Better safe than sorry?

The preventive use of Community Treatment Orders under New Zealand's Mental Health Act

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A dissertation submitted in partial fulfillment of the degree of Bachelor of Laws (with Honours) at the University of Otago, New Zealand

October 2017

“There is no health without mental health”
David Satcher.

Acknowledgements

To my supervisor, John Dawson, for your wisdom and kindness. Thank you for challenging me, and encouraging me to care.

To my flatmates and friends, for all the laughter and support.

To my parents, for everything you have done for me.

Abbreviations

CRPD	Convention on the Rights of Persons with Disabilities
CTO	Community Treatment Order
ICCPR	International Covenant on Civil and Political Rights 1966
ICESCR	International Covenant on Economic, Social and Cultural Rights 1966
MHA	Mental Health (Compulsory Treatment and Assessment) Act 1992
MHRT	Mental Health Review Tribunal
NZBORA	New Zealand Bill of Rights Act 1990
SRT	Southern Review Tribunal

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Introduction

This dissertation considers whether the legal criteria governing compulsory treatment under New Zealand's mental health legislation permit a person to be kept under a Community Treatment Order ("CTO") for "preventive" purposes. In other words, it considers whether a patient can be kept under compulsion even when their condition is currently stable and they present no immediate threat of harm to themselves or others. In such circumstances, can a person be kept under a CTO to prevent their future relapse?

Compulsory psychiatric treatment in New Zealand is governed by the Mental Health (Compulsory Assessment and Treatment) Act 1992 ("MHA"). This provides the civil route of entry into compulsory psychiatric care in New Zealand.[1] It permits people to be placed under compulsory treatment orders of two types: "Inpatient Orders", where the patient is detained in the hospital for treatment,[2] and "Community Treatment Orders", where the patient must accept treatment administered in their home or a community facility, but cannot be detained there.[3] CTOs were introduced in the wake of the deinstitutionalisation of psychiatric hospitals, following campaigns by civil rights activists and clinicians for the care of mentally ill patients in a less restrictive setting.[4] The MHA gives priority to CTOs over Inpatient Orders, requiring the order to be a CTO unless the patient cannot adequately be treated as an outpatient.[5]

CTOs in New Zealand today have "less restrictive" characteristics, as the patient is able to live in the community rather than in a hospital setting.[6] However, they also have "preventive" characteristics, as stable patients who do not present an imminent threat of harm to themselves or others can be kept on CTOs, based on a longitudinal assessment of risk.[7] This preventive use of CTOs can be both desirable and problematic. Maintaining a patient on a CTO can be advantageous as it may prevent deterioration into a mental state

[1] John Dawson "The Process and Criteria for Compulsory Psychiatric Treatment" in Ron Paterson and Peter Skegg (eds) *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) 425 at 425-426.

[2] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 29(1).

[3] Section 30(1).

[4] Tom Burns "Compulsion in Community Mental Health Care: Historical Developments and Current Provisions" in Andrew Molodynski, Jorun Rugkåsa and Tom Burns (eds) *Coercion in Community Health Care: International Perspectives* (Oxford University Press, Oxford, 2016) 13 at 14.

[5] Section 28(2).

[6] Burns, above n 4, at 16.

[7] Burns, above n 4, at 16.

in which the patient poses a serious danger to self or others, addressing safety concerns.[8] But the preventive use of CTOs can also be considered undesirable as it may disproportionately affect patients' rights to keep them under compulsion when they are currently in a stable condition. In New Zealand, CTO use is high compared to international use, and is increasing annually.[9]

Whether a person can be kept under a compulsory order depends on whether they meet the MHA's complex definition of "mental disorder" (or a "mentally disordered" person).[10] This definition comprises two parts, or limbs. The first limb requires that a person has an "abnormal state of mind", characterised by one of the listed disorders. The second limb requires that this abnormal state of mind "poses" a serious danger, or seriously diminishes the person's capacity for self-care. A person can be placed on a compulsory treatment order if they are "mentally disordered" in this sense, and the order is deemed necessary.[11] But if they cease to be mentally disordered at any time, they must immediately be taken off the order.[12] Consequently, to remain on a CTO, the person must *be* mentally disordered at the present time. This presents the main interpretive problem: "is" a person "mentally disordered" in the necessary sense, when their mental health is reasonably stable; or, in those circumstances, should they be released from control under the MHA, to protect their rights? A particular aspect of this concerns whether they "pose" a "serious danger", in that situation.

Two main approaches can be taken to the interpretation of the statutory definition of mental disorder: the purposive approach, and the rights-driven approach.[13] The purposive approach, codified in s 5(1) Interpretation Act 1999, states that:

> The meaning of an enactment must be ascertained from its text and in light of its purpose.

The rights-driven approach involves choosing an interpretation which is consistent with patients' rights under the New Zealand Bill of Rights Act 1990 ("NZBORA"). Section 6

[8] Burns, above n 4, at 17.

[9] Anthony J O'Brien "Community Treatment Orders in New Zealand: Regional Variability and International Comparisons" (2014) Australas Psychiatry 352 at 352.

[10] Section 2.

[11] Section 27.

[12] *Waitemata Health v Attorney-General* 21 FRNZ 216; [2001] NZFLR 1122 (CA).

[13] Dawson, above n 4, at 435.

NZBORA states that an interpretation consistent with the rights contained in the Act should be preferred. However, applying these approaches is a difficult task. The MHA has a dual purpose of allowing compulsion and protecting patients' rights, so either part of this purpose may be emphasised in different situations.[14] Furthermore, different views of what promotes patients' rights may be taken. For example, placing a patient on a CTO rather than an Inpatient Order may be viewed as protecting patients' rights to liberty by allowing them to live in the community. However, the same decision may be viewed as restricting patients' rights to liberty by forcing them to accept treatment at all. The application of the purposive and the rights-driven approaches to the same scenario may give the same result, but often the results will diverge, especially where compulsion for the purpose of protecting state interests is emphasised, and patients' rights are given less emphasis and expressly restricted as a result.

Consider, for example, the situation in *Re PT*.[15] PT had a schizophrenic type mental illness, but did not believe he was mentally disordered. He was admitted to hospital following an application for a CTO, but was subsequently fully discharged from compulsion. He was later readmitted to hospital under the MHA following a severe relapse of his condition after he stopped taking medication. He was placed under a CTO and some months later this order came before the District Court for review. At the time of the review hearing, PT was well-nourished, living at home with family support, not considered to be actively dangerous to himself or others, and his mental health was reasonably stable under his medication regime. Taking one approach, PT should be taken off the CTO as his condition is stable and it would be disproportionate to his rights to keep him on it. Taking another approach, PT should be kept on the CTO, as, though his condition is stable, if he was taken off the CTO he may stop taking his medication again and relapse into a severe condition. But "is" he mentally disordered in the necessary sense at the time of the hearing when his condition is reasonably stable? This example highlights the importance of interpretation, as PT's liberty is directly dependent on the approach taken.

PT was placed on a CTO, despite his stable condition at the time.[16] Whether this is legally correct requires an analysis of the main interpretations given to the concept of "mental

[14] Long title.

[15] *Re PT* [2001] NZFLR 79.

[16] Judge Walsh held that PT responded well to medication, but "his longitudinal history shows that when he is non-compliant with medication, he will suffer a relapse". When PT was non-compliant with medication, this started a cycle of relapse, which then led to a diminished capacity for self-care and dangerousness.

disorder" by New Zealand courts and tribunals, and whether these interpretations are convincing. Therefore, the main legal question this dissertation will address is whether the dominant interpretation of the notions that a person "is mentally disordered" and "poses a serious danger" in these situations is correct, and therefore whether the preventive use of CTOs is legal.

Chapter 1 will introduce the surrounding legal context, including the legal standards governing entry into and exit from compulsion, the dominant interpretive approaches to these standards, the power conferred by CTOs, and the relevance of the NZBORA. Chapter 2 will address the main aspects of the interpretive problem, particularly the interpretation of "poses a serious danger", and "intermittency", in the "mental disorder" definition. I will consider a concept of "danger" that would allow stable patients to be kept on CTOs, the notion of "danger" within a paradigm of "risk", and whether "intermittency" in the first limb affects interpretation of the second limb. Chapter 3 will analyse the courts' approach to interpretation in preventive cases, and whether the "serious danger" test is being interpreted within a risk paradigm. Finally, Chapter 4 will evaluate this approach, including consideration of whether enough emphasis is placed on rights, whether the approach taken is legitimate, whether there are any residual issues with the preventive use of CTOs, and how these may be addressed.

Therefore, a CTO was necessary to make sure PT was compliant with treatment: *Re PT*, above n 15, at [17]-[18].

Chapter 1: The Surrounding Legal Context

To understand the significance of the interpretive issues I briefly outlined in the introduction, the surrounding legal context needs to be considered. This context includes the MHA's provisions covering the legal standards governing entry into and exit from compulsion, the dominant approaches to the interpretation of these criteria, powers conferred by a CTO, and the relevance of the NZBORA. This chapter will discuss these elements and concludes with a further explanation of the main interpretive problems, in light of this legal context.

A The Legal Standards Governing Entry into and Exit from Compulsion

The legal definition of "mental disorder" in the MHA governs both entry into and exit from compulsory treatment under that Act. Anyone over 18 who believes a person may be suffering from a mental disorder can apply to have that person assessed.[17] If the person's allocated responsible clinician has "reasonable grounds for believing" they are "mentally disordered", the person may be certified for compulsory assessment.[18] Following compulsory assessment, if the responsible clinician is still of the opinion that the patient is not fit to be released from compulsory status, they must apply to the court for the making of a compulsory treatment order.[19] This represents the first way a CTO can be made: by a District Court judge, upon application for an order by a patient's responsible clinician.[20] The second way a CTO can be made is when the patient is transferred from an Inpatient Order to a CTO by their responsible clinician.[21]

1 Entry criteria

The criteria for the making of a CTO by a judge under the MHA require that the patient be presently "mentally disordered", and the order be "necessary" with regard to the circumstances of the case.[22] If a patient is found to be "mentally disordered" and the order is "necessary", the order must be a CTO unless the patient cannot adequately be treated as

[17] MHA, s 8(1).

[18] MHA, s 10(4).

[19] MHA, s 14(4).

[20] MHA, ss 27, 29.

[21] If a patient's responsible clinician considers that they can be treated adequately as an outpatient rather than an inpatient, they can direct the patient to be discharged from the hospital. The order is then deemed to be a CTO: MHA, s 30(2).

[22] MHA, s 27.

an outpatient.[23] Before making a CTO the court must also be satisfied that the patient will receive care appropriate to their needs on an outpatient basis, and the patient's social circumstances are adequate for his or her care in the community.[24]

2 Review and exit criteria

The responsible clinician has a continuing duty to consider whether the patient meets the criteria for compulsion.[25] Formal review of a CTO is carried out by the responsible clinician at 3 months, and at 6 monthly intervals thereafter.[26] Patients found not fit to be released in a formal clinical review are entitled to have their status reviewed by the Mental Health Review Tribunal ("MHRT").[27] As there is no "no longer necessary" test in the exit criteria, there is no precise symmetry between the criteria governing entry into and exit from the MHA.[28] A patient must simply be released from compulsion when they are "fit to be released".[29] "Fit to be released from compulsory status" is defined in s 2 MHA as "no longer mentally disordered and fit to be released" from compulsory status. The Court of Appeal in *Waitemata Health v Attorney-General* unanimously held that the use of "and" in that phrase introduces a consequence, so it means "no longer mentally disordered *and therefore* fit to be released".[30] The implication is that a patient must be immediately released from compulsion if they are no longer mentally disordered.[31] Despite the fact that there is no comparable standard about a CTO being no longer "necessary" expressed in the exit criteria, this makes little difference in practice as the MHRT has held that the decision whether a patient is still "mentally disordered" involves consideration of the overall justification for compulsion, and thus whether the order is still necessary.[32] If the responsible clinician decides the patient is not fit to be released upon expiry of the order,

[23] MHA, s 28(2).

[24] MHA, s 28(4).

[25] If the responsible clinician considers that a patient is fit to be released at any time when they are on an order, they must immediately release them. The meaning of "fit to be released" is discussed shortly: MHA, s 35(1).

[26] MHA, s 76.

[27] MHA, s 79.

[28] The Court of Appeal held that "it is not at all clear from the scheme of the Act that the clinicians upon whom, subject to review, the principal responsibility for discharge rests, are concerned with anything other than the question of continuing mental disorder": *Waitemata Health*, above n 12, at [88].

[29] MHA, ss 35(1), 79(8).

[30] At [95].

[31] *Waitemata Health*, above n 12.

[32] *Applicant 08/184* [2009] NZMHRT 22 (13 February 2009) at [27].

they must apply to the District Court for an extension.[33] Appeals from the MHRT are also heard in the District Court.[34]

3 Discharge from the MHA does not prevent a person being placed under it again

It is important to note that discharge from the MHA does not prevent a person being placed under it again in the future. If a patient is released from compulsion because they no longer meet the "mental disorder" definition, but their situation changes and the entry criteria are again met, they can immediately be placed under the MHA. [35]

B The Dominant Approaches to Interpretation of these Criteria

The main interpretive strategy used by the MHRT when applying the "mental disorder" definition focuses on whether compulsory treatment is justified in the circumstances.[36] This is guided by proportionality: the limits placed on patients' rights must be proportionate to the intervention, and the likely impact on rights must be balanced with state interests in placing a person on an order.[37] As many key terms in the definition are undefined, a "dynamic", or flexible approach to interpretation is said to be required.[38]

1 "Mentally disordered" in the necessary sense

The definition of "mental disorder" in the MHA is a legal one, not a psychiatric definition, although the language is in part drawn in psychiatric terms. Consequently, the legal definition does not cover all forms of mental illness. However, application of the criteria is still "heavily dependent on the assessment of clinicians", as psychiatrists have been given key roles under the MHA and emphasis is placed on psychiatric opinions in determining

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[33] MHA, s 34.

[34] MHA, s 83.

[35] Dawson, above n 1, at 432.

[36] John Dawson "The Complex Meaning of "Mental Disorder"" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 29 at 30.

[37] Dawson, above n 36, at 31.

[38] This means that considerations relating to the first limb of the "mental disorder" test can aid in interpretation of the second limb, and vice versa. Dunlop gives an example of how the second limb can aid the first limb: a man who engages in self-harming behaviour (second limb consideration) may be regarded as mentally disturbed because of this (first limb consideration), whereas a man who engages in harmless behaviour is unlikely to be considered disturbed. In these cases, interpretation requires consideration of how the second limb impacts on the first: Nigel Dunlop "Compulsory Psychiatric Treatment and "Mental Disorder"" (2006) NZLJ 225 at 228.

the meaning of technical terms.[39] As stated earlier, there are two limbs of the definition: the descriptive limb, and the consequences limb. Both limbs must be satisfied in order for a person to be considered "mentally disordered". There must be a nexus between the person's mental state and the specified consequence, as the abnormal state of mind must be "of such a degree that it" results in one of the consequences. The causal relationship between the first and second limbs is necessary to differentiate a mentally disordered person from a violent offender, who may "pose a serious danger", without this danger being caused by an abnormal state of mind.

(a) Abnormal state of mind

The first limb requires that a person has an "abnormal state of mind", characterised by delusions, disorders of mood or perception, or disorders of volition or cognition. Though there is no direct reference to major diagnoses given in psychiatry such as schizophrenia or bipolar disorder, the major manifestations of most of these serious disorders such as delusions or hallucinations are included in the statutory definition.[40] A person must meet at least one of the stated disorders in full, rather than aspects, or "strands" of several disorders.[41] Whether a person's state of mind is "abnormal" requires an objective consideration of their mental state compared to others in the general public. It is not a test of whether their mental state is normal for them.[42] The abnormal state of mind can be of continuous or intermittent nature, which means it may not be present at the time of assessment. "Intermittent" has been interpreted to mean "having stopped, is expected to recur".[43] One off episodes which are not expected to recur will not meet this definition.[44]

(b) Poses a serious danger

The first consequence of the second limb requires that the person's abnormal state of mind is of such a degree that it "poses a serious danger to the health or safety" of self or others.

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[39] *Waitemata Health*, above n 12, at [68].

[40] Dawson, above n 1, at 441.

[41] The tribunal has stated that "it is incorrect to assert that whilst delusions or disorders of mood, perception, volition or cognition may not of their own be established, nonetheless, if there are disturbances in a number of these areas which have potency in combination, then the first limb may be satisfied. Delusions or one of the four named disorders either exist or they do not. If none individually exist, there cannot be a finding of mental disorder": *G 05/133* [2006] NZMHRT 133 (2 March 2006) at [7].

[42] Dawson, above n 36, at 32.

[43] *Applicant 10/073* [2010] NZMHRT 3 (26 August 2010) at [107].

[44] Dawson, above n 36, at 32.

This is arguably the most contentious part of the "mental disorder" definition. The tribunal considers serious danger on the basis of four parameters: nature or magnitude of the likely harm, probability, imminence, and its frequency.[45] Evidence that is both "intrinsic" to the patient, for example their mental state, and "extrinsic", for example where they live and their family support, will be considered.[46] A gradual widening of the notion of "serious danger" has occurred since the introduction of the test. "Serious danger" was initially limited to physical violence,[47] but it has been held that the use of the word "health" in the definition also includes damage to psychological health due to emotional and psychological harm.[48] Previously, an emphasis was put on the criterion of imminence, but the MHRT has moved away from the requirement that the danger be immediate.[49] Currently, a patient does not have to score highly on all 4 parameters to pose a "serious danger", so although imminence is often sufficient, its absence is not decisive. For example, if the predicted harm is very serious, or has occurred at a high frequency in the past, the patient may still be found to be a "serious danger" even if they do not present a current danger.[50] This takes into account the fact that the immediacy of dangerous behaviour may depend on relapse, which might not occur right away if current compulsory treatment is preventing it.[51] The MHRT has held that likelihood of relapse is critical in predicting future danger, so factors should be considered such as the degree of causal connection between relapse and dangerousness, the expected time lapse between discharge from the MHA and cessation of treatment, whether interventions by others can prevent a relapse in its early stages and the ability of clinicians to reinitiate assessment under the MHA.[52]

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[45] *Re Mental Health [Serious Danger]* [2012] NZFLR 1 at [57].

[46] *Re KMD* MHRT 04/139 (27/04/05).

[47] In *In the matter of JK*, it was held that the "serious danger" test requires "a demonstrable risk of no less than serious physical violence": *In the matter of JK* [1994] NZFLR 678 at 702.

[48] Judge Doogue held that "the concept of "serious danger to a person" tends to indicate the risk must be a risk of physical harm, but "serious danger to the health or safety of a person" may exist where there is no necessary risk of physical harm, at least of imminent and direct physical harm (allowing for the possibility that damage to emotional and psychological health may lead eventually to physical harm).": *In the matter of D* [1995] NZFLR 28 at 45-46.

[49] *Re GM (Mental Health)* [2001] NZFLR 665 at 670-671.

[50] *Re Mental Health [Serious Danger]*, above n 45, at [59].

[51] Kris Gledhill "Risk and Compulsion" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 62 at 68.

[52] The tribunal held that these considerations are in effect a restatement of the four parameters already referred to at [57]: *Re Mental Health [Serious Danger]*, above n 45, at [60]-[61].

(c) Seriously diminished capacity for self-care

The second consequence of the second limb requires that the person has a "seriously diminished capacity for self-care". Deciding whether a person has a "seriously diminished capacity" necessitates the use of a mixed objective and subjective test, requiring assessment of what an ordinary citizen would find an acceptable minimum level of self-care, for a person in the patient's circumstances.[53] In practice, most patients' capacities for self-care are so diminished that only an objective assessment is required, and there is no need to engage in a subjective assessment.[54] "Capacity for self-care" involves more than having the necessities for survival. It is the ability to cope adequately in the community with available assistance, and the ability to seek and use this assistance.[55]

(d) The two limbs are interactive

The MHRT has noted that the two limbs are interactive, as the strength of the evidence for one part can influence the other. For example, a person with a particularly serious abnormal state of mind, who poses a less serious danger, can come under the MHA, and a person with a less serious abnormal state of mind but who poses a very serious danger can also be compelled.[56]

2 Other legal principles involved

(a) Making a CTO is "necessary"

As stated previously, in making a CTO, there is also the requirement that compulsory treatment is "necessary". For a CTO to be considered "necessary" the benefits of the order must outweigh the encroachment on patient rights, to ensure that the least restrictive approach is taken in the particular circumstances.[57] An order may not be "necessary" where treatment is unavailable or ineffective, or the patient would accept treatment voluntarily.

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[53] *Re C* DC Auckland CAT132/99, 28 August 2000; discussed in Matthew McKillop "Seriously Diminished Capacity for Self-Care" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 77 at 83-85.

[54] McKillop, above n 53, at 85.

[55] McKillop, above n 53, at 82.

[56] Dawson, above n 1, at 439.

[57] Richard Mullen "Personality Disorder and the Mental Health Act" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 46 at 55.

(b) Exclusionary rules

Section 4 of the MHA precludes any person from being placed under the Act by reason only of their political, religious or cultural beliefs, their sexual preferences, their criminal or delinquent behaviour, substance abuse or intellectual disability. This prevents assumptions being made that a person is mentally disordered simply because they may have different beliefs or engage in certain behaviour.

(c) Implicit factors for discharge

Aside from the explicit criteria included under the MHA in deciding whether a patient should be discharged from compulsion, there are other implicit criteria the tribunal relies on. These are not stated in the MHA, but are drivers in the tribunal's decision making and can heavily influence the decision to discharge a patient. These are factors such as a patient's insight into their illness, their past success as a prediction for the future, and whether the order is still necessary.[58]

C Powers Conferred by a CTO

A CTO can "require the patient to attend at the patient's place of residence" or other specified location for "treatment", and to "accept that treatment".[59] If a patient refuses to attend for treatment, a duly authorised officer may "take" the patient to that place, with police assistance if necessary,[60] and "at all reasonable times, enter the patient's place of residence or other place so specified" to treat the patient'.[61] If the responsible clinician considers the patient can no longer be treated adequately as an outpatient, he or she can recall them to hospital and direct inpatient treatment for up to 14 days, or direct further compulsory assessment.[62] There is no power to detain a patient in the community,[63] and a CTO cannot be used to order a patient to live at a specified address.[64] If there is an

[58] See Kate Diesfeld "Implicit Factors for Discharge by the Mental Health Review Tribunal" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 114.
[59] MHA, s 29(1).
[60] MHA, ss 40, 41.
[61] MHA, s 29(2).
[62] MHA, s 29(3).
[63] John Dawson "Powers, Rights and Review Procedures" in P.D.G. Skegg and R Paterson (eds) *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) 451 at 470.
[64] *Department of Health v D* [1999] NZFLR 514.

"emergency", a patient can be detained and taken to the place of treatment and treated using "such force as is reasonably necessary in the circumstances",[65] but there is no express power to restrain a patient to administer medication outside hospital.[66]

A range of rights and interests of a patient can be affected by the exercise of these powers. These are derived from the NZBORA, common law, international treaties to which New Zealand is party, and other statutes. Rights expressly protected by the NZBORA include the right to refuse to undergo medical treatment,[67] the guarantee of freedom of movement,[68] the right not to be arbitrarily arrested or detained and the right to be informed of reason for detention and to be treated with respect.[69] Relevant human rights treaties which New Zealand is party to include the International Covenant on Civil and Political Rights 1966 ("ICCPR"), the International Covenant on Economic, Social and Cultural Rights 1966 ("ICESCR") and the Convention on the Rights of Persons with Disabilities ("CRPD"). These treaties are not directly enforceable in New Zealand courts, but statutes should be construed to meet these obligations,[70] and the NZBORA affirms New Zealand's commitment to the ICCPR.[71] Rights protected by these treaties include the right to health,[72] right to life,[73] right not to be subjected to inhuman or degrading treatment,[74] right to liberty[75] and rights to privacy and autonomy.[76] Common law rights such as privacy of the person and property and security of the person may also be implicated.[77]

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[65] MHA, ss 122B(1), 122B(3).

[66] See John Dawson "The Powers Conferred by Community Treatment Orders" in Mark Henaghan and Jesse Wall (eds) *Law, Ethics, and Medicine: Essays in Honour of Peter Skegg* (Thomson Reuters, Wellington, 2016) 243.

[67] New Zealand Bill of Rights Act 1990, s 11.

[68] NZBORA, s 18.

[69] NZBORA, s 23.

[70] Kris Gledhill "A 'Rights' Audit of the Mental Health Act" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 285 at 286.

[71] NZBORA, purpose.

[72] The right to health is protected by Article 12(1) ICESR, which states that it recognises "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". It is also protected by Article 25 of the CRPD, which emphasises the right to the highest standard of health.

[73] The right to life is protected by Article 6(1) ICCPR, which states that all humans have an "inherent right to life" which cannot be lost "arbitrarily". Section 8 NZBORA affords the "right not to be deprived of life".

[74] The right not to be subjected to inhuman or degrading treatment is protected by Article 7 ICCPR which prohibits "torture or... cruel, inhuman or degrading treatment".

[75] The right to liberty is protected by Article 9 ICCPR.

[76] Article 17 ICCPR states that "no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence".

[77] John Dawson "Community Treatment Orders and Human Rights" (2008) 26 Law in Context 148 at 154.

D Relevance of the NZBORA

The current MHA was enacted just after the NZBORA and shortly before the Human Rights Act 1993, at a time when rights discourse was at the fore of Parliamentary decision making. There are many examples of Parliament's intention to protect patient rights in the MHA, for example Part 6 guarantees patients certain statutory rights and provides a complaints mechanism,[78] and the purpose of the MHA emphasizes the protection of the rights of the patient.[79] The MHA directly affects rights contained in the NZBORA, such as the right to refuse to undergo medical treatment,[80] so its interpretation is necessarily affected by sections 4, 5 and 6 of the NZBORA. Section 6 requires a rights consistent interpretation of an enactment to be preferred. However, the NZBORA is not entrenched in New Zealand's constitution, so it does not have supreme law status above other legislation.[81] Section 6 is qualified by sections 4 and 5 NZBORA. Section 5 states that the rights contained in the NZBORA are subject to justified limitations, and section 4 states that no other enactment is impliedly repealed or invalid simply because it is inconsistent with the NZBORA. Thus in interpreting the "mental disorder" definition, if a rights consistent meaning can be given, it must be preferred, unless it has the effect of nullifying or impliedly repealing the enactment, or rendering it ineffective by subverting its powers.

E The Main Interpretive Problems Explained Further, In Light of this Legal Context

The current interpretive approach used by the MHRT allows the preventive use of CTOs on stable patients who may not have caused any harm to self or others for a long time. This could be viewed as a grave encroachment on patient rights, so it is important to determine the proper interpretation of "mental disorder", as this is the main criterion for whether a patient is kept on a CTO or discharged. A patient must presently be "mentally disordered" to be kept on a CTO, so they must presently have an abnormal state of mind (although this can be intermittent), and must presently pose a serious danger or have a seriously diminished capacity for self-care.

[78] MHA, s 75.

[79] Long title.

[80] NZBORA, s 11.

1 "Poses a serious danger"

For the purposes of this dissertation, the first aspect of the interpretive problem concerns the meaning of "poses a serious danger". As the "mental disorder" definition requires the patient to be currently mentally disordered, this suggests that they must "pose a serious danger" right now, even when their condition may be relatively stable. Therefore, there needs to be a notion of danger that is enduring, or continuous in some latent sense. What is this concept of "dangerousness", and can it be enduring even if the patient is not presently acting violently?

2 Intermittency

The second aspect of the interpretive problem relates to intermittency. The word "intermittent" is only included in the text of the first limb of the definition of "mental disorder", which says the abnormal state of mind can be of "continuous or intermittent" nature. But does this mean the concept of intermittency is limited in application to the first limb? It seems that if a patient was stable, and their abnormal state of mind only intermittently present, then the consequence of that abnormal state of mind, the "serious danger" which it posed, would also be intermittent. Is that permissible, under the statute, or must the "danger" be more than "intermittent", to keep the patient under the MHA? To say the "danger" can be "intermittent" might be a counter-textual reading of the definition, as Parliament did not include intermittency in the second limb. Despite this, can a notion like intermittency be in some way implied into the second limb?

These are the main interpretive questions that will be tackled in subsequent chapters.

Chapter 2: Aspects of the Interpretive Problem

I will now analyse aspects of the interpretive problem, concerning whether a stable patient, maintained on a CTO preventively, can be considered "mentally disordered". Close textual analysis of the definition is critical. The definition requires a patient to have an "abnormal state of mind" (which may be continuous or intermittent), characterised by one of the listed disorders, that is "of such a degree that it" ("it" meaning the abnormal state of mind) "poses", presently, a "serious danger" to self or others.[82] I say "presently" because the word "poses" is expressed in the present tense. Expressed this way, it appears to require that the "abnormal state of mind" poses this serious danger right now.

Thus, for a patient to be kept on a CTO preventively, the danger must be "serious", and present right now, even though the patient's abnormal state of mind may still be intermittent. The central question I am raising in this dissertation is whether there is a convincing interpretation for this notion of serious danger, as used in the legal definition, that permits us to say the danger is posed right now, even though the person's abnormal state of mind may be intermittent. If so, the person may still *be* "mentally disordered" in the relevant sense, even though their condition currently seems stable and they are not acting violently at this moment.

A "Poses a Serious Danger"

So, what does "poses a serious danger" mean, when deciding whether a person *is* mentally disordered? In order to justify keeping stable patients under compulsion, there must be a concept of "danger" which allows for periods of stability, and consequently periods of non-violence in that patient. This concept must fit the parameters provided by Parliament in the "mental disorder" definition, so the patient must "pose a serious danger" to self or others at this present time, even though they may not currently be acting violently. Therefore, the preventive use of CTOs will only be lawful if there is some concept of "danger" which is in some way continuing, or enduring, even when the patient is stable.

[82] MHA, s 2.

1 Danger as an enduring characteristic, or a situational occurrence?

Dangerousness and violence are difficult to study, and the causes of violent behaviour in humans have been debated for decades.[83] I will consider two views of the concept of danger in this section: danger as an enduring characteristic, and danger as a situational occurrence, and consider whether either can represent a concept of "danger" which allows a stable patient to be kept on a CTO.

(a) Danger as an enduring character trait

If a person is to "pose a serious danger" at the present time, even when their condition is relatively stable, this might seem to suggest that the person needs to be inherently dangerous, in some sense. It suggests that "dangerousness" would be some enduring part of their character, which continues, or is present, right now, in some latent sense, even though they may be calmly seated in a chair, having not assaulted anyone in months. It suggests that a person would be intrinsically dangerous: that they were born a "dangerous person" perhaps, and continue to have this characteristic regardless of upbringing and environmental input.

However, the idea that dangerousness is an enduring character trait of this kind reflects outdated theories, and is not in line with contemporary psychiatric ideas of the concept of danger in mental health settings.[84] Instead, dangerousness is thought to be affected by biological, sociological, and psychological factors.[85] Mental health professionals currently understand dangerousness as a situational occurrence, which occurs when a combination of intrinsic and extrinsic factors are present and interact to produce violence.[86]

(b) Danger as a situational occurrence

This concept of danger as a situational occurrence in mental health settings takes into account both intrinsic factors to the person and extrinsic, situational factors present at a

[83] Stal Bjorkly "Psychological Theories of Aggression: Principles and Application to Practice" in D. Richter and R. Whittington (eds) *Violence in Mental Health Settings: Causes, Consequences, Management* (Springer, New York, 2006) 27 at 28.

[84] Arie Bauer and others "Dangerousness and Risk Assessment: The State of the Art" (2003) 40(3) IJP 182 at 183.

[85] Bauer and others, above n 84, at 183.

[86] Bauer and others, above n 84, at 183.

certain time.[87] Biological and psychological factors are just parts of a multifactorial interaction which produces violence.[88] In very simple terms, the idea is that violence is produced when a person's individual neurobiology and their mental state interact with situational variables present at a certain time, such as their alcohol consumption, or running into a loathed ex-partner. Though neurobiological and psychological factors are components of the occurrence of violence, they are not the sole causes of it, rather they may merely act in facilitating or inhibiting the violence.[89]

Danger as a situational occurrence, rather than an enduring character trait, is therefore more in line with current psychological thinking. But we still face the question: what if the relevant situational factors are not present at the current time, and therefore no violence is occurring? It seems difficult in that case to describe that person as "posing a serious danger" right now, as the definition seems to require. But it seems sensible to consider danger as a situational occurrence, in line with current professional thinking, and to use that approach in our interpretation of what "posing a serious danger" means. So, can the concept of "danger" in the MHA be understood as a situational occurrence, but one which also allows for current nonviolence?

2 The concept of "risk"

Understanding the notion of "danger" within a "risk" paradigm permits this interpretation of the "poses a serious danger" test. If the terms "danger" and "risk" address the same concerns, the difference is purely semantic. It is the assessment of risk that is currently undertaken by psychiatrists in determining whether mentally ill patients may harm self or others in the future. Perhaps it is therefore legitimate to use these terms interchangeably, when psychiatrists are placed by Parliament at the centre of the assessment process under the MHA.

On this view, for a person to "pose a serious danger" right now, and so meet the "mental disorder" test, they would have to pose a serious risk of causing harm to self or others at the present time. They would do so, I would argue, if the concept of "risk" was enduring,

[87] Richard Whittington and Dirk Richter "From the Individual to the Interpersonal: Environment and Interaction in the Escalation of Violence in Mental Health Settings" in D. Richter and R. Whittington (eds) *Violence in Mental Health Settings: Causes, Consequences, Management* (Springer, New York, 2006) 47 at 48.

[88] Whittington and Richter, above n 87, at 49.

[89] Whittington and Richter, above n 87, at 49.

or continuous, and therefore present even when a patient was stable and not acting violently. So, in this part I will analyse the concept of "risk" to see whether it can be considered enduring, and whether the "poses a serious danger" test can be legitimately interpreted within this paradigm of "risk".

(a) A shift from "dangerousness" to risk assessment in psychiatry

In determining whether a patient might cause violence or harm to others in the future, psychiatrists rely on the assessment of risk. Historically, the original conception of risk was linked to natural events that may cause harm, rather than harm caused by humans.[90] Modernity saw the concept of risk "scientised" into a concept which was quantifiable, could be predicted, and was linked to human behaviour.[91] Subsequently, use of the concept of "risk" has become mainstream not only in clinical settings, but in many different non-scientific arenas.

However, before the emergence of risk assessment, there was a focus in clinical settings on the prediction of "dangerousness".[92] This concept of "dangerousness" focused on the idea that certain individuals were inherently dangerous,[93] an idea which, as I have already discussed, has since fallen out of favour in psychology. The move from dangerousness prediction to risk assessment was based on the notion that "every patient has the potential for dangerous behaviour", which may occur under certain circumstances.[94] Whereas dangerousness prediction focused on an individual's potentiality for dangerousness in the future, risk prediction focuses on probabilities of violence at the population level, based on a combination of "risk factors".[95] Unlike dangerousness prediction, risk assessment takes into account both personality and situational factors, properly reflecting the current thinking discussed earlier that violence is a situational occurrence, rather than an enduring characteristic of the person.[96] For example, a patient will be assessed on the basis of different dispositional, historical and contextual risk factors, in order to assess their risk of

[90] D Lupton *Risk: Second Edition* (2nd ed, Routledge, Abingdon, 2013) at 6.

[91] Lupton, above n 90, at 7.

[92] Bernadette McSherry *Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour* (Australian Institute of Criminology, July 2004) at 2.

[93] Lupton, above n 90, at 123.

[94] Bauer and others, above n 84, at 182.

[95] Lupton, above n 90, at 124-125.

[96] Bauer and others, above n 84, at 183.

acting violently in future.[97] It is therefore clear that the concept of "risk", rather than the concept of "dangerousness", is the most current view of determining whether a patient may cause violence or harm in the future.

(b) Definitions of "risk"

Defining "risk" is more difficult than it seems, as there is not one recognised meaning for the concept. Although it is often narrowly defined to mean "the likelihood of some harm occurring", it concurrently takes many different forms across different settings.[98] In the social sciences, "risk" is commonly defined on two dimensions: one concerning probability, and the other concerning effect.[99] It can be the probability of a negative event occurring during a certain time period, or the severity of the harm caused by the negative event.[100] Although these conceptions of "risk" can be differentiated, they have been amalgamated over time and the term "risk" is often used to refer to both.[101] Upon the emergence of risk in the scientific realm, it was thought of as an objective concept, capable of quantitative assessment and prediction.[102] However, the use of risk in modern everyday parlance has moved away from probability calculations, and the term is now often loosely used to refer to threats, danger, or potential harm.[103] The term "risk" is also often used to refer to "uncertainty", but these concepts are not the same.[104] Whereas risk is usually based on known probabilities, the term uncertainty is used to denote situations where probabilities are unknown and not calculable.[105] Despite this distinction, "risk" is usually used to refer to situations where there is a likelihood of harm, regardless of whether the probability of this is calculable or not.[106]

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[97] Paul Mullen "Assessing Risk of Interpersonal Violence in the Mentally Ill" (1997) 3 Adv Psychiatr Treat 166 at 166.

[98] GM Breakwell *The Psychology of Risk* (2nd ed, Cambridge University Press, Cambridge, 2014) at 3.

[99] Breakwell, above n 98, at 3.

[100] Breakwell, above n 98, at 3.

[101] Breakwell, above n 98, at 3.

[102] Lupton, above n 90, at 7.

[103] Lupton, above n 90, at 10.

[104] Sven Ove Hansonn "Risk" (11 August 2011) Stanford Encyclopedia of Philosophy < https://plato.stanford.edu/entries/risk/>.

[105] Sven Ove Hansonn "What is Philosophy of Risk" (1996) 62(1-2) Theoria 169 at 170.

[106] Hansonn, above n 104.

(c) The case that danger (or risk) is a continuing concept

In the context of risk assessment in the mental health setting, the Ministry of Health, in official guidelines, has described risk as "the likelihood of an adverse event or outcome".[107] Risk in this sense is viewed as a propensity of a person to do certain things, in certain situations, which will vary in degree between individuals. It is viewed as capable of having a probability attached, rather than as an uncertainty where probabilities are unknown.[108] Thus, despite the move away from probability calculations in other arenas,[109] there is still a strong focus in the mental health setting on risk as a probability of a certain person acting violently toward self or others. If at any time a person is posing such a risk, then there is a calculable likelihood, or probability, of at least some degree, that an adverse event will occur. Though it may fluctuate between different values, this probability is present all the time. On this reasoning, it could be said that "risk" in a mentally disordered person is therefore enduring and continuously present. Though a person may pose a low risk of causing harm, there is still some degree of risk present all the time, and if it is serious enough, it will necessitate compulsion of that person. Ulrich Beck, who coined the term "the risk society", argues that risks are "always events that are threatening", which supports the notion that risks are always present, even though a patient may not be acting violently at the present time.[110] The question then is whether it is "serious" enough.

I submit that this conception of risk as an enduring concept is a convincing one, in this context, in light of the purposes of the MHA. Part of the purpose of the MHA is to "redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment", or, in other words, to allow compulsion.[111] Viewing "risk" as an enduring concept is in line with this purpose as it will allow compulsion of all those who pose a serious enough risk of causing harm or violence

[107] Ministry of Health *Guidelines for Clinical Risk Assessment and Management in Mental Health Services* (July 1998) at 2.

[108] Hansonn, above n 105, at 170.

[109] Lupton, above n 90, at 10.

[110] Ulrich Beck, a German sociologist, describes modern society as a "risk society", because society is "increasingly occupied with debating, preventing and managing risks", which are produced by the society itself. Beck posits that though it seems that catastrophes have increased in modern times, risk does not equal catastrophe. Rather, a risk is the anticipation of a catastrophe. The increased focus on risk indicates not an increase in risk, but an increase in fear, fueled by the mass media: Ulrich Beck "Living in the World Risk Society: A Hobhouse Memorial Public Lecture Given on Wednesday 15 February 2006 at the London School of Economics" (2006) 35(3) ES 329 at 332.

[111] Long title.

in the future. It may also be fair to say that the MHA has some preventive purposes, as though it probably does not authorise indefinite compulsion, it is implausible that a patient should be released as soon as they stop acting violently. For example, if a patient was violent for three days, and then stopped acting violently for the two days following, should they immediately be released? This was surely not Parliament's intention, so there must be some sense in which the "danger" is meant to be viewed as continuing.

(d) The case that danger (or risk) is not present when the person's condition is stable

Though Beck describes risks as "always events that are threatening", he also describes them as existing in a state of virtuality and "becoming real".[112] Risks are not catastrophes, rather the anticipation of catastrophes, and once they become real, because a catastrophe has occurred, they cease to be risks.[113] Risk is also described as "always becoming", something that does not yet exist but which may become real in the future.[114] This suggests that as risks are never fully "real", and only become real upon their expiry, so "risk" is not continuous or enduring. It could also be said that the concept of risk has moved on from being purely objective and prediction based, and instead has subjective value in its modern everyday use, as discussed above.[115] That is, risk is viewed by many as an uncertain, virtual and subjective concept, rather than objective and capable of having probability attached. If this means it is not fully real, how could it be continuing? This alternative notion therefore threatens the idea that risk can be considered as present all the time, even when the person is not acting violently.

Moreover, the conception of "risk" as continuing would allow stable patients to be kept on CTOs for as long as they pose a serious risk of danger to self or others. This could be viewed as a significant encroachment on patients' rights, which are affected by the use of CTOs. It could therefore be said to contravene the MHA's purpose to protect patient rights.[116] Rights such as the right to refuse to undergo medical treatment[117] and the guarantee of freedom of movement[118] enshrined in the NZBORA would be directly affected by viewing risk as continuing. Thus, it could be argued that there are two possible

[112] Beck, above n 110, at 332.
[113] Beck, above n 110, at 332.
[114] Lupton, above n 90, at 10.
[115] Lupton, above n 90, at 10.
[116] Long title.
[117] NZBORA, s 11.
[118] NZBORA, s 18.

interpretations of "risk", and that the latter interpretation - that "risk" is not enduring or continuing - should be preferred, as the NZBORA requires a rights-consistent interpretation to be given to such legislation where possible.[119]

(e) The most convincing conception of "risk" in this legal context

The existence of these different views of risk in different contexts means there are arguments both for and against interpreting "risk" as an enduring concept and as a legitimate substitute for the notion of "danger" in the MHA. Finding the best interpretation should turn on which is most convincing in light of the purposes of the MHA, because this is the context in which the concept is being used. The concept of risk as enduring focuses on risk as something which can be predicted and which is capable of having probability attached, whereas risk as a non-enduring concept focuses on the subjective, virtual nature of risk, which is never really in existence until a catastrophe occurs. Considering risk as capable of having probability attached is most in line with psychiatric risk prediction, thus there is a strong argument that this conception of risk is the correct interpretation in the mental health setting. Surely Parliament intended that psychiatrists would try to predict the probability of compulsory patients acting violently if not controlled under the MHA.

Furthermore, though the NZBORA requires a rights-consistent interpretation to be given, it only requires this occur where that interpretation is viable or "can" be given. If the provision cannot be interpreted viably in a rights-centered way, the other interpretation prevails regardless.[120] It may be argued that the only plausible interpretation of the "poses a serious danger" test with regard to the purposes of the MHA is risk as enduring, as risk as a non-enduring concept is not in line with risk prediction used by psychiatrists. It could also be argued that risk as an enduring concept constitutes the correct balance between state interests and patient rights. In addition, though this interpretation is less rights-friendly than risk as a non-enduring concept, there is still the inclusion of the term "serious" in the "poses a serious danger" test. It provides a separate safeguard against too much compulsion. Only those who pose a "serious" risk of danger can be kept under the MHA, so those who pose a risk that is anything less than "serious" must immediately be released.

It may therefore be legitimate to understand the notion of "posing a serious danger" in this context as synonymous with the current psychiatric concept of "risk", provided the risk is of the necessary degree to be called "serious".

[119] NZBORA, s 6.

[120] NZBORA ss 4, 6.

B Intermittency

The second interpretive issue relates to the notion of "intermittency". Specifically, should the fact that the "mental disorder" definition expressly contemplates that the "abnormal state of mind" may be "intermittent" affect our interpretation of the meaning of the second limb?

1 "Intermittency" is not implied in the second limb

I am not suggesting that the notion of "intermittency" is implied in the second limb, as it is not in the text of that limb, rather it is only included in the first limb. Parliament could surely have written it into the second limb had it so desired. Furthermore, my argument that "risk" should be understood as an enduring concept negates the idea that the "risk" may be intermittent. As I have explained, understanding "risk" to be an enduring concept means it is continuous and present at all times, even when a patient is currently well and their state of mind is not currently abnormal. Thus it would not be correct to say that intermittency can be implied into the second limb.

2 Nevertheless, should "intermittency" in the first limb affect our understanding of the second limb?

I submit that the fact that the "mental disorder" definition expressly contemplates that the "abnormal state of mind" may be "intermittent" affects our interpretation of the meaning of the second limb, as it determines the way we must understand the "poses a serious danger" test. We know that a patient can have an intermittent abnormal state of mind, and still meet the "mental disorder" definition. We also know that the two limbs are causally connected as the abnormal state of mind must be "of such a degree" that it poses the serious danger. Therefore, there must be a concept of "danger" which permits the abnormal state of mind to be present intermittently, otherwise the definition would not be coherent. Understanding "danger" within a "risk" paradigm allows this. Although I have submitted that the concept of "risk" is enduring and therefore not intermittent, it still allows a person to "pose a serious danger" even when they do not currently have an abnormal state of mind. "Risk" as an enduring concept means every person poses some risk of acting violently at all times. This risk may only be small, but it is continuously present, whether a person's state of mind is abnormal or not. Therefore, the inclusion of "intermittent" in the first limb does seem to affect our interpretation of the second limb, as it influences the way we must interpret "poses a serious danger".

C Conclusion

To summarise, this chapter has considered the interpretation of the phrases "poses a serious danger" and "intermittency". For stable patients to be kept on CTOs, there must be a concept of "danger" which allows for current non-violence. Modern understandings of the concept of "danger" suggest that danger is a situational occurrence, rather than an enduring character trait, where intrinsic factors of a patient interact with external, situational factors present at a certain time to produce violence. Thus it seems sensible that "danger" in the MHA should be understood in this way. Understanding the notion of "danger" within a paradigm of risk permits the "serious danger" test to be interpreted in this way. I considered the concept of risk, and noted that risk would need to be viewed as continuing to allow the preventive use of CTOs. I then considered whether risk could legitimately be viewed as an enduring concept, and submitted that it could, in light of the purposes of the MHA. Finally, I considered the notion of "intermittency" in the first limb of the "mental disorder" definition, and whether, because the definition expressly contemplates that the "abnormal state of mind" may be intermittent, this may affect our interpretation of the second limb. I submitted that, though it would not be correct to say intermittency can be implied into the second limb, it still affects our understanding of the second limb. Parliament must have intended that a patient with an intermittent abnormal state of mind could still meet the "serious danger" test, therefore there must be a concept of "danger" which permits this intermittency.

Chapter 3: The Courts' Approach to Interpretation in Preventive Cases

Now that I have considered aspects of the interpretive problem in depth, this chapter will focus on the approach taken in the courts (and the MHRT). How do the courts interpret and apply the "mental disorder" definition in cases where CTOs are used preventively? I will consider whether the courts interpret serious danger within a "risk paradigm", and if so, whether this approach can be seen consistently over time and between cases.

A Summary of the "Risk Paradigm"

As discussed in Chapter 2, it is probably legitimate to understand the notion of "poses a serious danger" within a paradigm of risk. This risk-based approach to interpretation of the test has a number of features or elements. Risk in the context of the MHA is a statistical or probabilistic concept, based on the "likelihood" of violence occurring in future. The "risk" is considered "enduring" and is continuously present, even when the person's condition may not pose an immediate threat of harm. Risk assessment is based on the analysis and balancing of a number of factors and dimensions, some intrinsic to the person, and some extrinsic and situational. These are the standards against which I will assess the courts' reasoning in preventive cases.

B Do the Courts Interpret "Serious Danger" Within a Risk Paradigm?

In determining whether the courts (or quasi-judicial bodies) take a risk-based approach to the interpretation of the phrase "poses a serious danger", I will focus mainly on the approach taken by the MHRT. As the tribunal's role is to determine whether patients should be discharged from compulsion or not,[121] it is able to approve the preventive use of CTOs. Furthermore, it has considered the interpretation of the concept of "mental disorder" in the most depth.

1 Overview of the MHRT's general approach to the "serious danger" test

The general approach taken by the MHRT to interpreting the "poses a serious danger" test was discussed in Chapter 1. To summarise, the early focus of District Courts on physical and imminent danger[122] was replaced by a wider approach, which includes psychological

[121] Nigel Dunlop "The Mental Health Review Tribunal" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 97 at 97.

[122] For example, *In the matter of JK*, above n 47; *Re O* [1993] NZFLR 545; and *Re M* [1992] 1 NZLR 29.

damage[123] and does not require the danger to be immediate.[124] Although the four parameters of serious danger (nature or magnitude of likely harm, probability, imminence and frequency) are still key considerations in the interpretation, these are now considered collectively, and the weighting of one factor can reduce the significance of another.[125] Factors such as relapse, insight and compliance are also relevant to whether a patient should be kept on a CTO.[126]

2 Indicators of a "risk based" approach

There are indications in preventive cases that the MHRT is interpreting "serious danger" within a paradigm of risk, some of which are explicitly clear, and some which are more implicit in the reasoning. I will analyse these indications below.

(a) Direct references to "risk" and "risk assessment"

In some cases, the MHRT makes direct reference to assessing "risk".[127] This can be seen even in older cases, where the stricter approach to "serious danger" was used. For example, in *In the matter of T*, a case from 1994, though there is emphasis on the need for physical and imminent violence to meet the "serious danger" test, the Southern Review Tribunal ("SRT") still makes reference to "predicting future conduct", by undertaking what it calls an "assessment of risk".[128] The MHA Guidelines also describe the four parameters as useful in "conducting a risk assessment".[129] Often, the MHRT will not refer to risk assessment specifically, but will still refer to future risk and the degree to which it exists, in its approach.[130] This seems to suggest that the tribunal's determination of the risk involved in

[123] *In the matter of D,* above n 48, at 45-46.

[124] *Re Mental Health [Serious Danger]*, above n 45, at [59].

[125] *Re Mental Health [Serious Danger]*, above n 45, at [58]-[59].

[126] *Re Mental Health [Serious Danger]*, above n 45, at [60].

[127] In *Re RJ* SRT 80/98 (30/10/98) at 8-9, the SRT referred to the need to "make a determination on the risks imposed"; and in *In the matter of T* [1994] NZFLR 946 at 951-952, the SRT referred to undertaking "the assessment of future risk", and noted that "predicting future conduct is a notoriously difficult task", so "what is undertaken is an assessment of risk".

[128] At 952.

[129] Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (November 2012) at [1.1.5].

[130] In *Re CDW* DC Nelson FAM-2003-009-004445, 29 June 2011 at [33], the Court stated that "past history is always a good predictor of future risk"; in *Re VAP* MHRT 09/122 (11/12/09) at [27], the tribunal noted that "the fact that the Applicant has not assaulted others since 1999 attests not to the absence of risk, but to the treatment which she has received"; and in *Re GM (Mental Health)*, above n 49, at 671-672, the District

each case is at the core of its decision whether a person "poses a serious danger", even if the tribunal makes no explicit reference to "risk assessment" itself.

(b) The use of probabilistic terms

The use of probabilistic terms by the MHRT has become increasingly common. Originally, patients were assessed using the parameters of the nature of likely harm, magnitude, imminence and frequency.[131] In other words, this required it to ask "what kind of harm, how grave, how soon, and how often?"[132] The MHRT would then consider evidence for each of these considerations. This showed a kind of probabilistic analysis, as the tribunal was collating evidence for each of these considerations, and then deciding the likelihood (or probability) that a patient would act violently in the future. Recently, a slight alteration of these parameters over time demonstrates a further trend toward probabilistic thinking. In *Re Mental Health [Serious Danger]*, the considerations of the "nature" and "magnitude" of the harm have been amalgamated and an extra consideration added: the "likelihood" or "probability" of the likely harm occurring.[133] In that case, the applicant had a schizophrenic type illness, was subject to an indefinite CTO, and lived independently in the community. Though he had no criminal record and no past history of physical violence, the tribunal found that the nature of his delusions, threats made to others and their proximity to him, the absence of insight, and the likelihood of immediate relapse were he to go off the order, necessitated the order being continued.[134] It is unclear whether this shift was intentional or not, but, even if it was not, it suggests that probability, a central notion in risk assessment, is becoming a key part of the tribunal's approach. References to "prediction" of future violence have also been made in some preventive cases.[135] For example, in *Re CDW* the District Court stated that "past history is always a good predictor of future risk".[136] This showed probabilistic thinking as the Court was using a patient's history to predict the likelihood of their acting violently in future, effectually making calculations of risk.

Court states that serious danger will be established where there is a "real and substantial risk to the lives of other people".

[131] *Re KMD*, above n 46.

[132] Dawson, above n 1, at 445.

[133] At [57].

[134] At [63]-[64].

[135] For example, in *In the matter of T*, the SRT stated that "predicting future conduct is a notoriously difficult task", implying that the "serious danger" test involves prediction: *In the matter of T*, above n 127, at 952.

[136] *Re CDW*, above n 130, at [33].

(c) Analysis of risk factors

The MHRT sometimes explicitly undertakes an analysis of risk factors in order to determine whether a patient poses a serious danger.[137] The most striking example of this is *Re Mental Health [Serious Danger]*. There, the MHRT directly considers indicators and contra-indicators as to whether the Applicant poses a serious danger, and concludes that the "indicator factors outweigh the contra-indication factors".[138] The factors considered include the Applicant's mental state, previous criminal history and violence, and situational factors such as the proximity of victims and the Applicant's living situation.[139] This demonstrates a clear analysis of risk factors, and shows consideration of both intrinsic and situational factors, in line with the current psychiatric thinking on risk (and danger) as a situational occurrence, discussed in Chapter 2.

(d) Longitudinal approach to interpretation

In most preventive cases, the MHRT states that it must take a "longitudinal" approach to determining whether a patient "poses a serious danger".[140] This means the tribunal considers not only the patient's current state at the time of the hearing, but their history as

[137] For example, in *Applicant 13/122*, the tribunal identified reasons favouring the Applicant's release from compulsion (such as her current good health, stable accommodation and intention to continue treatment voluntarily), and reasons favouring her continued compulsion (such as her limited insight, history of non-compliance and high likelihood of relapse were she to discontinue treatment). It then went on to balance these and found that the considerations favouring continued compulsion outweighed those favouring release: *Applicant 13/122* [2013] NZMHRT 122 (18 November 2013) at [31]-[37].

[138] At [63]-[65].

[139] At [61]-[64].

[140] In *Re PT*, above n 15, at [16]-[17], the Family Court stated that it must consider "the longitudinal history of relapse", and goes on to consider PT's responses to medication over time; in *In the matter of T*, above n 127, at 956, the SRT noted that the "longitudinal history of the applicant" must be taken into account; in *L v Director of Mental Health Services* [1999] NZFLR 949 at 956, the Family Court held that "questions as to whether there is an abnormal state of mind, or serious danger or serious diminution of capacity for self-care, and whether it is necessary to make a compulsory treatment order, are all matters where the Court should take a longitudinal view of the available evidence"; and in *Re RJ*, above n 127, at 9, the tribunal stated that in assessing serious danger to the health of the patient, the SRT must consider the longitudinal history of relapses.

well, including their mental state when unwell,[141] history of relapses,[142] past incidents of violence and drug use,[143] and other factors relevant to their condition. This emphasis on a longitudinal approach is effectively another form of risk prediction, involving analysis of risk factors. By considering a patient's history, the tribunal is considering factors that suggest the patient may act violently again in the future, and factors suggesting they will not. Again, these are both intrinsic and situational to the patient, reflecting current danger and risk research.[144] An example of this is *Re CDW*. In that case, the Court took a longitudinal approach, noting that the "absence of overt symptoms of a mental disorder or violence" at the time of assessment would not stop a patient being kept on a CTO.[145] It was further stated that the Court was "entitled" to consider past history, and the "clinical examination does not occur in a vacuum".[146] The Court found that the applicant's longitudinal history of assault, threats to others, lack of insight and illicit drug use necessitated him being kept under a CTO.[147]

(e) Considering "risk" as still present even when the patient's condition is stable

In many preventive cases, it is clear the MHRT considers "risk" as still present, even when a patient's condition is currently stable. This is evident in one of the early cases where a CTO was used preventively, *Re RJ*. In that case, a patient with a bipolar disorder who was currently well was kept on a CTO on the reasoning that if her noncompliance and consequent relapses continued, there was "a real likelihood…. of the Applicant's mental health being seriously undermined".[148] This suggests that though the patient's condition was currently stable and there was no immediate danger of harm, the tribunal considered there was still a serious risk, or "likelihood" that she would deteriorate into a condition where she would be a danger to her own mental health. Similarly, in *In the matter of T,* the

[141] In *Re CDW*, the Court held that it was "entitled to have regard to any history of mental health issues and the earlier findings which have been made about this by previous clinicians": *Re CDW,* above n 130, at [29]-[30].

[142] In *Re RJ*, the SRT considered that there was a clear longitudinal history of relapse, as though the Applicant had some consecutive years of stability in the past, in recent years he had been admitted to hospital more frequently and was spending shorter periods of time in the community: *Re RJ,* above n 127, at 9-10.

[143] In *Applicant 11/019*, the tribunal considered that the Applicant's history of cannabis was of concern, as it may "serve to destabilise his mental health": *Applicant 11/019* [2011] NZMHRT 19 (11 May 2011) at [56].

[144] See Whittington and Richter, above n 87.

[145] At [29].

[146] At [29].

[147] See discussion at [26]-[37].

[148] At 11.

SRT found that there was a high "likelihood of any deterioration" if the patient was taken off the order, suggesting that the risk of deterioration into a state where he may cause serious danger to self and others was still present, despite his presently improved condition.[149] Furthermore, references to patients having a "propensity" for violence in certain situations suggest that this propensity is viewed as continuing even when the patient is stable, in line with the concept of risk as enduring.[150]

(f) Compliance, insight and relapse

The final indication that the MHRT is interpreting "poses a serious danger" within a risk paradigm is its recurrent reliance on factors such as the likelihood that the patient will comply with treatment, their degree of insight into their condition, and the probability of their future relapse if they are discharged from compulsion and discontinue treatment. Kate Diesfeld describes these as "implicit factors governing compulsory status", because they "seem to influence discharge decisions but are not expressly listed in the Act".[151] Often, the decision about whether a patient should be kept on an order will hinge on the likelihood of relapse, which is partly dependent on the patient's insight into their illness and the likelihood of compliance with treatment if they are released from compulsion. In the case *Applicant 11/019*, the tribunal had to decide whether to keep a patient with a schizo-affective disorder on a CTO, whose condition had been stable for almost 10 years.[152] The tribunal noted that it had to "consider such issues as the likelihood and consequences of a relapse were the Applicant released from compulsory status", which necessitated consideration of "whether or not the Applicant has a sufficient understanding of his illness and the means to manage it such that future serious dangerousness may be avoided".[153] It was decided that the patient must be kept under compulsion because of his lack of insight into his illness, his future intentions to cease treatment and contact with mental health services, and the seriousness of his condition were it to relapse.[154] In *Re Mental Health [Serious Danger]*, the tribunal outlined relevant matters to consider regarding relapse,

[149] At 958.

[150] In *Re CDW*, above n 130, at [32]-33], the Court considered that the Applicant had a propensity for violence, and it was necessary to decide whether this was linked to his mental disorder; and in *In the matter of T*, above n127, at 951, the SRT stated that "the history of an applicant is only relevant in so far as such proven reported acts of actual physical violence prove an indicator of the applicant's propensity for future acts".

[151] Kate Diesfeld, above n 58, at 114-115.

[152] *Applicant 11/019*, above n 143, at [5].

[153] At [54].

[154] At [55]-[57].

including the expected time lapse between release and cessation of treatment and between noncompliance with treatment and relapse, the ability of clinicians to reinitiate the processes under the Act, and whether early intervention under the powers conferred by the CTO may lessen the prospect of a relapse.[155] The tribunal then noted that these considerations are effectively a restatement of the four parameters of serious danger, which I have discussed previously.[156] Its use of these "implicit" factors therefore seems to be another way of assessing risk. By assessing a patient's insight into their illness and compliance with treatment, the tribunal is trying to predict their likelihood of relapse, and is therefore assessing the risk that they will become unwell again and act violently in the future.

There are therefore many indications in the tribunal's reasoning to suggest that a "risk based" approach to the interpretation of "serious danger" is being used. Though the courts do not always explicitly refer to risk, the implicit assessment of risk and the treatment of risk as something still present even in stable patients suggests that "risk" is being used as a central concept in the reasoning in deciding whether patients "pose" a serious danger to self or others.

C Conclusion

In summary, there are many explicit and implicit indicators that the tribunal is interpreting "serious danger" within a risk paradigm, and there is an underlying consistency in this approach. This is likely due to the fact that most cases I have analysed were decided under the guidance of long term MHRT convener, Nigel Dunlop, who has had substantial input into the development of the "serious danger" test. However, some variation over time and between cases is still evident. As discussed earlier, the test has been widened over time to allow "danger" which is not imminent to still be considered "serious" under the test, demonstrating a shift from a stricter to a broader approach. This gradual widening of the "serious danger" test has been described as reflecting "the apparent increasingly risk-averse nature of society".[157] This suggests that the "serious danger" test has become more "risk" focused over time, and this seems clear in my analysis, as recently there has been a more explicit focus on risk assessment and a greater emphasis on "danger" as a continuing concept. The shift from the requirement that the danger be immediate has also been described as reflecting the long lasting effects of modern treatment such as injections of

[155] At [60].

[156] At [61].

[157] Gledhill, above n 51, at 68.

slow release anti-psychotic drugs. Patients receiving this treatment are unlikely to relapse immediately on ceasing medication, but may still in time relapse seriously with "dangerous" consequences.[158] There is less explicit consideration of risk factors and risk assessment in the MHRT's approach than psychiatrists would undertake when assessing mentally ill patients. However, most cases I have analysed are dated pre 2012. The most recent assessment of the "serious danger" test undertaken in 2012 in the case *Re Mental Health [Serious Danger*] shows a much more explicitly risk-based approach, and this is likely the best example of the approach the tribunal is taking at present.

From this material, it is possible to predict how the tribunal is likely to reason about the presence of "serious danger" when assessing whether a currently stable patient should be discharged from a CTO. It is likely to follow the approach described in *Re Mental Health [Serious Danger]*. It would likely place most importance on a patient's longitudinal history of relapse and past incidents of dangerous behaviour, as well as their insight into their illness and predicted compliance with treatment. It would consider whether the patient would continue to stay well once off an order, which is directly related to compliance, insight and therefore risk of relapse. The tribunal would also consider external factors such as family support, and the likelihood of timely intervention if the patient were to start to relapse. These factors would be balanced against each other and a determination made of whether an order is still justified. In summary, the tribunal would make predictions of a patient's future conduct, based on balancing factors intrinsic and extrinsic to the patient. Again, this clearly demonstrates that the tribunal is working within a risk paradigm.

[158] Gledhill, above n 51, at 66.

Chapter 4: Evaluating the Tribunal's Approach

I concluded in Chapter 3 that the tribunal is interpreting the "serious danger" test within a paradigm of risk, consistent with the the approach I outlined in Chapter 2. This chapter will evaluate the tribunal's approach and assess whether it pays enough attention to rights issues, as well as to the apparent preventive purposes of the MHA. Following my analysis of preventive cases undertaken in the previous chapter, it is clear that the tribunal pays little direct attention to "rights" issues when engaging in its risk-based interpretive approach. Is this legitimate, in light of the fact that important individual rights of patients are affected by the powers conferred by CTOs? As discussed in Chapter 1, the correct balance must be struck between the limits placed on patients' rights, and state interests in placing them under compulsion.[159] It is therefore necessary to consider the relevance of human rights principles, especially those emphasised in the NZBORA.

A Why Does the Tribunal Pay Little Attention to Rights Issues?

The widening of the "serious danger" test since the introduction of the current MHA has undoubtedly resulted in greater encroachment on patients' rights than the previous, stricter approach. It allows stable patients to be kept on CTOs when they do not pose an immediate threat of danger, based on an assessment of risk. Nevertheless, the tribunal seems to be paying less attention to patients' rights than it did in earlier cases. Patients' rights are not explicitly considered in many cases, and when they are, it is usually decided that state interests in preventing the risk of a stable patient acting violently in the future outweighs that patient's right to liberty. Why does the tribunal pay so little attention to rights issues in its decisions? There are several reasons why this might be so.

Section 6 NZBORA requires that an interpretation consistent with the rights contained in it is to be preferred, where it can be given such a meaning. This means that the tribunal must consider whether there are more rights-consistent alternatives to interpretation in its approach. It is possible that the tribunal does not see this interpretive question as difficult, or controversial, so as to engage section 6 at all. It may view the risk-based approach to interpretation, and restriction of rights that comes with it, as necessary to protect state interests, therefore other more rights-consistent alternatives are not feasible. Thus it may see a risk based interpretation as the only viable interpretation of the "serious danger" test. Another explanation is that the tribunal may consider the MHA to clearly authorise the

[159] Dawson, above n 36, at 31.

relevant rights to be limited. Section 4 NZBORA states that courts cannot hold another enactment impliedly repealed or invalid just because it is inconsistent with the NZBORA. This means that the tribunal cannot hold the MHA impliedly repealed or invalid simply because it is not very rights-friendly. Thus the MHRT may be simply giving effect to the MHA, so as not to render it in any way "ineffective". Alternatively, the tribunal may not consider that there is a major limit imposed on rights in these circumstances. It may view the encroachment on rights as minimal compared to the alternative of the patient not being under compulsion and potentially causing harm to self or others. Finally, the tribunal may consider the limits on rights "demonstrably justified". Section 5 NZBORA states that the rights contained in the NZBORA are subject to justified limitations, so the MHRT may consider that the limits imposed on rights by keeping stable patients on CTOs are justified in the circumstances. The tribunal may also consider it a "proportionate" limit on rights, in light of the compelling purposes of the MHA to allow compulsion and provide treatment to patients, and in light of the other benefits a CTO may confer on the patient and those around them.

These are all plausible reasons why the tribunal may not be giving much consideration to rights issues in its interpretation of the "serious danger" test. Next, it must be considered whether it is actually legitimate for the tribunal to take such a view.

B Legitimacy of the Tribunal's Rights-Restrictive Approach

Despite the restriction of rights that occurs when a stable patient is kept on a CTO, I submit that it is legitimate for the tribunal to take such a view, because of the following reasons.

1 Consistency with the text and purpose of the MHA

The tribunal's approach is consistent with the text and purposes of the MHA, thus it is probably not especially controversial for it to take this approach. The criteria for compulsion require that a patient be presently "mentally disordered", and if they are not, they must be immediately released. The tribunal's interpretation of "serious danger" within a risk paradigm is consistent with this, as stable patients can be considered currently "mentally disordered" and kept under compulsion if they pose a risk of harm to self or others that is serious enough. As discussed in Chapter 2, it is likely that the MHA has preventive purposes, so keeping stable patients on CTOs in order to prevent deterioration into a state where they may harm self or others is consistent with that purpose. Another purpose of the MHA is to provide treatment to patients in order to bring them to a stable state, and this would be undermined if stable patients showing no current symptoms were

released, only to relapse soon afterwards. The Ministry of Health, in official guidelines, describes one of the purposes of the MHA to "ensure that both vulnerable individuals and the public are protected from harm", suggesting that ensuring the safety of all those involved is paramount.[160] This supports a protective approach, as intervention can occur before any harm can occur. Thus a risk-based approach to the "serious danger" test in order to keep stable patients well is in line with these purposes.

2 Mental health professionals are given significant powers under the MHA

Furthermore, I suggest it is fair for the tribunal to interpret the notion of "serious danger" in a manner consistent with the concepts and practices of mental health professionals, as Parliament has put them at the centre of patients' assessment under the Act, and the legal criteria must be directly applied to a patient's situation by these professionals in their functions. Beginning at the assessment stage, psychiatrists (where reasonably available) are appointed to perform the initial assessment examination.[161] This responsible clinician may then undertake further assessment and treatment for five days if necessary,[162] and for a further period of 14 days if they have reasonable grounds for believing the patient is mentally disordered.[163] At the end of the assessment period, the clinician decides whether the patient is fit to be released, and can subsequently discharge the patient or apply for the making of a compulsory treatment order.[164] They must also conduct periodic reviews of the patient's condition,[165] and have a continuing duty to consider whether the patient is fit to be released (in other words, whether they still meet the "mental disorder" definition).[166] They can also direct a patient to be moved from outpatient to inpatient status, and vice versa.[167] The MHA requires that one of the three people on the tribunal is a psychiatrist,[168] and psychiatrists are called upon to provide expert evidence of whether they consider a patient to be mentally disordered in tribunal cases. It is clear that Parliament intended to give mental health professionals substantial powers under the MHA, including interpreting

[160] Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, above n 129, at 1.
[161] MHA, s 9(3).
[162] MHA, s 11.
[163] MHA, ss 12, 13.
[164] MHA, s 14.
[165] MHA, s 76.
[166] MHA, s 35.
[167] MHA, ss 29, 30.
[168] Section 101(2).

the "mental disorder" test. Thus taking a psychiatric risk based approach to interpretation of the "serious danger" test is consistent with this legal framework.

Moreover, the MHA does clearly authorise limits to be placed on patient rights, via the powers conferred by CTOs. These powers allow mental health professionals and others to treat the patient, recall the patient if they cannot adequately be treated as an outpatient, and use force to treat the patient in emergency situations. It would be improper to render this regime "ineffective" just because it restricts patient rights.

3 History of relapse justifies compulsion

Finally, the tribunal could reasonably conclude that where the patient does have a history of repeated relapses following cessation of treatment, there are compelling justifications for placing such limits on rights. If a patient is likely to relapse soon after they come off medication, they may pose a danger of harming self or others. Furthermore, Dawson contends that as well as ideas about negative liberty, concerns about positive liberty are also relevant: a person's capacity for self-governance, to set goals and meet these.[169] Though keeping a patient under compulsion may encroach on a patient's rights to autonomy and to refuse treatment (negative liberty), it can also aid in enhancing the patient's ability to achieve their own ends (positive liberty) by keeping them in a stable condition over a long period of time.[170] Thus there are clear justifications for keeping such patients under compulsion.

4 Conclusion

Therefore, there are several compelling reasons why the approach taken by the tribunal is legitimate. Firstly, the approach is consistent with the text and purposes of the MHA. Mental health professionals are also given significant functions and powers under the MHA, so an approach in line with that taken by these professionals should be preferred. The MHA does authorise limits to be placed on patient rights, and keeping a patient under compulsion is justified where they have a history of relapse following cessation of treatment. Overall, the approach is not "disproportionate"; it correctly balances patient rights and state interests.

[169] John Dawson "Concepts of Liberty in Mental Health Law" [2009] Otago L R 2.

[170] Dawson, above n 169.

C Residual Issues with Preventive CTOs

Though I have concluded that the tribunal is interpreting "serious danger" within a risk paradigm, and it is legitimate to interpret it in this way, there are still some dangers of this approach.

1 Too much movement away from a "hard" approach?

It may be said that the tribunal has moved too far away from the "harder" approach to the "serious danger" test used early in the Act's life. Under the early approach, the need to avoid arbitrary detention was emphasised. In *In the matter of JK*, the "serious danger" test would only be met if there was a "demonstrable risk of no less than serious physical violence".[171] This requirement that the danger be imminent acted to protect patient rights, as only those who met this high threshold test could be kept under compulsion. The approach in *In the matter of JK* is said to reflect the reasoning behind criminal detention, where the loss of liberty involved with incarceration is only justified in high risk situations.[172] It can be said that the liberty lost through compulsion under the MHA is the same, if not worse than under the criminal law, as it may become indefinite.[173] Thus a similar approach to that taken in criminal law, requiring a high threshold for detention, is attractive. Using such an approach, loss of liberty only occurs when a serious imminent threat exists. Furthermore, in both the criminal and mental health setting, there is significant stigma attached to detention and compulsion, suggesting that the criteria for compulsion under the MHA should be equally as strict.[174] It also avoids discrimination against mentally ill patients who may not be placed under the same restrictions if it were not for their condition.[175]

However, this approach was quickly abandoned, under the reasoning that the main concern when deciding cases is treatment, not detention, and that mental health law was designed to be protective, rather than punitive, so it should not be treated the same as criminal law.[176] It is arguable that if a harder approach was taken, as in *In the matter of JK*, patients may get too unwell before intervention can occur, exposing self and the public to the

[171] At 702.

[172] Gledhill, above n 51, at 68.

[173] Gledhill, above n 51, at 69.

[174] Gledhill, above n 51, at 69.

[175] Gledhill, above n 51, at 69.

[176] Gledhill, above n 51, at 69.

consequences of that. Furthermore, the harder test requiring imminence would not allow a stable patient who is intermittently unwell to meet the "mental disorder" definition. This cannot be correct, as the definition expressly allows patients who have an intermittent abnormal state of mind to come under the definition. Thus there are problems with the "harder" approach which are difficult to reconcile. Nevertheless, some of the emphasis on patient rights in the "harder" approach could be brought into the current approach taken by the tribunal to make it more rights-friendly.

2 Error in risk assessment

The assessment of risk is a difficult task, and carries a real danger of error.[177] The Ministry of Health describes risk assessment as "an estimation of the likelihood of particular adverse events occurring under particular circumstances within a specified period of time".[178] It involves consideration of dispositional, historical, and contextual factors of a patient,[179] and should be based on "a thorough collection of information from all available sources and cover all aspects of the illness, background, behaviour and circumstances of the individual".[180] As expected, there are limitations involved, and risk assessment can never be perfect.[181] There are many guidelines as to risk factors that should be assessed, but it is probably impossible to identify all the risk factors present in a certain case.[182] The shift from dangerousness prediction to risk assessment has been said to have improved reliability in short term predictions, but long term predictions are much more difficult to make, and the reliability of these predictions is still uncertain.[183] There is also danger of using actuarial assessments of the general population to assess mentally ill patients, as the same risk factors may not be generalisable.[184] Ethical issues involved in risk assessment pose another problem. Restricting a patient's liberty on the basis of prediction, rather than evidence of actual violence, raises a major ethical issue, and there is potential for discrimination when

[177] Gledhill, above n 51, at 76.

[178] Ministry of Health *Guidelines for Clinical Risk Assessment and Management in Mental Health Service*, above n 107, at 2.

[179] Mullen, above n 97, at 166.

[180] Ministry of Health *Guidelines for Clinical Risk Assessment and Management in Mental Health Service*, above n 107, at 4.

[181] Ministry of Health *Guidelines for Clinical Risk Assessment and Management in Mental Health Service*, above n 107, at 5.

[182] Ministry of Health *Guidelines for Clinical Risk Assessment and Management in Mental Health Service*, above n 107, at 5.

[183] Mullen, above n 97, at 166.

[184] Mullen, above n 97, at 166.

using actuarial factors in the risk assessment of the mentally ill. For example, violent crimes in the general population are predominantly committed by males, but this distinction is not so marked in those with mental illness, so there is the potential for discrimination against mentally ill men in using actuarial risk assessment.[185] Thus there are many issues faced when undertaking risk assessment which threaten the validity of such predictions and jeopardise patient rights. This highlights a need to promote reliable risk assessment in this context.

3 MHA not a "backstop"

The tribunal has stated on multiple occasions that compulsory treatment under the MHA is not meant to be used as a "backstop" measure in case of relapse,[186] and the possibility of a patient coming under the Act again at a later stage is not sufficient reason to keep them under it now.[187] It is not clear that the MHRT consistently acts on this principle, however. It may be said that in the current approach, the tribunal is using the MHA as a precaution, when the Act's process could just be reinstated, and the patient placed under compulsion again if the patient is discharged and relapses soon after. Though a patient may have a lifelong mental illness, the tribunal has stated that this does not necessarily mean that they will be kept under compulsion indefinitely, as the nexus between the abnormal state of mind and dangerousness may not always be strong enough to meet the "mental disorder" definition.[188] The tribunal has also noted that "although, in appropriate cases, extended periods of compulsory treatment are appropriate to address risk related issues, it is important to remember that such compulsion is not to be continued lightly".[189] It should be remembered that the test for compulsion is whether the patient is *presently* mentally disordered. The tribunal has also stated that it needs to avoid taking a paternalistic and

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[185] Mullen, above n 97, at 166-167.

[186] In *Re MJB*, it was stated that "orders should not be regarded as backups in case something goes wrong": *Re MJB* MHRT 06/090 (22/09/06) at [25].

[187] Diesfeld, above n 58, at 121-122.

[188] In *Re TAK*, the tribunal stated that "the mental disorder definition in the Act is a legal construct. Whilst from a psychiatric point of view, the Applicant might be regarded as having a life long illness with enduring characteristics, that is not to say that the Applicant must continue to be deemed mentally disordered while he remains ill. With the effluxion of time and changing circumstances, the assessment of dangerousness may change notwithstanding the enduring nature of the illness which gives rise to the abnormal state of mind". It then went on to state that the Applicant was "moving toward the time when a Tribunal might be prepared to determine that he is no longer mentally disordered because the nexus between his abnormal state of mind and dangerousness is becoming progressively less clear as a result of a long period of stability": *Re TAK* MHRT 03/047 (14/05/03) at 6.

[189] *Applicant 13/160* [2013] NZMHRT 160 (3 March 2014) at [40].

cautious approach, in order to balance competing interests.[190] Despite this, it seems that stable patients are being kept on CTOs for long periods, even though these comments suggest that preventive use is not acceptable. Though the MHA probably allows some preventive use of CTOs, this should be confined to patients who pose a "serious" risk of danger. Otherwise, there is a risk that CTOs will be used preventively more and more often, on patients who do not actually need to be compelled.

4 Conclusion

The hard approach taken in earlier cases such as *In the matter of JK* is likely not correct in light of the purposes of the MHA. However, the danger of error in risk assessment and the fact that the MHA is not meant to be used as a backstop measure suggest that the tribunal's current approach may need some adjustments to afford better protection of patient rights. Suggestions as to how this might be achieved will be discussed in the next section.

D Suggestions to Make the "Serious Danger" Test More Rights-Friendly

In this part I will offer some suggestions as to how the dangers described in the last section can be minimised. This could be achieved through a greater emphasis on the "serious" component of "serious danger", proper balancing of risk factors, and more stringent risk assessment.

1 Greater emphasis on "serious"

The mental disorder definition requires that a patient poses a "serious" danger, in order to place or keep them under compulsion. In placing this qualifying adjective before "danger", Parliament clearly intended that the danger of the patient causing violence in the future must be significant, and more than just a low or moderate risk. The inclusion of the word "serious" seems to be often overlooked in recent cases, as the tribunal's approach does not explicitly consider whether the danger posed by a patient is serious enough to justify compulsion. Earlier cases emphasise the importance of the word "serious". For example, in *Re O*, Judge Boshier highlighted the fact that the danger must be "serious", therefore "the requirements of the Act are strong".[191] However, the word was taken to mean that the

[190] Diesfeld, above n 58, at 122.

[191] At 546.

danger must be imminent,[192] a requirement which has since been removed from the approach. The current approach seems to have subsumed the word "serious" into it, as the test can be met through different weightings of the four factors of magnitude, likelihood, frequency and imminence, and through considerations around relapse and compliance.

I submit that though my recommended approach does not require physical and imminent danger, the earlier emphasis on the importance of "serious" was correct. The definition of "mental disorder" only applies to patients who pose a "serious" danger to self or others, therefore anything less than "serious" danger should not be accepted. The intentional placement of the word serves the purpose of protecting patient rights by only compelling those who meet the high threshold of the "mental disorder" test. Though the current approach is broad and the test can be met via a number of combinations of factors, there should still be an explicit consideration of whether the risk of a patient acting violently in future is of a degree serious enough to require compulsion. This will ensure that patients who do not pose a severe risk to self or others are not unfairly restricted by compulsion.

2 Proper balancing of risk factors

Psychiatric risk assessment requires that different dispositional, historical and contextual risk factors of a patient are weighed up, in order to decide the level of risk of violence a patient might pose to self or others in the future. This was done particularly well in *Re Mental Health [Serious Danger]*,[193] but most other cases do not undertake a proper balancing exercise, incorporating all the possible risk factors for a patient. The proper identification of all the risk factors involved is important in order to increase the reliability of risk assessment, and avoid arbitrary detention of patients who may not actually pose a serious risk of danger to self or others. I submit that the tribunal should make sure it is listing all the risk factors for a patient that indicate serious danger, and all of those which do not, and balance these against each other to make sure patients are being fairly assessed.

3 More stringent risk assessment

Good risk assessment is critical to ensure that orders under the MHA are being properly used. As discussed above, there are many features of the risk assessment process that

[192] For example, in *In the matter of E*, Judge Carruthers stated that "the contrast has to be between "serious" danger and danger without any qualifying adjective. When seen in that light "serious" danger enhances the word "danger" by requiring components of imminence": *In the matter of E* [1994] NZFLR 328 at 333.
[193] At [60]-[65], see Chapter 3 for discussion.

threaten its reliability, so every effort should be made to make as accurate predictions as possible. A skeptical approach should be taken, where only reliable evidence of recent past conduct is accepted. Information on which assessment is based should be accurate, retrieved from as many sources as possible, such as family and friends, clinicians, other practitioners and police and court records, and should be based on both factual information and informed opinion.[194] Accuracy of prediction is increased where it is intended to apply to the near future, rather than long term,[195] and a combination of actuarial and clinical methods should be used to avoid the issues posed by just using actuarial methods alone.[196] Regarding the ethical issues posed in risk assessment, Paul Mullen suggests that predictions will be ethical if they are based on reasonable empirical evidence of relevant characteristics confirmed by independent sources, motivated by the intention to provide the patient with the best treatment available, and formulated in a way that expresses the uncertain nature of prediction and which takes into account the possibly adverse implications of prediction for the patient.[197] Thus mental health professionals can aid the tribunal by providing up to date assessment of the patient's mental state, history of their condition and compliance with medication, outline the conditions under which the patient is likely to be violent and suggest treatment options.

E Conclusion

After undertaking a thorough analysis of the tribunal's approach to the "serious danger" test, it seems that it is interpreting "serious danger" within a paradigm of risk, in line with the approach outlined in Chapter 2. In this approach, the tribunal seems to pay little attention to rights issues. This may be because the tribunal does not see the interpretive question as controversial, so as to engage s 6 NZBORA, or it may simply be giving effect to the MHA, so not to render it ineffective per s 4 NZBORA. Alternatively, the tribunal may view the encroachment on rights as minimal when balancing it with the potential harm if the patient was not under compulsion, or it may consider the limits imposed on rights "demonstrably justified", per s 5 NZBORA.

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[194] Ministry of Health *Guidelines for Clinical Risk Assessment and Management in Mental Health Service*, above n 107, at 6.

[195] Ministry of Health *Guidelines for Clinical Risk Assessment and Management in Mental Health Service*, above n 107, at 3.

[196] Ministry of Health *Guidelines for Clinical Risk Assessment and Management in Mental Health Service*, above n 107, at 3.

[197] Mullen, above n 97, at 171.

Despite the tribunal's approach not being very rights-friendly, I submitted that this approach is still legitimate as it is consistent with the text and purposes of the MHA, and the MHA gives mental health professionals significant functions and powers. Thus a risk-based approach to interpretation should be preferred. The MHA does authorise limits to be placed on patient rights, and keeping a patient under compulsion is justified where they have a history of relapse following cessation of treatment. There are some dangers to the tribunal's approach, but these could be minimised by the tribunal placing a greater emphasis on the "serious" component of "serious danger", proper balancing of risk factors, and more stringent risk assessment. If these suggestions were followed, the tribunal's approach would be legitimate, despite the impact on rights.

Conclusion

The preventive use of CTOs on stable patients, who display no current symptoms of mental disorder, is a major concern for human rights advocates in New Zealand. Though early campaigns for less restrictive community care received support from civil rights activists,[198] criticisms about overuse of compulsory treatment orders have become widespread.[199] This dissertation has considered whether the MHA permits CTOs to be used preventively in order to keep stable patients well, and if so, whether this constitutes the correct balance between state interests and patients' rights.

Whether a patient can be kept on a CTO hinges on the definition of "mental disorder" in the MHA. A patient must presently have an "abnormal state of mind", whether "continuous or intermittent", which is of such a degree that it either "poses a serious danger", or seriously diminishes the patient's capacity for self-care. If they are not currently "mentally disordered", they must immediately be released from compulsion. Thus whether CTOs can be used preventively turns on the interpretation of the "mental disorder" definition. The phrase "poses a serious danger" in the second limb, and the notion of "intermittency" in the first limb are the focus of interpretation in this dissertation.

Stable patients will only meet the "serious danger" test if there is a concept of "danger" which is continuing, and present even when they are not acting violently. "Dangerousness" is currently understood as a situational occurrence, rather than as an enduring character trait, and psychiatrists use risk assessment to predict whether a patient may act violently in the future. The concept of "risk" as enduring is convincing and a legitimate substitute for the notion of "danger" in the "mental disorder" definition, in light of the purposes of the MHA. In this fashion, the "serious danger" test can be understood within a paradigm of risk, where a patient is assessed on a number of risk factors in order to determine the likelihood of their acting violently in future. Concerning intermittency, though it would not be correct to say that this notion can be implied into the second limb, it is plausible that it affects our understanding of the "serious danger" test, as there must be a concept of "danger" which allows for intermittent patients to meet the "mental disorder" definition, to make sense of the definition as a whole.

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[198] Burns, above n 4, at 15.

[199] Tina Minkowitz *No-Force Advocacy by Users and Survivors of Psychiatry* (Mental Health Commission, 2006) at 2.

The analysis presented has shown that the courts, particularly the tribunal, take this kind of risk-based approach to the "serious danger" test. This is evidenced though references in the tribunal's reasoning to risk and risk assessment, the use of probabilistic terms, analysis of risk factors, the longitudinal approach taken to interpretation, considering "risk" as still present even when the patient's condition is stable, and the use of implicit factors such as compliance, insight and relapse. This approach has become more risk-based over time, as the "serious danger" test has been widened from the initial, strict approach requiring imminent, physical violence. Though the tribunal's approach is consistent with a psychiatric, risk-based approach, it is not very rights-friendly. There are several reasons why this may be, that rely on sections 4, 5 and 6 NZBORA. Despite the fact that the approach is rights-restrictive, it may be legitimate for the tribunal to take such a view. This is because the approach is consistent with the text and purpose of the MHA, mental health professionals are given significant powers under the MHA, the Act clearly authorises limits to be placed on patient rights, and the tribunal could reasonably conclude that a patient's history of relapses justifies compulsion.

Finally, though the tribunal's approach may be legitimate, there are still some dangers in it. The original "hard" approach requiring imminence placed a much greater emphasis on patient rights than the current risk-based approach, and the process of risk assessment used currently is difficult and carries danger of error. Furthermore, the MHA is not supposed to be used as a "backstop" measure in case of relapse. I concluded by suggesting ways to make the "serious danger" test more rights-friendly, such as placing greater emphasis on the word "serious", the tribunal making sure it properly balances risk factors, and undertaking more stringent risk assessment.

This dissertation also raises broader issues about the interpretation of mental health law. As the MHA involves the use of public powers, that directly affect patients' rights, there is always a need to balance rights and state powers. Consequently, interpretation requires the balancing of rights-driven and purposive approaches. It seems that in the context of preventive CTOs, the purposive approach often outweighs human rights considerations. The trend toward using risk assessment in determining whether a patient should be compelled also points to wider societal trends surrounding preventive laws and the use of the language of risk. The use of risk in conjunction with preventive laws by the state has been described as a way of maintaining government power, and as a tool for managing fear against certain groups in society.[200] Are we heading toward a time where precaution against

[200] B McSherry *Managing Fear: The Law and Ethics of Preventive Detention and Risk Assessment* (Taylor and Francis, New York, 2014), see Chapter 2: Theories of Risk and Precaution at 12.

the unknown is favoured, and the consequent restrictions on human rights are considered unavoidable? This is concerning in the context of mental health law, where those who are affected are vulnerable and reliant on the help of others. In the future, maybe societal attitudes will shift back, and a more rights-friendly approach will again be accepted.

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