annual meetings of these groups (see also paragraph 12 Orientation) and in having coordinating representatives of both official visitors and district inspectors. However, the details are not fully worked out, and there are difficulties involved, such as the election of this person, and his/her functions and purpose. Responses to these suggestions would be very useful.

3 AREAS OF RESPONSIBILITY

There has been some discussion over whether the geographical districts of official visitors and district inspectors should correspond with those in the Hospital and Area Health Boards Acts. The Working Party's view is that it would be more appropriate to allow the Director of Mental Health to decide areas as local needs dictate. Authority could be given for appointees to have a broader responsibility for psychiatric services in their designated area. In other words, responsibility need not be just for a designated hospital, but also for any halfway houses, rest homes or day care centres in an area.

4 APPOINTMENT

It is considered that Ministers of Health should continue to make appointments of official visitors and district inspectors, on the basis of recommendations from the board concerned. With respect to official visitors, it would be advisable in many cases for boards to seek, from the public, nominations on the basis of which recommendations will be made.
5 CULTURAL ISSUES

At the moment most official visitors and district inspectors are pakeha. However the rate of first admission to psychiatric hospitals and institutions for Maoris in 1982 per 100,000 of population, was 50% higher than the rate for non-Maoris. Maoris are thus over-represented in psychiatric hospitals in terms of their proportion of the population.

As all people relate more easily to those who understand their culture and speak their language, an effort should be made to recruit members of cultural groups as official visitors and district inspectors. While the major group concerned is Maori, other groups are also involved - Polynesians and Indo-Chinese. At the very least, visitors and inspectors should receive some instruction on the basic cultural differences, and on the need to enlist the services of interpreters where required.

The Working Party considers that minority socio-cultural groups have special needs which should receive clear recognition in the hospital setting but it is not proposed that this will be covered by legislation. This will be a matter for standards and guidelines.

6 TERMS OF APPOINTMENT

Consideration has been given to the time span for which visitors and inspectors should be appointed. There was some discussion as to whether five years is too long as an initial period of appointment, and whether three years would be more appropriate. It has also been suggested that officers should be reappointable only for one further term.

No firm proposal on this matter has yet been agreed, and the Working Party would welcome comments and suggestions on this point.

7 PAYMENT

(1) Official Visitors

The pros and cons of payment of official visitors has been widely discussed by the working Party. It has been argued that the voluntary nature of the official visitor's job should be preserved, but that official visitors should be fully reimbursed for any expenses associated with fulfilling their duties. This matter needs further discussion, particularly with regard to costs which would be involved if full payment was decided. We would be pleased to receive views on this matter.

(2) District Inspectors

As district inspectors provide specialist legal advice during time when they continue to incur office expenses,
it is proposed that district inspectors continue to receive payment for undertaking specific inquiries, and in addition, a small honorarium to cover additional activities.

8 NUMBER OF VISITORS

The Working Party debated the viability of establishing a set number of official visitors for hospital boards, or for psychiatric hospitals. It is suggested that the number of official visitors should be tied to the number of patients.

9 FREQUENCY OF VISITS

It has been argued that district inspectors and official visitors should not be confined to rigid timetables, but there is still a strong case for a greater number of visits. In the opinion of the Working Party, the minimum number of visits should be increased in the new Bill to at least one visit every month. There would be some advantage if visitors and inspectors were to work out a schedule of visits between them. Guidelines for visitors however, will stress the importance of more frequent visits than the specified minimum.

10 ACCESSIBILITY

It is important that official visitors and district inspectors be known to patients, relatives and staff. Any person should be able to contact an official visitor about matters relating to patients.

The Working Party believes that patients should be made more aware of the functions of official visitors and district inspectors, and of the particular visitors and inspectors attached to their hospital. Names and contact telephone numbers should be on display, and easily readable in all wards. A display of photographs of these people in wards has been suggested. The wearing of name tags is also supported.

Patients should be able to contact official visitors and district inspectors directly, and staff should draw the attention of visitors and inspectors to patients wishing to speak to them.

It would also be constructive for official visitors to be notified of the admission of new patients to the hospital or institution.

There is no proposal for the new Bill arising from this section, but these matters will be included in the guidelines.

11 RELATIONSHIP WITH HOSPITAL STAFF

Hospital staff as well as patients and their relatives should be aware of their right to raise matters of concern over patient welfare with district inspectors and official
visitors. Furthermore staff should have a responsibility to draw the inspectors' and visitors' attention to patients who would like to speak with them, perhaps by drawing up a list. This would not prevent patients directly contacting official visitors and district inspectors.

12 ORIENTATION

New official visitors and district inspectors receive no training or orientation to prepare them for these jobs. Official visitor appointees in the past year have been given some written information on how to approach the job, on their rights, and some background on types of patients and problems which may be encountered. Information should also be given on cultural issues and patients' rights. There is no doubt that the jobs would be more efficiently performed if new appointees were given an orientation course, and if some continuing form of education/seminars including annual meetings, were to be instituted. This applies to both official visitors and district inspectors who would probably have no previous acquaintance with psychiatric hospitals. Such proposals have administrative and resource implications, and will need further consideration. Views on how they could be achieved, and on the practical considerations in terms of resources required, would be welcomed.

It was agreed that official visitors and district inspectors would benefit from meetings with each other and with hospital superintendents.

13 PATIENTS' RIGHTS

The issue of patients' rights has emerged as a substantial one. It has been proposed (in one of the Working Party's initial Proposals) that written information be easily available to patients on their rights, and that one specific member of the hospital staff be responsible for ensuring that patients have copies of such information. Official visitors and district inspectors must be aware of patients' rights and entitlements, and be prepared to discuss and clarify those rights if required. A summary of patients' rights should be displayed prominently in each ward or day room. It would be the responsibility of the district inspector and official visitor to check that this is done.

Official visitors and district inspectors should be aware of the guidelines established for hospital staff, as well as patients' rights.

These functions will not be prescribed in legislation, but will be included in expanded guidelines to official visitors and district inspectors.

(For further discussion of official visitors' and district inspectors' roles in relation to patients' rights, such as the right to receive mail, see Paper 11, Patients' Rights.)
14 REVIEW PROCESS

The power of official visitors and district inspectors in the present Act to report to the Minister matters relating to the continuing detention of patients, needs to be considered in relation to proposals for Review Tribunals, covered in paper 8.

15 REPORTING

There needs to be some procedure for ensuring that boards and the department receive feedback on a regular basis, and that problems raised by visitors are adequately followed up. The fact that a visit has taken place should be recorded. The form and extent of reporting required needs to be investigated. Various suggestions were considered by the Working Party: that visitors and inspectors regularly report to the board, which will forward copies to the Director of Mental Health; that regular reports be made to the board, and every six months or in special circumstances directly to the Director of Mental Health. A report on general observations at the end of a three year term was also suggested.

Comment from official visitors and inspectors on how reporting would best be done, and appropriate follow-up, is welcomed.

16 COMPLAINTS PROCEDURES

The subject of complaints procedures for patients has been raised by people commenting on the department's position paper. Machinery is already in place — for example, through official visitors, district inspectors and charge nurses — and should be referred to in guidelines. No legislative measures are suggested but all those involved should be made further aware of existing procedures.

SECTION THREE: LEGISLATIVE PROPOSALS

1 That the positions of district inspector and official visitor be retained, and their roles more clearly articulated.

2 That district inspectors and official visitors have wider responsibility for psychiatric patients in an area, as local needs dictate.

3 That official visitors and district inspectors continue to be appointed by the Minister, after consultation with the appropriate hospital board.

4 That official visitors be fully reimbursed for all expenses arising from their work.

5 That district inspectors continue to receive payment for undertaking specific inquiries, and a small honorarium.

6 That the number of official visitors established in a board region should be related to the number of psychiatric patients in hospital or community care.
7. That the legislation should provide for visits by district inspectors and official visitors at least once a month.

8. That the reporting procedures of official visitors and district inspectors be revised.
SECTION ONE: INTRODUCTION

Part VII of the present Mental Health Act deals with the 'Administration of Estates of Mentally Disordered Persons', and provides for the estates of all committed patients to be managed by the Public Trustee or the Maori Trustee, or any other person appointed by a court. Every contract made by such a patient is voidable by him/her or by the manager of his/her estate. The Public Trustee, or manager, has very wide powers relating to the estates of all patients under their protection.

This Part of the Act has a very significant impact on the lives of people in psychiatric hospitals, and while it is obviously designed to protect people's interests, it can also be seen as being unnecessarily restrictive. It should further be noted that the administration of these sections of the Mental Health Act requires a considerable amount of staff time in both Public Trust offices and the Patients Affairs sections of psychiatric hospitals.

The Working Party in its original discussion paper indicated that while it had not at that stage fully worked out its proposals, it did not wish to see the present system continue whereby committed patients automatically lose the power to administer their own estates. While this may be desirable in some cases it is not necessary in all; furthermore the Working Party considered that there is a proportion of informal patients in need of some 'commercial supervision'. Although the Mental Health Act does provide for informal patients to become 'protected patients' in the same way as committed patients, it does not appear that this provision is often used. There are therefore very few informal patients whose affairs are managed by the Public Trust.

HISTORICAL BACKGROUND TO ISSUES

The Working Party was aware, in its deliberations on this matter, that general discussions on the issues of the administration of the affairs of less than fully competent people and the related question of 'guardianship' had been proceeding for a number of years in a number of different settings. In addition to the Mental Health Act, the Aged and Infirm Persons Protection Act 1912 relates to the administration of the affairs of mentally impaired people. Furthermore many organisations have expressed concern regarding the need to safeguard the rights of a wide variety of people including the intellectually handicapped, the mentally impaired confused elderly, and indeed some physically handicapped people whose ability to communicate and manage their own affairs is impaired by virtue of their disability.
The Aged and Infirm Persons Protection Act (A & IPP Act) 1912 is administered by the Department of Justice, and is the present principle legislative vehicle by which a manager can be appointed to administer the estate of a person living in the community. Comparatively little use is made of this provision - in 1983 there were 86 appointments of the Public Trustee under this Act. It is expensive for the individual concerned, and therefore does not assist in cases where the estate is small. It is generally agreed that the A&IPP Act is too cumbersome a vehicle by which the Public Trustee can become involved in the affairs of an informal patient; and there is also general consensus that both the A&IPP Act and Part VII of the Mental Health Act should be brought up-to-date, integrated in one piece of legislation, and be applicable to the wide variety of people concerned.

The recent history of proposals can be briefly summarised as follows:

1981 - the Department of Justice circulated a paper 'Legislating to Assist Handicapped Persons; possible Scheme'

1982 - the New Zealand Institute of Mental Retardation circulated 'Guardianship for Mentally Retarded Adults'

June 1983 - the Department of Justice circulated an outline of proposed legislation for the administration of 'Incapacitated Persons Property'

August 1983 - the Department of Justice circulated a further paper 'Dependent Persons Bill - Possible Outline'.

September 1984 - the Department of Justice circulated two draft bills - The Incapacitated Persons Property and the Incapacitated Persons Welfare Bills.

The Property Bill will involve the repeal of Part VII of the Mental Health Act 1969, dealing with 'The Administration of Estates of Mentally Disordered Persons'. The Working Party does not propose, therefore, that there be any provisions in the new Mental Health Bill relating to the administration of patients' affairs.

SECTION TWO: SUMMARY OF INCAPACITATED PERSONS PROPERTY BILL INCAPACITATED PERSONS WELFARE BILL

These Bills provide for applications to a Court, (in general the Family Court) to be made regarding questions of the arrangement of property or matters concerned with personal welfare. Before making an order, the Court must be satisfied that the person is incapacitated, or wholly or partially unable to manage his/her property. Courts are to make the least restrictive intervention possible, bearing in mind both the degree of incapacity and that a person's rights, privileges and authorities are to remain as far as possible those of a person who is not incapacitated. If it is decided
that the person is not capable of giving agreement or consent, the Court may make an order without the incapacitated person's agreement.

Under the Property Bill a 'manager' may be appointed; under the Welfare Bill a 'mentor' may be appointed. Both have the overriding role of promoting the interests of the incapacitated person, and encouraging that person to regain his/her ability to manage property or own affairs. In order to promote the person's ability the 'mentor' will encourage him/her to act on his/her own behalf wherever possible, and the manager may allow him/her to have control over and deal with any part of the property, as seen fit. In carrying out their duties, the 'mentor' and 'manager' are required to consult the person, and any members of the family, relatives, friends or others, who are interested in the person, and competent to provide advice. At least once every 6 months these two persons are required to consult each other (only in cases where the incapacitated person has both a 'mentor' and 'manager'). Both may apply to the Court for clarification of duties.

The Court may decide to appoint counsel either to assist the Court, or to represent the person in respect of whom an application is being made. Fees and expenses related to the proceedings will not be met by the person in respect of whom the application is being made.

The grounds for making an order under the Property Bill are

(1) A Court may make an order under this section where it is satisfied that the person in respect of whom the order is sought is unable, wholly or partially, to manage his affairs in relation to his property.

(2) Without limiting the matters a Court may take into account in determining whether to make an order, the Court may have regard to whether the person in respect of whom the order is sought -

(a) Suffers from any physical or mental disability, illness, or condition;

(b) Can make reasoned decisions about his affairs in relation to his property free from any undue influence;

(c) Is taking or using in excess alcoholic liquors or any intoxicating, stimulating, narcotic, or sedative drug, whether such taking or using is continual or episodic.

An application under this Act may be made by: the incapacitated person, a relative, 'mentor', trustee corporation, hospital superintendent (for a committed or special patient), or any other person approved by the Court.
The Welfare Bill defines an incapacitated person as one who

'(a) Wholly or partially lacks the capacity to understand the nature and appreciate the consequences of decisions in respect of matters relating to his personal care and welfare; or

(b) Has the capacity to understand the nature and appreciate the consequences of decisions in respect of matters relating to his personal care and welfare but, because of physical handicap or brain damage, wholly lacks the capacity to communicate decisions in respect of those matters.'

The Court, bearing in mind factors mentioned previously (the least restrictive intervention etc) can make several different kinds of orders (clause 10) relating to, for example:

1. appropriate remuneration for work performed
2. suitable arrangements for the care of the person after death of parents or guardian
3. entering or leaving a specified institution
4. the need for training
5. the appointment of a 'mentor' to look after specified areas relating to the care and welfare of the incapacitated person.

The Court shall not make an order to appoint a 'mentor' unless it is satisfied that the person is wholly incapable of making or communicating decisions in one or more areas of his/her personal care or welfare, and that the appointment of a 'mentor' is the only way to ensure that appropriate decisions are made for the incapacitated person.

The mentor may be any person older than 20 years of age, believed by the court to be capable of carrying out a 'mentor's' duties in a satisfactory manner. As specified by the court, the 'mentor' will have the authority to make and carry out decisions on the incapacitated person's behalf.

Any order will expire at the end of one year, unless it has been fulfilled earlier, or the Court sets a different time limit when it makes the order. A pre-hearing conference can be arranged, and reviews and appeals can be held.

The two Bills are related in that when the incapacitated person is already subject to or becomes subject to the Property Act, the Welfare Act shall take precedence. The 'manager' may apply for variation, suspension or further directions on the implementation of an order under the Welfare Act.
SECTION THREE : RELEVANCE TO PSYCHIATRIC PATIENTS

1 Specific Proposals

The Working Party supports, on the whole, the principles expressed in the Justice Bill although there are a number of points which the Working Party has suggested require further consideration.

The Working Party feels that it is particularly important to ensure that the procedures relating to the appointment of managers are not overly 'legalistic', lengthy, cumbersome or time-consuming. The Working Party is pleased to note, therefore, that clause 13 of the Property Bill provides for a relative or a 'mentor' to apply to a trustee corporation for a person to become subject to the Act if the person's estate does not exceed $40,000. Such an application must be accompanied by two medical certificates indicating the effect of any physical or mental disability, illness, or condition of the applicant on his/her ability to manage his/her affairs in relation to his/her property. If the trustee corporation is satisfied that the application is appropriate, it is accepted and filed with a Court within 30 days of the making of the application.

This proposal should be a relatively straightforward means of ensuring that the estates of mentally impaired people for whom it is appropriate receive supervision.

A further proposal of particular relevance to psychiatric patients is clause 10, which provides that in cases where a District Court Judge is exercising jurisdiction in respect of committal processes, he/she may also exercise the jurisdiction of a Family Court in respect of the Property Act. This means that the compulsory admission and appointment of a 'manager' can be dealt with at the same time, if this is appropriate, although the two issues remain separate.

2 Implementation of the two Bills

The Welfare Bill

The concepts behind the Incapacitated Persons Welfare Bill are quite new in New Zealand legislation, and it is difficult to predict the extent to which it will be used and the impact it will have on services for the intellectually handicapped, the elderly and the mentally impaired. It may be that the Welfare Bill will prove to be of less relevance to the psychiatrically ill than to other groups of people. Psychiatric patients requiring supervision and guidance in one or more aspects of their lives, will either be in hospital, in which case they are already receiving the required supervision, or in the community, under a Community Treatment Order, where they will be receiving some assistance from extramural staff. It would be necessary to obtain a Court Order under the Welfare Act only in a very few instances where additional statutory authority was required.
The Property Bill

There is no doubt that the enactment of the Incapacitated Persons Property Bill will have a significant impact on psychiatric patients and will necessitate considerable changes in hospital administrative procedures. The most fundamental difference between the present situation and that which will be created in the new Act is that while committed patients currently lose their rights automatically to manage their own estates, the new Act will mean that, in order for anything to happen in respect of an 'incapacitated' patient, the hospital staff will have to initiate matters.

It is likely that, although provisions in the Bill will enable a number of people and organisations to be 'managers' of estates, the Public Trustee will in most cases continue to manage estates of psychiatric patients.

The Working Party proposes (this would be an administrative, not legislative procedure) that in respect of all patients of whatever status - informal, compulsory, special - that not later than 21 days after admission to hospital, the hospital must ensure that a decision is made by the multidisciplinary team responsible for the patient as to whether an application should be made for his or her estate to be administered by a manager. If it was decided that this would be appropriate, the following options would be available:

1. In the case of small estates (which would be perhaps the majority of psychiatric patients, especially if the limit of $40,000 is increased in accordance with the Working Party's recommendation to the Department of Justice), appropriate medical certificates would be provided and the application sent to Public Trustee (or Maori Trustee).

2. In the case of larger estates, and where the person is to be made the subject of an In-patient Order, thus necessitating the involvement of a District Court Judge, an application will be dealt with by the District Court Judge at the same time as the question of an In-patient Order is determined.

3. In the case of larger estates where the person is not be become the subject of an In-patient Order an application will be sent to the local Family Court.

If the person is to become the subject of a Community Treatment Order, which necessitates the involvement of a District Court Judge (see paper 3) following the decision of the multidisciplinary team an application for a property order can be sent to the Judge as he/she considers the question of a Community Treatment Order.

If the person (whether informal or admitted compulsorily) is discharged prior to the 21st day there will be no administrative requirement for an automatic assessment of a person's 'commercial competence', and applications for
orders under the Property Act will be made on the basis of staff initiative. In order to assist hospital staff, guidelines will provide criteria for determining 'commercial competence'.
PAPER FOURTEEN

STANDARDS AND GUIDELINES

The new Mental Health Bill is designed to provide a legal framework governing affairs in psychiatric hospitals and institutions, and compulsory treatment in the community. It will not, and cannot, cover all practical working details. There will be, therefore, some very important areas which will not be included in the Act. It has of course been necessary for the Working Party reviewing the Mental Health Act to consider issues in the broad perspective, recognising that details not suitable for incorporation in the Act need separate development elsewhere.

As is usual practice with Department of Health legislation, it has been decided that to complement the Act, other guidance material needs to be prepared. This will be in two forms:

1. A guide to the Mental Health Act, in non-legal language, to inform all persons who may use the Act - patients, relatives, general practitioners, nurses, social workers, psychiatrists and so on - of its provisions and implications in a readily understandable and approachable format. This will basically be an information document.

2. A guide or Code of Practice, for health professionals’ use, issued by the Director-General of Health under the provisions of the Act, which will cover practical procedures in greater detail, and will set standards of performance for psychiatric services.

At the same time as the review of the Mental Health Act has been taking place, an independent review of psychiatric hospitals has been undertaken by the department. This review, which commenced in June 1984, will provide information on existing services and procedures as well as information which will be of assistance for service planning, and on present standards.

A third working party has been set up to combine information from, and to liaise with, both the above groups. It will also review working practices in psychiatric services overseas. From these various inputs, and with the help of a small professional nucleus, a set of preliminary draft standards and guidelines for psychiatric hospitals will be prepared. At this stage the Working Party will be formally set up as a specialist technical advisory committee, comprising co-opted experts, and departmental representatives. The committee's terms of reference will include finalising standards in consultation with staff in psychiatric hospitals, and professional organisations, and regularly updating them. (These standards will be, as set out in number 2 above, the guide for health professionals).
After the initially agreed standards have been approved, they will be kept up to date by this technical advisory committee, which will maintain an ongoing review of provisions in the Code and its implementation.

The question of whether an independent body should be responsible for the implementation and monitoring of standards in psychiatric hospitals has been discussed by the working party, bearing in mind the model of the UK Mental Health Act Commission. This possibility was, however, rejected as being unnecessary and inapplicable in the New Zealand setting. See further discussion in Appendix 3.

The new Mental Health Act will provide that the Director-General of Health may from time to time approve and issue a Code of Practice for psychiatric services.
PAPER FIFTEEN

RELATIONSHIP OF MENTAL HEALTH BILL TO OTHER LEGISLATION

1 Introduction

It will be clear from the preceding papers that many of our proposals for charges to the Mental Health Act will have direct or indirect implications for other legislation. These will principally involve the Criminal Justice Act and the Crimes Act (discussed in paper 6 on special patients); and the proposed 'Incapacitated Persons Property Bill' and 'Incapacitated Persons Welfare Bill' (discussed in paper 13 on Administration of Estates).

2 Alcohol and Drug Addiction Act 1966

Another important piece of legislation which concerns issues of central relevance to the Mental Health Act is the Alcoholism and Drug Addiction Act 1966. The basic purpose of this Act is to make provision for the compulsory treatment and detention of persons whose alcohol or drug dependence is 'firmly established'. There has been significant pressure for change to the legislation, in the main from those organisations most closely associated with the implementation of its provisions. A subcommittee of the department's Task Force on Alcohol Related Issues has been engaged for approximately one year, on a review of the Alcoholism and Drug Addiction Act. Members of both groups have been keenly aware of the necessity of ensuring consistency in the approaches taken in the two reviews.

The question of whether in fact there should be an Alcoholism and Drug Addiction Act has been discussed by the ADA Working Party. The options considered were:

- that there should be no provisions relating to the compulsory treatment of substance abusers in any legislation

- that there should be some such provisions, but that they could be incorporated in mental health legislation

- that there should continue to be an Alcoholism and Drug Addiction Act, but that it should be updated.

The ADA Working Party decided that there should continue to be provisions for the compulsory detention of substance abusers, more perhaps for humanitarian reasons rather than a conviction that compulsory treatment was necessarily effective. The ADA Working Party also believed that the needs and characteristics of substance abusers were sufficiently different from those with psychiatric disorders to justify two separate pieces of legislation. The third option, that of amending the ADA Act, was therefore chosen.
The following principles have been adopted as guidelines for change to the Alcoholism and Drug Addiction Act:

**Principle 1**

Compulsory detention under the Alcoholism and Drug Addiction Act should apply only when no alternative and reasonable remedy for assisting the alcohol or drug dependent person is available or accepted.

**Principle 2**

The definition of an alcoholic or drug addict for the purposes of the legislation should be narrowed so that the requirement for compulsory treatment for such alcoholics or drug addicts would apply in only limited circumstances.

**Principle 3**

Provisions designed to protect the rights of the committed patient under the Alcoholism and Drug Addiction Act should be developed in conjunction with, and be comparable to those in the proposed Mental Health Bill.

While the proposals for compulsory treatment/detention procedures have not yet been clearly formulated, they are likely to be quite different from those outlined for the Mental Health Act Bill in paper 3 on Compulsory Admission: Criteria and Procedures, although the desirability of assessment is recognised. The areas where consistency between the two Acts is considered most necessary, are:

- the review process
- patients rights.

(1) **The Review Process**

It is proposed that the 'review process' for patients compulsorily detained under the Alcoholism and Drug Act be identical with those in the Mental Health Bill (see Paper 8). In other words, ADA patients should after 6 months detention be automatically and formally reviewed by a 'hospital review'. This clinical review would be conducted, in the main, by hospital or licensed institution staff. If the patient was not satisfied with its outcome, the ADA patient could apply to the Review Tribunal for a hearing into his/her case. Care would be taken to ensure that at least one person on the Tribunal had special knowledge of the subject of substance abuse.

(2) **Patients Rights**

It is proposed that the district inspector and official visitor appointed to hospital board areas should also be responsible for any person detained under the ADA Act, in both psychiatric hospitals and gazetted institutions.
PAPER TWO: OBJECTIVES

That the objectives of the Act, in facilitating the provision of the highest possible standards of mental health services in New Zealand, be:

1. to enable mental health services to be as available, accessible and comprehensive as possible;
2. to enable the highest possible standards of mental health services to be established and monitored;
3. to ensure that mental health services are where appropriate integrated with other health services;
4. to enable patients to receive the best possible care and treatment;
5. to ensure that individual rights and freedoms are respected in the provision of services, and to ensure that treatment and care involves the least necessary disruption of and restrictions to the person's ordinary life;
6. to ensure that both the providers of mental health services and the community accept their responsibilities in maintaining a high level of service;
7. to ensure that mental health services are oriented as far as possible to the community, recognising that the nature of New Zealand society is heterogeneous and multicultural;
8. to ensure that mental health services are delivered by a range of health professionals in a range of health settings.

PAPER THREE: COMPULSORY ADMISSIONS: CRITERIA AND PROCEDURES

1. That 'mental disorder' alone will not be sufficient ground for compulsory treatment or admission.

2. That the criteria for becoming subject to a compulsory order be:
   - that the person is mentally disordered and
   - the health or safety of self or others is endangered or
(b) the person is gravely disabled so as not to be capable of ensuring his/her physical or social survival.

(3) That there be five compulsory stages:
- a compulsory assessment interview
- a three-day order
- a twenty-one day order
- an in-patient order
- an order for compulsory treatment in the community.

(4) Compulsory Assessment Interview
that this will be the initial stage in considering a person as subject to a compulsory order
that a request for such an interview may be made by any person 18 years or over
that the request or application should state the reason for seeking the assessment, and the applicant's relationship to the person in respect of whom the application is made
that the request or application be accompanied by one medical certificate
that the compulsory assessment interview will be conducted by a specialist or a medical practitioner to whom the Medical Superintendent has delegated his/her powers that the interview be conducted at the most convenient place for the persons involved.

(5) That the police have the power, where a person is completely unwilling to take part in the assessment interview, to take that person directly to hospital.

(6) That after the interview, the specialist or medical practitioner to whom the Medical Superintendent has delegated his/her powers, complete a second medical certificate.

(7) That the second medical certificate will provide for 3 options; the specialist or medical practitioner to whom the Medical Superintendent has delegated his/her powers will certify one of the following:
(a) that he/she considers the person does not have a significant degree of mental illness/disorder;
(b) that the person has significant mental illness/disorder, but not of an extent which endangers the health/safety of self or others, or renders him/her incapable of ensuring his/her own physical or social survival;

(c) that the person's physical or social survival, or the health/safety of self or others is endangered because of mental illness/disorder.

(8) That on the basis of the second medical certificate a decision will be made for an order or treatment.

- In the case of (b), treatment on a voluntary or outpatient basis will be suggested.
- In the case of (c), compulsory treatment in the community, or compulsory in-patient detention for care and treatment for up to 72 hours, will be arranged.

(9) That the second medical certificate provide space for input from health professionals.

(10) That a decision for in-patient care may be implemented only if the second medical certificate is completed not later than seven days after the first medical certificate.

(11) **Three Day/Seventy-two Hour Order**

That the 72 hour order will be to enable:

- assessment over a longer period than is possible in the interview;
- completion of reports from other health professionals;
- treatment of the person;

that a person will be eligible to be placed under this order only if he/she has:

either already had a compulsory assessment interview

or been a voluntary patient.

that discharge from the 72 hour order will occur:

- automatically at the end of 72 hours, if no other relevant order is made;
- or at any earlier time if the person is found by the superintendent 'fit to be discharged'.


that at the expiry of the 72 hour period, the following options are available:

- the person is not found to have a mental disorder for which treatment is desirable; the 72 hour order automatically lapses;

- the person is found to have a mental disorder for which treatment is desirable, but not essential as the person's health/safety or that of others is not endangered; the 72 hour order automatically lapses, but voluntary treatment is recommended;

- the person has a significant mental disorder, and is a danger to self/others or gravely disabled; an order may be made (where no less restrictive alternative is available), to authorise the person to be made subject of either a community treatment order, or an order for admission for 21 days.

(12) Twenty-One Day Order

that the 21 day order will be to provide for a period of treatment, which should be sufficient to stabilise most conditions.

that discharge from the 21 day order will occur

- automatically, if no other order is made

- at an earlier time, if the person is found 'fit to be discharged' by the Medical Superintendent

- if transfer to informal status occurs

that transfer from the 21 day order to another order will occur with the approval of the District Court Judge.

that the District Court Judge for the purpose of transferring a person from one order to another, will hold a hearing, for which reports must be prepared by psychiatrists involved, as well as by any other health professionals responsible for the care and treatment of the patient.

that the Judge will then make

either a community treatment order

or an in-patient order to a hospital or licensed institution.

that any patient has the right to seek a district court hearing on one occasion at any time before the end of the 21 day period.
that on application by a patient, the Judge will have the further option of directing that the 21 day order continue.

(13) In-Patient Order

that this order will allow a patient to be compulsorily detained for care and treatment for up to 6 months.

that the patient may be discharged by the Medical Superintendent at any time during this order if he/she is found 'fit to be discharged'.

that the order will automatically lapse at the end of 6 months, unless the hospital review has endorsed the need for the in-patient order to continue.

that a patient may at any time be transferred from an in-patient to a community treatment order.

(14) Community Treatment Order

that this order will allow for treatment in the community for up to 6 months.

that the order will automatically lapse at the end of 6 months, unless the hospital review endorses the need for the order to continue.

that the order will take effect from the time that the medical practitioner completes the appropriate form.

that the order must be validated by the district court judge not later than 3 weeks after the completion of the form.

that, if validating this order, the district court judge will hold a hearing at which the patient will be invited to attend.

that the district court judge is to determine whether this is the most appropriate order to meet the patient's needs.

that when any staff member with responsibility for the patient, considers that the patient is not managing successfully in the community, he/she will make a request for the patient to attend a compulsory assessment interview, and will obtain a medical certificate from the person's general practitioner.

(15) Leave

that patients subject to either 21-day or in-patient orders may be granted leave from the hospital for a maximum of one month, or where the 21-day order is concerned, for no longer than the remainder of that order.
PAPER FOUR: FACILITIES FOR PSYCHIATRIC PATIENTS

(1) That the term psychiatric hospital continue to have a legal definition enabling them to take special patients.

(2) That all general hospital facilities be empowered to admit all legal categories of psychiatric patients, except special patients.

(3) That sections 38-40 which provide for the detention of 'Single Patients' be repealed.

(4) That a section equivalent to the present section 9 which governs the establishment of private licensed institutions, be retained.

(5) That the Director-General or his/her deputy, be empowered to inspect such licensed private institutions.

(6) That the Standards of Care approved by the Director-General of Health apply to private psychiatric facilities as well as public hospitals.

PAPER FIVE: INFORMAL PATIENTS

(1) That provision will be made in the Mental Health Bill for authority for subordinate legislation, such as by-laws.

(2) That informal patients should be notified in writing of their discharge.

(3) That there be statutory provision for the regular review by hospital staff of informal patients.

(4) That there be provision for change of status from informal to a 72 hour order, which will require two medical certificates.

(5) That all provisions in the Bill will apply to all patients regardless of status, unless stated otherwise.

PAPER SIX: SPECIAL PATIENTS

(1) That there be statutory provision for the regular review by hospital staff of special patients in the following categories: 39G(1)(a), 39G(5), (Criminal Justice Act) and section 42 and 43 (Mental Health Act).

(2) That special patients in the categories listed above have the right to apply to Review Tribunals for a review of their case although the Tribunals would only have the power to recommend and not discharge.

(3) That a section equivalent to the present section 74 be retained, ie that patients, including special patients, may ask a high court judge to inquire into their case.
(4) That the authority to make transfers between prisons and hospitals of convicted persons be vested primarily in the superintendents of the institution concerned.

(5) That the present provision relating to the transfer of special patients between psychiatric hospitals be retained.

(6) That there be provision for long leave to be granted to 'under disability' patients.

(7) That short leave should only be given to section 42 and 43 special patients with the consent of the prison superintendents involved.

(8) That the present provisions relating to the escape of special patients remain unchanged.

(9) That a provision allowing the Minister of Health to declare any psychiatric hospital to be a security institution should be retained.

PAPER SEVEN : CONSENT TO TREATMENT

(1) That the importance of full and regular communication will be stressed in guidelines, but legislation will refer to the role of the responsible health professional in communicating the nature and purpose of the proposed treatment, with its possible side effects, and alternative treatments, to all patients.

(2) That documentation will be required by legislation, and its exact nature spelled out by regulations.

(3) That legislation will establish two categories of special treatments, the first of which will require, for all patients, consent of the patient and a second specialist opinion; and the second, for compulsorily admitted patients, consent of the patient or a second specialist opinion. Treatment will be included in a Schedule to the Act.

(4) The legislation will allow for the provision of treatment without consent in emergencies.

PAPER EIGHT : THE REVIEW PROCESS

(1) That regular six monthly hospital reviews be conducted for all categories of patient: that is, informal, compulsorily admitted and special patients.

(2) That the hospital review be primarily concerned with the patient's clinical condition, but will also involve consideration of social and legal factors.
(3) That all health professionals closely involved in the patient's care and treatment should take part in the hospital review.

(4) That forms used in documenting such reviews will indicate this multidisciplinary involvement.

(5) That if the hospital level review does not occur at the appropriate time, the compulsory order will lapse.

(6) That, after the hospital review has taken place, the patient be informed of any decision made concerning his/her legal status, and of his/her right to apply for a hearing by the Review Tribunal, if wanted.

(7) That regional Review Tribunals be established.

(8) That each tribunal panel consist of a lawyer, who shall be the chairperson, a psychiatrist, and a third person, which could be a health professional or a lay person.

(9) That panels be drawn from regional pools, consisting of at least two persons in each of the above categories.

(10) That each regional pool have a chairperson, who would be one of the lawyers.

(11) That appointments of pool members be for three years, renewable for one further three year term.

(12) That no person should be permitted to hear cases in which he/she has a close personal or professional interest.

(13) That pool members be paid fees and travelling expenses in line with comparable statutory bodies.

(14) That the functions of the Review Tribunal be to review the case of any compulsorily admitted or special patient who applies to the tribunal in his/her region.

(15) That patients may apply to the tribunal at intervals of not more than once every six months; but that their first application may be within three months of admission.

(16) That persons other than the patient, such as friends or relatives, may apply for a hearing on the patient's behalf, but must state in writing the nature of their relationship to the patient, and their reasons for seeking the review.

(17) That a decision to proceed with a hearing, when a person other than the patient has made the application, be at the discretion of the pool chairperson.
(18) That the Review Tribunal focus on the legal status of the patient, but will also involve consideration of clinical and social factors.

(19) That Review Tribunals have a function in relation to consent to treatment procedures, particularly in relation to obtaining second opinions.

(20) That Review Tribunals have the authority to make decisions:

(a) in relation to patients under compulsory orders to:
   - discharge from the compulsory order
   - transfer the patient from detention to a community treatment order
   - continue the order
   - adjourn proceedings.

(b) in relation to special patients, to make recommendations to the appropriate authorities.

(21) That the new Bill will contain provisions equivalent to the present sections 34 (which provides for appeal against reception orders alleged to be invalid, incorrect or deficient) and 74 (which allows committed and special patients to apply to a judge for an inquiry into their case).

(22) That section 73 of the 1969 Mental Health Act will be repealed.

PAPER NINE: THE ROLE AND RESPONSIBILITIES OF THE PSYCHIATRIC HOSPITAL SUPERINTENDENT

(1) That legislation will continue to provide that superintendents of psychiatric hospitals be medical practitioners.

(2) That superintendents be ultimately responsible for the functioning of the hospital.

(3) That superintendents may delegate any of their powers and responsibilities under the Act to whoever is considered most appropriate.

(4) That in the superintendent's absence, a Deputy Superintendent will exercise all the Superintendent's powers and responsibilities.

(5) That the section in the 1969 Act which provides that any medical officer may exercise any or all of those powers without special delegation, shall not be included in the new Act.

(6) That superintendents should ensure that an individual treatment plan is drawn up and followed for each patient.
(7) That the superintendent should ensure all patients are notified of their discharge, in writing.

(8) That offences punishable by summary conviction in Court be provided when:

(a) without due cause the superintendent causes a person to be detained

(b) the superintendent knowingly permits an offence against the Act, or against a patient.

(9) That sexual intercourse with a psychiatric in-patient is an offence.

PAPER TEN : ROLE AND FUNCTIONS OF HEALTH PROFESSIONALS IN THE IMPLEMENTATION OF THE MENTAL HEALTH ACT

(1) Medical Practitioners

(a) that the first medical certificate initiating a compulsory assessment interview usually be completed by the person's general practitioner.

(b) that the second medical certificate made at the conclusion of the compulsory assessment interview be completed by a specialist psychiatrist or a medical practitioner to whom a Medical Superintendent has delegated his powers.

(c) (i) that certificates relating to:
- 11 day orders
- in-patient orders
- community treatment orders; and

(ii) documents relating to
- discharge
- review
- consent to treatment
- transfer etc.

be completed by a medical practitioner to whom the Medical Superintendent has delegated his powers.

(2) Other Health Professional

(a) that any person may initiate compulsory assessment/admission procedures.

(b) that health professionals other than medical practitioners have statutory functions relating to
- compulsory orders
- the review process
- consent to treatment
PAPER ELEVEN : PATIENTS RIGHTS

(1) That one of the objectives of the Mental Health Bill will be to ensure that patients receive the 'best possible care and treatment'.

(2) That a provision similar to that in the 1969 Act, relating to the right of patients to be visited, be retained.

(3) That all patients have a general right to communication with persons and organisations outside the hospital.

(4) That, as at present, mail to, or by an informal patient should not be read or withheld.

(5) That mail sent by a compulsorily admitted or special patient be withheld only if the person to whom it is addressed has requested that communication to him/her by the patient should be withheld.

(6) That mail sent to a committed patient should not be read or withheld.

(7) That mail sent to a special patient may be opened and withheld if the superintendent believes this is necessary to prevent the patient being a danger to self or others.

(8) That all patients have an absolute right to correspond with the following persons:

- a Minister or MP;
- the Ombudsman;
- any court or tribunal;
- the Director of Mental Health;
- the district inspector and official visitor;
- the Medical Superintendent;
- any legally qualified person instructed by the patient;
- the person's usual medical practitioner;
- the person's usual religious or spiritual adviser;
- any mental health professional in relation to proceedings or proposed proceedings;
- the person's mentor/adviser, pursuant to the Incapacitated Persons Welfare Bill;
- the person's manager, pursuant to the Incapacitated Persons Property Bill.

(9) That superintendents have the responsibility of notifying the Police of admissions of patients holding firearms licences.

(10) That patients retain the right (as in Section 29 of the 1969 Act) to ask to inspect records relating to their detention.
(11) That sections which provide for the making of regulations in relation to the employment of patients, Section 126(e) and (i), be retained.

(12) That documentation of Restraint and Seclusion practices be retained (as in the 1969 Act).

(13) That provisions relating to the removal of patients from New Zealand be retained (Section 72, 1969 Act) and modified as follows:-

(a) on the basis of professional opinion and in the best interest of the patient;

(b) consequent upon the existence of relatives or friends willing to undertake care in the receiving country;

(c) depend on satisfactory evidence that appropriate treatment is available and arranged;

(d) not be restricted to aliens only, and New Zealanders with families abroad would be included.

PAPER TWELVE : OFFICIAL VISITORS AND DISTRICT INSPECTORS

(1) That the positions of district inspector and official visitor be retained, and their roles more clearly articulated.

(2) That district inspectors and official visitors have wider responsibility for psychiatric patients in an area, as local needs dictate.

(3) That official visitors and district inspectors continue to be appointed by the Minister, after consultation with the appropriate hospital board.

(4) That official visitors be fully reimbursed for all expenses arising from their work.

(5) That district inspectors continue to receive payment for undertaking specific inquiries, and a small honorarium.

(6) That the number of official visitors established in a board region should be related to the number of psychiatric patients in hospital or community care.

(7) That the legislation should provide for visits by district inspectors and official visitors at least once a month.

(8) That the reporting procedures of official visitors and district inspectors be revised.
That there be provision for the Director-General of Health to approve and issue a Code of practice for psychiatric services.
APPENDIX ONE

ORIGINAL PROPOSALS - FEBRUARY 1983

MENTAL HEALTH ACT REVIEW: POSITION PAPER

BACKGROUND

As you may be aware, the Department of Health has been reviewing the Mental Health Act 1969 with the aim of making recommendations so that it might reflect new directions in psychiatric practice and contemporary community attitudes. The initial steps taken were:

1. a request for comments on specific points from a number of relevant individuals and organisations;
2. a review of legislation in other relevant countries;
3. discussions within the Department of Health

This present position paper embodies themes derived from these three sources.

INTRODUCTION

The role of legislation in determining the quality of health care is important, but is really restricted to the provision of a framework within which the actual delivery of services - principally in the hospital component - occurs. However, particularly in view of the increasing degree of integration of general and psychiatric services, several aspects of the review may be applicable to other areas of health care; indeed the review of mental health legislation will inevitably highlight issues which are relevant also in the broader context of health care generally.

With these factors in mind, the most expedient and constructive course of action will be to recommend appropriate and, if necessary, substantial amendments to the current Mental Health Act. It is hoped that the amendments to this Act will be ready for presentation in the 1984 legislative year.

The department has now reached the stage of formulating tentative general proposals with regard to the Mental Health Act. These are set out below from page 3 onwards, and deal, in the main, with the principles of compulsory admission, review procedures, and consent for treatment. Other specialised issues, such as the legislation with regard to psychiatrically disturbed offenders, will be addressed in the near future.
Your comments and suggestions on the proposals below are invited. As the review is still at a preliminary stage, it would be helpful if you could indicate whether you agree with the principles embodied in these proposals, and briefly explain any reservations or objections you may have. It would be appreciated if these could be returned to the department no later than Monday April 11th.

SPECIFIC ISSUES AND PROPOSALS

I Legislation Concerning Compulsory Admission

One of the more complex and difficult mental health legislative issues arises from the fact that a small but significant number of patients require compulsory admission. This section does not deal with the great majority of admissions, which are on an informal basis. It is important to make it clear, however, that people not unwilling to enter hospital, such as, for example, the elderly and confused, should continue to be admitted with the same lack of formality as people with any condition entering a general hospital.

Another difficult, and related, issue is that of defining mental illness in any helpful and meaningful way. After much consideration it has been decided that an attempt to define mental illness would result in little benefit: the essential point is, rather, to define the conditions for which compulsory admission may be justified.

Virtually all mental health Acts in other relevant countries specify two general requirements for compulsory admission— the need of the patient, and the need of others. The degree of need, and the degree of specificity with which this need is defined, varies considerably. The present New Zealand wording is very wide, namely that a compulsory admission should be made when the person is mentally disordered and requires detention either for his own good or in the public interest.

It is believed that the following principles should provide the base on which procedures for compulsory admission are formulated:

(1) Compulsory admission, when it becomes necessary, should involve the least possible interference with the rights of the individual.
(2) Whilst retaining all reasonable legal safeguards, the initial committal process should not be procedurally cumbersome.
(3) Care and treatment should be for as short a period as is reasonable and necessary.
(4) Patients should be informed of their entitlements under the Act.
The department proposes criteria and procedures for compulsory admission (Proposal 1) and also specific exclusions to committal criteria (Proposal 2), which, taken together, should facilitate the process of admission for those in need of treatment, while at the same time safeguarding the liberty of those who are not mentally ill (in the sense of Proposal 1).

Proposal 1

That a person be compulsorily admitted only when 'because of mental illness, his/her physical, psychological or social survival or the health of others is seriously endangered' and when 'an alternative and reasonable remedy is not available'.

Proposal 2

That no person be committed, under the Mental Health Act, by reason alone of:

(1) any religious or political opinion;
(2) sexual preference, sexual orientation or sexual promiscuity;
(3) immoral or illegal conduct;
(4) mental retardation or developmental disability of mind;
(5) drug taking unless this last actually produces frank psychiatric disorder.

The word 'alone' is necessary since many psychiatric illnesses may present themselves with, for example, religious or political beliefs, or behaviour of an aberrant kind.

Proposal 3

That there should be a register of medical practitioners designated as being able to certify patients for compulsory admission (other than emergency admissions). Doctors would be eligible to be placed on this register by virtue of their 'special experience and/or training in psychiatry'.

Proposal 4

That initial compulsory admission should be for no longer than 72 hours. It is anticipated that at the end of this period the majority of such patients will be ready for discharge or for admission as informal patients. Should this not be the case, sufficient time will have elapsed for valid reasons to be given for continued compulsory detention.

Proposal 5

That one medical practitioner should be sufficient to admit a patient to hospital for this period, provided he/she is on the
special register; otherwise two doctors should be necessary except in emergency, the nature of which must be clearly specified.

Proposal 6

That on compulsory admission patients should have the immediate right to contact a lawyer. (Comment is welcome on organisational arrangements including access to legal aid and the availability of independent legal advice).

Proposal 7

That the initial 72 hour period can be extended to not more than 21 (or 28 days - please comment on the preferred duration) in the first instance. This would always require the involvement of a doctor on the special register denoting special experience and/or training in psychiatry.

Proposal 8

That committal for a period beyond the 21 or 28 days should require the approval of a district court judge.

Proposal 9

That patients or their nearest relative should have the right, either acting on their own behalf or through their lawyer, to ask that the judicial examination and decision be completed at any time before the expiry of the 21 or 28 day period.

Proposal 10

That admissions should be based on medical grounds leaving the courts to provide oversight in respect of the civil and human rights involved in the referral and admission process. Although medical and legal issues concerning committal are clearly connected, it is important that they should be kept separate.

Proposal 11

That upon admission, all patients (formal and informal) and where appropriate their relatives, should be informed of their entitlements under the Act, verbally and in writing and that their understanding of these entitlements is confirmed at a later stage.

II Personnel Designated for Facilitation of Compulsory Admission

Proposal 12

That relatives and others should be able to be guided and assisted in decisions about admission by designated health professionals working in the community. These professionals,
who would have special experience or training, would have a role specifically related to the Mental Health Act.

III Review Procedures for Compulsory Admission

Proposal 13

That review tribunals should be set up on a regional basis and be charged with the responsibility of reviewing the legal status of psychiatric patients in hospital under compulsion.

Proposal 14

That these tribunals should consist of three persons - a psychiatrist, a lawyer and a lay person who should be capable of meeting frequently and rapidly; otherwise their purpose would not be fulfilled.

Proposal 15

That patients who have not otherwise been discharged on the agreement of the responsible medical practitioners should have the right to apply to a review tribunal at any one time within three months of committal, and within any six month period after that, up to a limit of three years. A similar right of appeal should apply to the nearest relative. In the event of a patient or his/her relative not taking this action, review by a tribunal should be automatic, at the same time intervals, for three years after committal. After that time, review should be automatic on an annual basis if the patient or the nearest relative has not applied to the tribunal during the previous twelve months.

IV Consent to Treatment

This issue has implications which extend beyond mental health legislation. It is suggested that mental health legislation should make it clear that treatments should ideally be given only on the basis of the competent and informed consent of the patient. Exceptions to this principle should be spelt out, and the consequences considered for those cases where the patient is not competent.

'Informed consent', is defined as involving explanation of the purpose, likely consequences and risks of a treatment to the satisfaction of the patient and the doctor. Mechanisms will need to be evolved to ensure that the explanations are indeed satisfactory to the patient, and that the patient is competent to comprehend their meaning.

The department favours consideration of proposals relating to the question of consent for treatment along the lines of those embodied in Britain's Mental Health (Amendment) Act 1982.
Proposal 16
That there should be three categories of medical treatment for mental disorder, defined in part by the Act itself and also by regulations.

Proposal 17
That the first kind of medical treatment (which includes psychosurgery) should require:

1. the consent of the patient, whose competence to understand the nature, purpose and likely effect of the treatment in question has been verified by the regional review tribunal; (lack of the patient's consent would prevent the performance of this category of treatment) and

2. a second specialist opinion from a medical practitioner, called in for the purpose by the review tribunal, who is required to consult with the patient and with at least two other health professionals concerned with the patient's management. These provisions would apply to informal as well as to committed patients.

Proposal 18
That the second category of treatment (including ECT and certain psychotropic drugs) should require informed and formal consent or, if this cannot be reasonably obtained, a second opinion by an appointed medical practitioner called in for the purpose by the review tribunal, who must consult with the next of kin where practicable and with two other health professionals concerned with the patient's treatment. This latter provision would apply only to committed patients.

Proposal 19
That the third category of medical treatment, such as general nursing care, should not require consent. This provision would apply only to committed patients.

Proposal 20
That the above provisions should not apply in cases of urgent treatment, which is defined as:

1. Treatment which is immediately necessary to save the patient's life; or

2. Treatment which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or

3. Treatment which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
(4) Treatment which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

For the purpose of this section treatment is deemed irreversible if it causes irreversible physical or psychological damage, and is deemed hazardous if it entails significant physical hazard.

V Legislation Regarding Management of Patient's Affairs

Proposal 21

That the question of a patient's ability to manage his/her affairs should be separated from the question of committability, and that transfer of management should not be automatic upon committal. Conversely it should be possible for informal patients to have their affairs managed for them when appropriate. It is considered that legislation in this area should be reviewed in relation to other legislation relating to dependent and infirm persons.

Department of Health - February 1983
## APPENDIX TWO

### REPLIES TO ORIGINAL PROPOSALS

**ORGANISATIONS AND INDIVIDUALS COMMENTING ON DEPARTMENT'S POSITION PAPER**

1. Auckland Hospital Board  
2. M Brieseman, Deputy Medical Officer of Health Christchurch  
3. J Reid, Medical Officer of Health, New Plymouth  
4. K D B Thomson, Medical Officer of Health, Wanganui  
5. A L Cowan, Medical Officer of Health, South Auckland  
6. A G Scott, Medical Officer of Health, Lower Hutt  
7. Peter Sander, Nurse Adviser, Head Office, Department of Health  
8. E J Hill, Waikato Hospital  
9. Ross St George, NZ Psychological Society Inc.  
10. D J Hibbs, Director of Psychiatry, Bay of Plenty Hospital Board  
11. L H Brett, Director, Psychiatric Unit, Waikato Hospital  
12. G S Cliff, Waikato Hospital  
13. R Parker, Chief Executive, North Canterbury Hospital Board  
14. A H Crawford, Christian Science Committee on Publication  
15. A G Fraser, Medical Superintendent, Kimberley Hospital and Training School  
16. P Kerridge, Chief Executive, West Coast Hospital Board  
17. J B Hannifin, Co-ordinator, Alcohol and Drug Dependency Services, Palmerston North Hospital Board  
18. G Page, Chief Executive, Taumarunui Hospital Board  
19. Philip Ney, Professor of Psychological Medicine, Christchurch Clinical School  
20. M H Durie, Director of Psychiatry, Palmerston North Hospital  
21. J R B Saxby, Psychiatrist, Tokanui Hospital
22 Wellington Health Services Advisory Committee (Mental Health Shadow Service Development Group, Marion Bruce)

23 A G Poynter, Medical Superintendent-in-Chief, Palmerston North Hospital Board

24 K C Fox, Director of Psychiatry, Timaru Hospital

25 Reverend W Ford, Methodist Church

26 N W Currie, Public Trustee

27 Otago Hospital Board

28 M Willemsen, Chief Executive, Vincent Hospital Board

29 M G Mackay, Psychiatrist, Cook Hospital

30 Peter A McKinnon, Medical Superintendent, Nelson Hospital Board

31 Graham Mellsop, Professor of Psychological Medicine, Wellington Clinical School

32 J Eaddy, Chief Executive, Taranaki Hospital Board

33 Mark Flowers, Chief Social Worker, Social Work Department, Napier Hospital

34 John Elvidge, President, Canterbury Association for Mental Health

35 L A Malcolm, Health Planning and Research Unit, Christchurch

36 R W Medlicott, Porirua Hospital

37 Hawkes Bay Hospital Board (Mental Health Advisors Group and Staff)

38 W Penniket, Medical Officer of Health, Hamilton

39 J Roxburgh, Medical Officer of Health, Nelson

40 E J McInnes, Convenor, Local College Members, Dunedin

41 Wellington Hospital Board

42 Q Angus, President, Disabled Persons Assembly (NZ)

43 Pat Carroll, Executive Director, New Zealand Nurses Association

44 B M Manchester, Acting Director-General, Department of Social Welfare
Dr Brett, Waikato Hospital Board
R E Harrison, President, Auckland Council for Civil Liberties
R A Fairgray, Medical Superintendent-in-Chief, North Canterbury Hospital Board
New Zealand Law Society
A Otago District Law Society
B Mr T F Fookes (Wellington)
M Abbot, Mental Health Foundation
W A Malpress, Medical Officer of Health, Christchurch
Barrett Street Hospital, New Plymouth
Peter Thomas Henaghan
Wellington Hospital Board
Diane Sleek, Faculty of Law, Victoria University of Wellington
V Breen, Chief Executive, Northland Hospital Board
Bay of Plenty Hospital Board (Senior Medical Staff and Board)
G R Perera, Medical Officer of Health, Napier
L King, Honorary Secretary, Royal New Zealand College of General Practitioners
J R E Dobson, Chairman, Psychological Medical Services, North Canterbury Hospital Board
A Fraser, New Zealand Branch, Royal Australia and New Zealand College of Psychiatrists
Lorraine Smith, Lawyer
L J Castle, Ombudsman, Office of the Ombudsman
K O Thompson, Deputy Commissioner (Operations), New Zealand Police
Social Workers, Auckland Hospital Board
A Millar, Medical Officer of Health, Rotorua
J C Pike, Department of Justice
R Parker, Chief Executive, North Canterbury Hospital Board
Mr C D Morpeth, Office Solicitor, Human Rights Commission

Mr Jim Murphy, Chairman, Health Interest Group, New Zealand Association of Social Workers, Hastings

A R Chittenden, Social Work Department, Waikato Hospital

Dr John Hall, Porirua Hospital

Dr J A Begg, Sunnyside Hospital, North Canterbury Hospital Board

Dr Roberta Highton, Ashburn Hall

National Coordinator, Schizophrenia Fellowship (NZ) INC, Christchurch

J D Maling, Secretary/Coordinator, Wellington Branch, Schizophrenia Fellowship

Mrs L M Webb, Social Work Department, Puketiroy Centre

Dr Jonathan Lichter, Otago Association for Mental health

Association Secretary, Auckland District Law Society

J B Munro, National Director, The NZ Society for the Intellectually Handicapped Inc

John Noble, Dunedin Psychological Service

Dorothy Howie, Lecturer in Education, Auckland University

Chief Executive, Wanganui Hospital

John McG Quirke, Clinical Psychologist, Tokanui Hospital

J Rennie, Chief Executive, Wellington Hospital Board

W L Renwick, Director-General of Education, Dept of Education

Margaret Barr, Community Health Service, Wellington Hospital Board, Porirua

Dr Barbara Brumby, Barrett Street Hospital

Wellington Patients' Association

New Zealand Medical Association
APPENDIX THREE

UNITED KINGDOM MENTAL HEALTH ACT COMMISSION AND ITS RELEVANCE TO NEW ZEALAND

BACKGROUND: ESTABLISHMENT OF UK MENTAL HEALTH COMMISSION

In the United Kingdom, a Mental Health Act Commission has been established by the Secretary of State as 'a special health authority' under the National Health Service Act 1977. It consists of a Chairman and approximately 12 lawyers, 12 nurses, 12 psychologists, 12 social workers, 12 laymen and 22 psychiatrists (medical members have extra duties giving second opinions and carrying out clinical examinations). It has a central policy committee based in London and three regional panels based in Nottingham, London and Liverpool.

The overall purpose of the Commission is to exercise a general protective function for committed patients and to carry out certain other functions given to the Secretary of State under the Act. Further, the Secretary of State may direct a special health authority to exercise any of his/her powers and duties and may give it directions as to how it carries out its functions. The Commission is thus responsible to the Secretary of State but is to be an independent body with members eminent in their different fields.

Specific functions of the Commission are as follows:

1. To keep under review the powers of detention under the Act. It is considered essential that the procedures leading to detention and to renewal of authority for detention should be subject to scrutiny by a body independent of those who have been concerned with the compulsory admission and detention. This is a delegated authority from the Secretary of State who has a responsibility to oversee the use of powers and the discharge of duties imposed by the Act in relation to detained patients. Commission representatives are authorised to visit hospitals and mental nursing homes and interview detained patients in private.

2. To investigate individual complaints consisting of:
   - complaints which patients believe have not been satisfactorily dealt with by hospital managers.
   - complaints as to the exercise of powers or the duties conferred or imposed in respect of a detained patient.

3. To appoint medical practitioners on behalf of the Secretary of State to provide independent second opinions in connection with consent to treatment requirements.
4. To prepare, on behalf of the Secretary of State, a Code of Practice. Section 118 requires the Secretary of State to prepare, and from time to time revise, a Code:

(1) for the guidance of medical practitioners, managers and staff of hospitals and mental nursing homes and approved social workers in relation to the admission of patients to hospitals and mental nursing homes under the Act,

(2) for the guidance of medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorders.

The Code should list treatment of 'special concern' in addition to any specified by Regulations (which are legally binding). It is intended that it will also give guidance on the procedures to be followed in deciding when a patient's consent is valid or when a second opinion should be obtained. It will advise the independent doctor on principles to be followed when deciding whether or not a form of treatment should be given. It may, in addition, refer to treatments from other forms of illness from which a patient may be suffering and to principles to be kept in mind when treating patients in an emergency. The intention is that guidance on good practice relating to all aspects of care and treatment formulated by the Commission will be included in the Code, and updated from time to time.

The Secretary of State is required to publish the Code currently in force.

5. The Secretary of State may direct the Commission to keep informal patients under review.

JUSTIFICATION FOR MENTAL HEALTH ACT COMMISSION

In the British Command Paper of November 1981, it is stated 'The most important safeguards to ensure that patients are not detained unnecessarily are the carefully drawn criteria for admission and renewal of detention and access to Mental Health Tribunals; but other checks are also needed.' The paper further states that because patients compulsorily detained under the Mental Health Act have no right to discharge themselves, and because it is essential to ensure that procedures for committal and renewal of this authority are subject to scrutiny, it is clear that the responsibility for undertaking this scrutiny should rest with a body independent of those who have been involved in the compulsory admission and continued detention. It is emphasised that the Commission is not intended to trespass in any way on the Mental Health Review Tribunals' role of deciding on the legal status of detained patients. Similarly, its functions are to be separate from other inspectorial bodies; that is, its concern will be the particular problems which arise from the detention of specific individuals in hospital rather than general services affecting all mentally ill and mentally handicapped persons.
SITUATION IN NEW ZEALAND

In the case of New Zealand, the Working Party does not believe there are sufficient grounds to warrant the establishment of a Commission similar to that in the United Kingdom. The first major reason is that those primary functions of the Commission which are also relevant to the New Zealand situation are either being carried out already to some extent at least, or can be performed in some other way eg the United Kingdom does not have Official Visitors and District Inspectors as New Zealand does. Secondly, the administrative costs of establishing and maintaining such a Commission, and the additional pressure its work load would put on already hard-working health professionals and health administrators cannot be justified in terms of the benefits a Commission could be expected to bring. A new broadly-based Departmental Committee (including representatives from a wide range of health professional and other interested organisations) would suffer from the same need to increase staff and bear increased administrative expense. A further reason is the smaller population in this country and the smaller proportionate number of qualified personnel.

The Working Party has, therefore, looked separately at each function of the UK Commission and considered how, if appropriate, the functions outlined could best be carried out in New Zealand.

1 To keep under review the powers of detention under the Act

It is believed that the function of overseeing the use of powers of admission and detention provided by a revised Act is most important. This function is seen as being a Health Department one in terms of the department's legislative and administrative responsibility for the Act itself, and because of practical experience in the department in the inspectorial role.

The question of monitoring standards of care is associated with this function as is the question of ongoing review of the provisions and implementation of a Code of Practice. This is further discussed under 4 below.

2 To investigate individual complaints

The Working Party's view is that the present complaints machinery in New Zealand could be given a few improvements, provide sufficient avenues through which complaints can be voiced and heard (eg hospital staff, medical superintendents, hospital boards, the Director of Mental Health and the Minister of Health). Ways of improving existing machinery and procedures are being considered in another context, with particular emphasis being given to articulating more clearly the role and responsibilities of Official Visitors and District Inspectors. This would involve more direction to,
and training of, such personnel in the duties required of them, and an attempt to maximise awareness of their functions amongst hospital staff and the patients themselves. There could usefully be a similar effort to increase awareness of other avenues for complaint.

3 To appoint medical practitioners on behalf of the Secretary of State to provide independent second opinions in connection with consent to treatment requirements.

Consent to treatment issues are discussed in detail in Paper 7. It is proposed that second specialist opinions will be required in both categories of treatment for which special safeguards should apply and for which there should be a special effort to obtain consent. In both categories, the written recommendation of a second specialist would be required before treatment could occur; in the first category (including psychosurgery), the consent of the patient would also be mandatory.

The proposal of the Working Party is that second specialists would be called in by Review Tribunals working from a list or panel of regional specialists drawn up by the department in consultation with the appropriate professional bodies.

4 To prepare on behalf of the Secretary of State, a Code of Practice.

It is intended that the British Code of Practice should be, firstly, for the guidance of medical practitioners, hospital staff and others involved in the admission of patients to psychiatric hospitals and homes and, secondly, for the guidance of medical and other health professions in relation to the medical treatment of patients suffering from mental disorder. A similar NI Code would, in particular, list treatments of 'special concern', and give guidance, for the benefit of all health professionals involved, on procedures to be followed in instances of emergency and when wishing to administer treatment without a patient's consent. This second group of functions is a complex one involving as it does delicate and expert decisions on treatment modalities and clinical practice.

Having considered several options, the Working Party concludes that the preparation of a Code of Practice similar to that in the United Kingdom could be initiated by a small working group in the department with the assistance of several suitably qualified professionals experienced in the hospital and treatment fields. Professional organisations, hospital staff and other appropriate bodies would be invited to comment.

There would be a continuing need for review of the Code and for advising the Minister on treatments of special concern to be covered by regulations. Monitoring standards of care in psychiatric institutions and overseeing the use of powers
incorporated in the Act are normally functions of the department. However, it may prove necessary to establish some mechanism to ensure that reviewing activities are co-ordinated and that people with the required expertise outside the department are involved in the process.

It will be noted that a Code of Practice would have no legal force; indeed, it is not appropriate to encode standards in this way. Nevertheless, the Working Party believes that a well-drafted Code, approved and issued by the Director-General of Health, would serve to create its own moral pressure, as well as providing useful guidelines for professional and administrative groups. It would exist alongside the Mental Health Act and other relevant health legislation and assist the process of audit, both by hospitals and the department. As in the United Kingdom, it is intended that the Code should be published and revised from time to time. (See Paper 14.)

5 The Secretary of State may direct the Commission to keep informal patients under review

At this point, the Working Party has no information as to whether the British Secretary has yet directed the Commission in this way. It should be noted, however, that while New Zealand's Mental Health Act is concerned principally with committed and special patients, it is not confined to them. 'Informal' patients also suffer a loss of liberty while in hospital and, like 'formal' patients, have rights which must be respected. It is the view of the Working Party that one of the provisions of the Bill will be that the case of informal patients will be reviewed regularly. (See Paper 5 - Informal Patients, and Paper 8 - The Review Process.)

CONCLUSION

In summary, the conclusion of the Working Party is that a Mental Health Act Commission similar to that in the United Kingdom is not necessary or a practicable proposition in New Zealand. It is believed, however, that the major functions of the Commission are valuable ones, and that they can be carried out in this country by different means.