Avoiding Arbitrary Detention of People with Dangerous and Severe Personality Disorder

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I Introduction

> [T]here appears to be almost universal agreement that there is a small group of individuals who will repeatedly cause serious harm. The public rightly expect the law to protect them so far as possible from that harm. But how is the law to define the circumstances in which there is a need for protection against that harm?[1]

This question posed by the New Zealand Law Commission will be the central concern of this paper. The 'small group of individuals', identified by the Law Commission, refers predominantly to people who suffer from dangerous and severe personality disorder (DSPD).[2] People with DSPD are likely to come to the attention of the criminal justice system (CJS), the mental health system (MHS), or both, during the course of their lives. However, the legal frameworks for the MHS and CJS may not apply adequately to people with DSPD. This creates what some commentators have called 'the lottery' - where placement of people with DSPD is dependent on chance.[3]

The MHS will be the focus for this paper. The MHS is designed to define and administer therapeutic benefit to a narrow group of mentally disordered people who pose a risk to themselves or others, and to do so in a manner that assures and protects human rights.[4] A patient can be treated in the MHS via a compulsory treatment order (CTO) if their condition can be framed as a 'mental disorder', in the necessary sense, and additional substantive and procedural criteria are satisfied. Whilst a patient is subject to the MHS, regular review of

[1] Law Commission *Community Safety: Mental Health and Criminal Justice Issues* (NZLC R30, 1994) at [58].

[2] I have adopted the term "dangerous and severe personality disorder" from the Department of Health and Home Office *White Paper, Reforming the Mental Health Act, Part II: High Risk Patients* (CM 5016-II Department of Health and Home Office 2001) (UK).

[3] See Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, Volume 1* (prepared for the Secretary of State for Health 1999) (UK) at [6.3.0].

[4] Mental Health (Compulsory Assessment and Treatment) Act 1992, Long Title.

their condition will occur.[5] Discharge from the MHS will occur if the patient no longer meets the definition of mental disorder.[6] Individuals may also enter the MHS via prison or by order of a criminal court where the necessary criteria are established.[7] However, movements of forensic patients in and out of hospital are subject to approval by the Minister of Health or Attorney General in New Zealand,[8] or by the Secretary of State in England.[9]

The 'lottery effect' is the result of a number of uncertainties that plague the concept of DSPD. In particular it is not known whether the concept can appropriately be framed as a mental disorder, in order for it to come within the scope of the MHS. This is because little consensus can be established between psychiatrists as to how it is defined and what features must be present to warrant a diagnosis.[10]

Nevertheless, some people with DSPD are committed to the control of the MHS,[11] but such commitments are doubtful as other people with DSPD fall exclusively within the CJS. These

[5] For New Zealand law see Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 33 and 34. A CTO will last initially for a six month period, after which, if it is found the patient is still disordered, the CTO will be extended for six months, with reviews occurring six monthly thereafter. For England and Wales law see Mental Health Act 1983, s 20, as amended by the Mental Health Act 2007: the duration of the treatment order will be six months, after which the patient must be discharged or the order renewed for a further six months. Where the criteria continue to be satisfied, treatment orders may be renewed yearly thereafter.

[6] *Waitemata Health v Attorney General* (2001) 21 FRNZ 216, [2001] NZFLR 1122: it was concluded, after a detailed analysis of the MH(CAT)A, that the criteria for discharge where a person is 'no longer mentally disordered and fit to be released from the requirement of assessment or treatment under this Act' rested solely upon whether the person is mentally disordered or not. This is because 'and' is to be read as 'and *therefore*', and so reference to "fit to be released" provides no additional information other than reinforcing that if a patient is no longer mentally disordered they must be released.

[7] For New Zealand law see Mental Health (Compulsory Assessment and Treatment) Act 1992, Part IV. For England and Wales law see Mental Health Act 1983, s 47, as amended by the Mental Health Act 2007.

[8] Mental Health (Compulsory Treatment and Assessment) Act 1992, s78(6).

[9] Mental Health Act 1983 (UK), s 42(2), as amended by the Mental Health Act 2007.

[10] John Gunn and Pamela Taylor *Forensic Psychiatry* (Butterworth Heineman, London, 1993) at 386.

[11] See *Re JC* (1997) 16 FRNZ 414, [1998] NZFLR 745 (MHRT-ST); *Re JLB* MHRT NRT 627/98, 30 September 1998; *Re NDU* MHRT NRT 937/01, 12 October 2001; *Re NJS* MHRT SRT 43/00, 18 September 2000; *Re PJT* MHRT NRT 286/00, 11 October 2000; *Re RR* MHRT ST37/93, 31 May 1993; *Re SJE* DC Auckland 50/98, 20 May 1998; *[Unknown]* MHRT NRT 425/96, 27 September 1996.

inconsistent outcomes may indicate an infringement of the rights of individuals - namely the right against arbitrary detention.[12]

Arbitrary detention is the notion that the state has detained an individual under unreasonable powers or has unreasonably exceeded the scope of its powers of detention.[13] To avoid arbitrary detention, the state must establish minimum legal standards that are capable of identifying a narrow class of people who may be subject to detention, and the circumstances in which detention may be justified.[14] The controversy surrounding the commitment of people with DSPD would suggest that mental health legislation is being imperfectly and arbitrarily applied to these people.

In addition, the danger exists that detention under the MHS may result from a desire to confine people with DSPD in a secure institution because of the threat they pose, rather than a desire to treat them. Effectively, this would transform the MHS into a backdoor for indeterminate preventive detention of anti-social people, rather than a system used to treat and manage mentally disordered people.

Nevertheless, it is heavily disputed whether DSPD can be treated at all.[15] Hence detention of people with DSPD under the MHS may be contrary to that system's primary therapeutic purpose. However, the courts and Mental Health Review Tribunals (MHRTs) in both England and New Zealand have not drawn this inference; nor have they approved a blanket exclusion of people with DSPD from the MHS. Therefore, it is desirable to examine comparative legislative frameworks to assess whether or not they provide sufficiently clear criteria to reduce the 'lottery effect' and avoid the charge of arbitrary detention.

The first part of this paper will elaborate on what is meant by DSPD and the ambiguities that result in its troublesome fit within the MHS. I will also examine why people with DSPD have such a high social cost and, therefore, why it is necessary to securely contain them.

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[12] New Zealand Bill of Rights Act 1990, s 22.

[13] Andrew Butler and Petra Butler *The New Zealand Bill of Rights Act: A Commentary* (LexisNexis, Wellington, 2005) at [19.8.1].

[14] *Thwaites v Health Sciences Centre Psychiatric Facility* (1998) 21 Man R (2d) (MBCA).

[15] Robert Hales, Stuart Yudofsky and Glen Gabbard (eds) *The American Psychiatric Publishing Textbook of Psychiatry* (5th ed, American Psychiatric Publishing Inc, Washington DC, 2008) at 831.

In the next chapter I will examine the notion of arbitrary detention within the civil detention context. I will show that arbitrary decision-making may be avoided by developing substantive legal standards to limit the discretion of decision-makers and provide clear guidance as to the circumstances in which detention may be justified. The chapter will conclude by discussing how the standards within the MHS may be undermined if they are extended to incorporate patients with DSPD.

In response to this problem, the next three chapters will explore whether it is possible for mental health legislation to adequately specify criteria for the detention and compulsory treatment of people with DSPD, with sufficient precision to avoid arbitrary detention. Three legislative approaches will be discussed: the former English and Welsh[16] regime – governed by the Mental Health Act 1983 (MHA 1983); the current English regime – governed by the Mental Health Act 1983, as amended by the Mental Health Act 2007 (MHA 2007);[17] and the current New Zealand regime – governed by the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT)A). My analysis of each regime will focus on two key features of the civil commitment standards: first, the threshold requirement that the person be 'mentally disordered,' and second, the issue of treatability.

The purpose of this analysis will be to clarify the costs and benefits of each legislative regime. This will enable a conclusion to be drawn concerning whether it is possible to reduce the 'lottery effect' and prevent arbitrary detention in relation to people with DSPD in the MHS, and if so in what way this can be done.

[16] The Mental Health Act 1983 (UK): this Act only applies to England and Wales despite being passed by the United Kingdom Parliament. Scotland's MHS is governed by the Mental Health (Care and Treatment) (Scotland) Act 2003 (Scot) and Northern Ireland's is governed through the Mental Health (Northern Ireland) Order 1986 (UK). As it would be too word intensive to continue to refer to both England and Wales when discussing the Act, this paper will simply refer to it as the English MHA 1983 Act.

[17] Mental Health Act 1983 as amended by the Mental Health Act 2007 (UK). The Mental Health Act 1983 remains in force. However, the introduction of amendments via the Mental Health Act 2007 has substantially altered the application of the Act. It is therefore necessary to distinguish between the Mental Health Act 1983 as it was before the amendments, and how it is now. Hence I will refer to the previous form of the Act as the MHA 1983 and current form of the Act as the MHA 2007.

II Dangerous and Severe Personality Disorder

A The Diagnostic and Statistical Manual of Mental Disorders

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) defines personality disorder generally as:[18]

> An enduring pattern of inner experience and behavio[u]r that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

The DSM-IV-TR lists ten types of personality disorder that are grouped into three broad clusters.[19] People who could be described as having a DSPD will most frequently meet the clinical diagnosis of having an anti-social personality disorder (ASPD), situated within the Cluster B category. The DSM-IV-TR describes ASPD in terms of "a pervasive pattern of disregard for, and violation of, the rights of others...."[20] People with ASPD have a number of maladaptive personality traits indicative of criminal behaviour including deceitfulness, impulsivity, irritability, aggressiveness, reckless disregard for safety, irresponsibility and lack of empathy.[21]

However, DSPD and ASPD should not be defined by the presence of anti-social or criminal behaviour alone.[22] It should be possible to distinguish mentally disordered individuals from 'normal' recidivist criminals. This is made particularly difficult as patients with personality disorder may display a varied range of personality traits, resulting in heterogeneous descriptions between patients from which no universal indicator of the disorder can be

[18] American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, American Psychiatric Association, Washington DC, 2000), at 685.

[19] Ibid, at 685.

[20] Ibid, at 701.

[21] Ibid, at 706. For an interesting case study of a person with ASPD/psychopathic disorder see Carl Elliot "Mind Games" *The New Yorker* (F-R Publishing Corp, New York, 6 September 2010). This article concerns Colin Bouwer, formerly the head of psychiatry at the University of Otago, who was convicted of murdering his wife Annette Bouwer in the late 1990's.

[22] Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, above n 3, at [6.4.22].

extracted.[23] Therefore, it is important for clinicians to show that when maladaptive traits are present they are firmly embedded within the patient's character and cause substantial deficits in the patient's functioning.[24]

B Causes of DSPD

Whether personality disorders erupt as a result of 'nature or nurture' is a contentious issue within psychiatry. In favour of a biological explanation, twin studies have shown a pattern of high concordance between identical twins rated on scales measuring socially deviant behaviour.[25] Similarly, adoption studies indicate that where an adopted child has biological parents who have anti-social personality traits, that child is likely to share the same qualities.[26]

However, in favour of an environmental explanation, people brought up in adverse environments with low parental attention are found, on average, to have increased tendencies towards anti-social behaviour.[27] People with personality disorders are also significantly more likely to be alcohol or drug abusers.[28] Yet the extent to which the substance abuse causes the personality disorder is unknown. Alternatively, it is the personality disorder which creates a tendency towards substance abuse.

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[23] Ronald Blackburn "On Moral Judgements and Personality Disorders" (1988) 153 B J Psych 505 at 511.

[24] American Psychiatric Association, above n 18, at 700-701.

[25] Essi Viding and others "Evidence for substantial genetic risk for psychopathy in 7-year-olds" (2005) 46(6) JCPP 592 at 592.

[26] Remi Cadoret, Collen Cain and Raymond Crowe "Evidence for Gene-Environment Interaction in the Development of Adolescent Antisocial Behaviour" (1983) 13(3) Behaviour Genetics 301 at 301.

[27] Michael Rutter "An Update on 'Maternal Deprivation'" in Peter Joyce and others (eds) *Development Personality and Psychopathology* (University of Otago Press: Christchurch, 1994) 7 at 10.

[28] Ministry of Justice and Department of Health "Dangerous People with Severe Personality Disorder: Useful Information" DSPD Programme: Dangerous People with Severe Personality Disorder <www.dspdprogramme.gov.uk >.

At present the cause of personality disorder is best attributed to a biosocial model – where an individual's environment can exacerbate the severity of the disorder but the foundational cause is a constitutional defect.[29]

The absence of a definite cause is problematic at a diagnostic level as it provides psychiatrists with no biological or social marker which can be used to certify absolutely the presence of a personality disorder. The lack of an identifiable cause, combined with the heterogeneous manifestations of the disorder, make it exceedingly difficult to identify reliably.[30]

C Prevalence

Estimates gathered from data in United Kingdom[31] and United States[32] show approximately ten per cent of the population have at least one form of personality disorder. The DSM-IV-TR states that the prevalence of ASPD is estimated at one per cent in females and three per cent in males.[33]

These figures are higher in prison populations. In a study commissioned by the New Zealand Department of Corrections, 59 per cent of the surveyed population of male and female inmates had at least one form of personality disorder.[34] The rates of antisocial personality disorder were 35.4 per cent for women and 41.0 per cent for men.[35]

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[29] L Sroufe and Michael Rutter "The Domain of Developmental Psychopathology" (1984) 55(1) Child Development 17 at 20.

[30] Blackburn, above n 23, at 511.

[31] Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, above n 3, at [6.1.6].

[32] Sven Torgensen "Prevalence, Sociodemographics, and Functional Impairments" in J Oldman, A Skodol and D Bender (eds) *Essentials of Personality Disorder* (American Psychiatric Publishing Ltd, Washington DC, 2009) 83 at 88.

[33] American Psychiatric Association, above n 18. at 704.

[34] A Simpson and others "National Study of Psychiatric Morbidity in New Zealand Prisons" (1999) Department of Corrections <www.corrections.govt.nz/> at 32.

[35] Ibid, at 52.

D Treatment

Personality disorders by definition are 'enduring', 'pervasive' and 'inflexible' – hence the presumption that personality disorders are notoriously hard to treat or untreatable.[36] People with a personality disorder may have displayed maladaptive personality traits from as early as infancy resulting in a lack of awareness that such traits are defective and require change.[37] Treatment is therefore aimed at reducing the consequences of the personality disorder, rather than attempting to 'cure' it in the conventional sense.

Group psychotherapy and psychoanalytical sessions have proven successful in some cases. These methods endeavour to increase insight, explore reasons why the patient is resisting change and pressure the patient into accepting feedback provided by other members of the group.[38] However, the presence of superficial, manipulative and callous personality traits, characteristic of many patients with DSPD, contraindicates the use of this style of treatment.[39]

Of burgeoning popularity amongst clinicians is the implementation of Behaviour Modification Programmes (BMP).[40] BMP commonly comprise two main parts: group therapy and skills training.[41] The purpose is to stabilise emotions and rehabilitate the person socially by improving insight, reinforcing good behaviour and developing ways in which negative behaviour can be changed.[42]

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[36] Hales, Yudofsky and Gabbard, above n 15, at 831.

[37] Ibid.

[38] Ibid, at 832.

[39] Ibid.

[40] See *[Unknown]*, above n 11, and *Re RR*, above n 11, for instances where BMP have been applied for people with personality disorders.

[41] Barbara Stanley and Beth S Brodsky "Dialectical Behavior Therapy" in J Oldman, A Skodol and D Bender (eds) *Essentials of Personality Disorder* (American Psychiatric Publishing Ltd, Washington DC, 2009) 235 at 239: the form of BMP described here is the Dialectical Behaviour Therapy. It is the form used most frequently in New Zealand.

[42] Ibid, at 238.

No specific pharmacotherapy has been developed for treating personality disorders.[43] Patients may benefit from Neuroleptic drugs designed to palliate the aggressive symptoms of personality disorder.[44]

In short, it is apparent that in some cases people with DSPD will benefit from mental health services. However, where a patient is unwilling to engage in treatment or unresponsive to interventions, as so many patients with DSPD are, then it is difficult to explain why these individuals warrant the specialised services provided by trained psychiatrists in the MHS.[45] Seemingly, in the absence of therapeutic benefit from clinical interventions, management of maladaptive personality traits could equally be provided through a prison environment via the counselling and social rehabilitative services provided there.

E DSPD, ASPD and Psychopathic Disorder

The term DSPD has courted much criticism as being a "neologism that has no medical or legal status".[46] However, no means of accurately bracketing this 'small group of individuals' has been developed in either the field of psychiatry or law. Therefore, the term DSPD is a useful descriptive tool to represent such people. The term is capable of including the concept of 'psychopathic disorder' (PPD) found in the former English legislation,[47] as well as a wide range of personality disorders, including principally ASPD.

The term 'dangerous' attaches to a person who, if released into the community, would "pose a substantial risk of harm to the public".[48] The term 'severe' indicates that the person is likely

[43] Sylvia Bell and Warren Brookbanks *Mental Health Law in New Zealand* (2nd Thomson/Brookers, Wellington, 1998) at [3.7].

[44] Paul Soloff "Somatic Treatments" in J Oldman, A Skodol and D Bender (eds) *Essentials of Personality Disorder* (American Psychiatric Publishing Limited, Washington DC, 2009) 267 at 269.

[45] Brenda Hoggett *Mental Health Law* (4th ed, Sweet and Maxwell, London, 1994) at 36. Following the publication of this text, the author's name changed from Hoggett to Hale. The author's works will be cited according to her name at the time they were published: Hoggett in this case.

[46] Frank Farnham and David James "'Dangerousness' and Dangerous Law" (2001) 358 Lancet 1926 at 1926.

[47] MHA 1983 (UK), ss 1(2), 3(2), 7(2)(a), 11(6), 16(2), 20(4)(a), 20(7)(a), 35(3)(a), 37(2)(a), 38(1)(a), 47(1), 72(1)(b), 72(4) and 145(1).

[48] Law Commission, above n 1, at [54].

to be unresponsive to treatment, has a serious risk of offending and suffers from a high degree of functional impairment and emotional instability.[49]

F Why are People with DSPD so Problematic?

1 Institutional management

The unwillingness of many clinicians to admit patients with DSPD is fuelled by the fact they require a high degree of security and supervision while confined to psychiatric institutions.[50] Patients with DSPD will push the boundaries of hospital rules, exploit weaknesses in staff and fellow patients, and engage in confrontational and highly disruptive behaviour.[51] These negative outbursts erode the hospital's therapeutic environment and consume a disproportionate amount of staff time.

Placing personality disordered patients into special units is not a desirable option either. This is evidenced in the report on the experimental personality disorder unit at Ashworth Special Hospital, which stated:[52]

> Putting personality disordered patients together also in one sense created a better 'psychopath'. In order to survive amongst manipulative, clever personality disordered patients one learnt the 'tricks of the trade'.

Interestingly, a survey conducted by the Royal College of Psychiatrists found that 75 per cent of the clinicians surveyed objected to the 'medicalisation' of DSPD for the purpose of civil commitment.[53] This is because where psychiatric interventions prove unable to effect an improvement of the patient's condition, psychiatrists see themselves merely as 'agents of

[49] A Haddock and others "Managing Dangerous People with Severe Personality Disorder: a survey of forensic psychiatrists' opinions" (2001) 25 Psychiatr Bull 293 at 294.

[50] Committee on Mentally Abnormal Offenders *Report of the Committee of Mentally Abnormal Offenders ('the Butler Report')* (prepared for Parliament by the Secretary of State for the Home Department and the Secretary of State for Social Services 1975) (UK) at [5.37].

[51] United Kingdom Department of Health, Ministry of Justice and Her Majesty's Prison Service *Dangerous and Severe Personality Disorder High Security Services for Men: Planning and Delivery Guide* (2008) (UK) at 18.

[52] Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, above n 3, at [1.25.11].

[53] Haddock, above n 49, at 293.

social control' as their role becomes only supervisory.[54] Arguably, it is offensive to psychiatric ethics to detain patients with DSPD and unfair to put extra pressure on an already stretched MHS from people who are notoriously hard to change.[55]

2 Re-offending

Criminal recidivism is a frequent trait in people with DSPD.[56] A study conducted at the University of Waikato showed that prisoners who scored highly on scales measuring psychopathic tendencies were more likely to repeatedly engage in criminal activity.[57] Those who had offended violently and have DSPD also have an increased chance of offending violently more often and after shorter periods of freedom from prison.[58] This reflects the belief that people with DSPD are often un-empathetic to human suffering, and act in ways which exclusively benefit their own short-term goals.[59] Thus punitive detention appears to be ineffectual at reducing maladaptive behaviour caused by people with DSPD.[60]

3 Public protection

If prisons and hospitals are not suitable environments for people with DSPD, must we simply release them back into society? Release into the community of a person with DSPD who presents a significant risk of harm to the public is a troubling option.[61] This is confirmed in the leading authority, *Waitemata Health v Attorney General,* where Elias CJ recognised that public safety is a valid consideration in decision making under the MH(CAT)A.[62]

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[54] Ibid, at 294.

[55] (15 January 1999) 325 GBPD HC 608.

[56] Beverly Powis *Offenders' Risk of Serious Harm: A Literature Review* (RDS Occasional Paper No. 81 United Kingdom Home Office 2003) at vi.

[57] Nicol Wilson "The Utility of the Psychopathy Checklist-Screening Version for Predicting Serious Violent Recidivism in a New Zealand Offender Sample" (PhD Thesis, University of Waikato, 2003).

[58] Powis, above n 56, at 6.

[59] Robert Hare *Psychopathy: Theory and Research* (John Wiley and Sons Inc, New York, 1970) at 7.

[60] Ibid, at 6-7.

[61] (15 January 1999) 325 GBPD HC 604.

[62] *Waitemata Health*, above n 6, at [78], [94] and [121].

High profile 'stranger offending' often captures media attention and fuels public fear, sparking governmental policies which favour a public protection approach.[63] This was reflected by the introduction in England of the Dangerous People with Severe Personality Disorders Bill in 1999 after the vicious murder of two strangers by a person with ASPD.[64] The Bill proposed the indefinite detention of people with DSPD, until such a time as they were no longer considered dangerous.[65] This was regardless of whether treatment was available.[66] In the event, the legislation was not passed.

Nevertheless, public protection is one of the purposes of the MHS as the public rightly deserve to be protected from the harm caused by another person's defective mental state. However, it is Parliament's duty to enact legislation which balances the rights of patients with the right of the public to safety.[67] In some cases no amount of prediction, assessment, treatment, legislation, or draconian measures (short of preventive detention) can avert the harm caused by mentally disordered offenders.[68] On the rare occasions where tragedies occur, the government must remain cautious before limiting patients' liberties disproportionately.[69]

G Summary

This chapter has carved out a basic understanding of the phrase DSPD. It has been criticised for its potentially wide and vague application which is largely due to the fact that a number of heterogeneous personality traits could be used to formulate a diagnosis of DSPD.

[63] Philip Fennell *Mental Health: The New Law* (Jordan Publishing Ltd, Bristol, 2007) at 4.

[64] Telegraph, "Straw puts off Psychopath Law until after Election" (2000) Telegraph.co.uk <www.telegraph.co.uk>: in 1998 Michael Stone, a patient with ASPD, randomly attacked and killed Lin Russell and her daughter Megan. Stone was known to the both criminal and psychiatric authorities but he was not deemed treatable and had not committed an imprisonable offence, thus no powers existed to authorise his detention. The horrifying attack moved the United Kingdom Parliament to examine ways to fill this gap in the law which had allowed Stone's release into society, such as the unsuccessful proposal of the Dangerous People with Severe Personality Disorder Bill 1999.

[65] Dangerous People with Severe Personality Disorder Bill 1999, cl 5.

[66] Ibid, cl 4(1)(b).

[67] Ministry of Health and Home Office, above n 2, at 5.

[68] The Butler Report, above n 50, at [4.12] – [4.14].

[69] Ibid, at [4.13] where it was queried "in deciding where society requires more protection, the question has to be faced: how many probably safe individuals should cautious policy continue to detain in hospital in the hope of preventing the release of one who is still potentially dangerous?"

Consequently little inter-rater reliability can be established between individual cases of the disorder.[70] This difficulty in identifying the disorder is compounded by insufficient knowledge about the cause of the disorder and what interventions can be implemented to treat it. These doubts about treatability are of particular concern as one of the primary purposes of mental health legislation is to provide treatment for patients. Public safety is a valid secondary consideration, although to detain patients exclusively for this reason would be an affront to psychiatric ethics and a waste of clinical time, resources and expertise. Moreover, it is essential that the disorder is not simply framed by the presence of anti-social behaviour; evidence of some form of adverse mental pathology and functional impairment is critical to establishing a proper diagnosis. It is desirable that laws are formulated to reflect this distinction of the 'mad' from the 'bad'.[71]

[70] Gunn and Taylor, above n 10, at 386-387.

[71] Bell and Brookbanks, above n 43, at [3.5].

III Arbitrary Detention

When a person is detained by the state for whatever reason it will result in a substantial loss of rights, such as the right to freedom of movement,[72] and freedom of association.[73] It is therefore necessary to ensure that detention only occurs under the correct circumstances and in accordance with the law.[74] If not then this may result in a further breach of human rights: in particular, the right not to be arbitrarily detained.[75] Thus detention must be in accordance with reasonable, predetermined procedures and objective standards.[76] Given that mentally disordered people are particularly vulnerable members of society it is critical that the law ensures their detention under the MHS is not arbitrary.

The following chapter will explore the concept of arbitrary detention within civil commitment regimes. From the discussion I will highlight the legal standards which are critical to the development of an objective threshold that can be used to ensure valid detention decisions are made. Furthermore, I will show how the inclusion of DSPD within the scope of mental disorder increases the potential for arbitrary detention, as the application of an objective threshold is complicated by uncertainties surrounding the concept.

A What is Arbitrary Detention?

The right against arbitrary detention is enshrined in s 22 of the New Zealand Bill of Rights Act 1990 (NZBORA) which reads "[e]veryone has the right not to be arbitrarily arrested or detained."[77] The New Zealand courts have no authority to limit the power of Parliament by

[72] New Zealand Bill of Rights Act 1990, s 18.

[73] Ibid, s 17.

[74] Butler and Butler, above n 13, at [19.5].

[75] New Zealand Bill of Rights Act 1990, s 22.

[76] Terry Carney, David Tait, Fleur Beaupert "Pushing the Boundaries: Realising Rights through Mental Health Tribunal Processes" (2008) 30(1) Syd LR 329 at 338.

[77] NZBORA, s 22: this section confirms New Zealand's commitment to the International Covenant on Civil and Political Rights which likewise prohibits arbitrary detention. A breach of this right may be bought to the attention of the Human Rights Committee of the United Nations.

striking down a piece of legislation if it can be seen to allow arbitrary detention.[78] However, when detention is arbitrary and unlawful the courts are empowered to order the immediate release of the person, and may award damages.[79] The leading interpretation of the meaning of arbitrary detention in New Zealand was given in *Neilson v Attorney General*:[80]

> Whether an arrest or detention is arbitrary turns on the nature and extent of any departure from the substantive and procedural standards involved. An arrest or detention is arbitrary if it is capricious, unreasoned, without reasonable cause; if it is made without reference to an adequate determining principle or without following proper procedures.

The MH(CAT)A has a comprehensive structure allowing for periodic reviews and appeals to ensure the commitment process occurs in strict compliance with the law.[81] So it is not deficiencies in procedure that are likely to generate claims of arbitrary detention.

Such claims are more likely to be based on the absence of substantive legal standards against which the validity of a person's detention can be measured. This is due to the debate surrounding the definition, application and scope of fundamental mental health concepts such as personality disorder. Therefore arbitrary detention may arise when there are insufficient legal criteria that are clear, specific and able to be reliably applied by the courts to achieve the legislative intentions of Parliament and limit the discretion of decision-makers.[82]

B Avoiding Arbitrary Detention in the Civil Detention Context

Civil detention regimes may exist for a variety of reasons but together they share a common aim: to remove a form of threat posed by an individual in order to protect the public or the

[78] NZBORA, s 4: this is qualified by s 6 which states that an approach to statutory interpretation that is consistent with the terms of the NZBORA is preferred.

[79] *Simpson v Attorney General* [1994] 3 NZLR 667 (CA) [*Baigent's case*] at 718.

[80] *Neilson v Attorney General* [2001] 3 NZLR 443, (2001) 5 HRNZ 334 (CA) at [34].

[81] See Mental Health (Compulsory Assessment and Treatment) Act 1990, Part I.

[82] Butler and Butler, above n 13, at [19.8.7].

individual.[83] However, an additional factor, aside from the presence of a threat, is required to justify a civil detention regime, such as a finding that the person is mentally disordered.[84] It is this additional factor that must be spelt out with sufficient clarity to ensure that civil detention only occurs for designated purposes, under specific conditions, and is applicable only to a narrowly defined class of people.

The argument that civil detention may not be valid due to imprecise legal criteria was raised in the United States case of *Kansas v Hendricks*.[85] The civil detention regime in question was the Kansas Sexually Violent Predator Act 1994 (SVPA) which allows for the detention of mentally abnormal or personality disordered persons who are likely to engage in "repeat acts of sexual violence".[86] It was contended in *Hendricks* that the powers provided by the SVPA were unconstitutional as the concept of mental abnormality was so obscure it did not sufficiently identify a narrow class of people who would be subject to the regime.[87] The Supreme Court, in a 5-4 decision, rejected this argument. The Court concluded that inter-jurisdictional differences in interpretation, and incongruence between the psychiatric and legal understandings of the term mental abnormality, did not present a barrier to its use in legislation.[88] Rather the definition of the term is derived from psychiatric evidence which is subject to scrutiny by the judiciary.[89] A positive finding in this regard, combined with irrefutable proof of prior sexual offending, justified the indefinite removal of the person from society.[90]

However critics of the decision argue that the concept of mental abnormality is simply a vague legalism constructed on insufficient psychiatric or academic grounding, and therefore

[83] See for example the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 – authorising the civil detention of intellectually disabled offenders, or the Tuberculosis Act 1948 – authorising the detention of people suffering from tuberculosis in order to prevent the spread of the disease.

[84] *Kansas v Hendricks* 521 US 346 (1997) (USSC) at 368 and 362.

[85] Ibid.

[86] Sexually Violent Predator Act Kan Stat Ann, Title 59 §29a01 (US).

[87] *Kansas v Hendricks*, above n 84, at 350.

[88] Ibid, at 359.

[89] Ibid, at 360.

[90] Ibid, at 358: although Justice Breyer gave the dissenting opinion he agrees with the majority that the use of the term mental abnormality is constitutional. He provides a good example of how the Supreme Court sought to give the term meaning by integrating psychiatric evidence within the legal context.

does not create a standard against which a narrow class of people can be defined.[91] The danger is that the decision will depend more on the subjective view of the person applying the criteria than the objective characteristics of the person to whom they are applied. This is not eliminated by relying on expert psychiatrists to provide meaning because discretionary opinion will always be liable to fluctuations, inconsistencies and inception of the personal views of psychiatrists.[92] Moreover, the subjective view of the judicial decision-maker is liable to depend heavily on fluctuating social views of what is 'normal', rather than what is considered 'normal' in a medical context.[93] As many people will deem sexually dangerous people to be abnormal for that reason alone, it is likely that detention will depend almost entirely on a finding of dangerousness, opposed to the presence of a clinical mental deficit.[94]

In essence, the view of the United States Supreme Court appears to avoid identifying any minimum standards for detention.[95] The decision is based on collusion between the judiciary and the expert witnesses that the person should be detained, not on agreement that the applicant's circumstances satisfy an identifiable objective threshold. While it is theoretically possible that arbitrary detention is avoided through judicial oversight of psychiatric opinion,[96] there are no assurances that this will occur. Thus, the presence of a mental abnormality determined through clinical judgments alone is not enough to justify the substantial removal of liberties that occurs in civil detention.[97] Rather, the legislature should indicate clear legal standards against which the judiciary can determine the validity of expert evidence.

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[91] Cynthia King "Fighting the Devil We Don't Know: Kansas v Hendricks, A Case Study Exploring the Civilisation of Criminal Punishment and its Ineffectiveness in Preventing Child Sexual Abuse" (1999) 40 Wm and Mary L Rev 1427 at 1444-1445.

[92] Gunn and Taylor, above n 10, at 861.

[93] King, above n 91, at 1445-1446.

[94] Ibid.

[95] On avoiding arbitrary detention in the mental health context, see John Dawson "Forensic psychiatry and public law" in W Brookbanks and S Simpson (eds) *Psychiatry and the Law* (LexisNexis, Wellington, 2007) at 107.

[96] This was the conclusion adopted in the New Zealand case of *Re: M* [1992] 1 NZLR 29 (HC) where Gallen J at [42] held that although psychiatric opinion was prone to fluctuations the courts "would not accept a capricious or arbitrary conclusion." However, Gallen J failed to pinpoint the standards the courts would use to determine whether a decision was capricious or arbitrary.

[97] Carney, Tait and Beaupert, above n 76, at 338-339.

The Canadian case *Thwaites v Health Sciences Centre Psychiatric Facility* provides valuable guidance on this point.[98] There the Manitoba Court of Appeal concluded that the Manitoba Mental Health Act offended s 9 of Canadian Charter of Rights and Freedoms 1982, which prohibits arbitrary detention.[99] The Act authorised detention "where any person in Manitoba is or is suspected or believed to be in need of examination and treatment in a psychiatric facility."[100] The Court concluded that the provision was not capable of sufficiently delineating a narrow class of people, nor did it clarify precisely the circumstances under which a person may be detained.[101] Dependence on expert evidence and "professional ability and integrity" could not adequately fill the gaps where objective standards were lacking.[102]

Aside from the fact that the legal criteria must establish standards that are valid, clear and reliably applicable, they should also concur with the overall purpose of the Act.[103] Civil confinement regimes are enacted to remove a threat to the public. However, dangerousness is exceedingly hard to quantify, so predictions of risk have been criticised on the basis they are arbitrary and valueless, and should not be used.[104]

Nevertheless, risk assessments are unavoidable in decisions about civil detention and should not be assumed to be arbitrary when based on current research concerning risk factors, and professionally regarded risk assessment techniques.[105] In *R v Rameka,* a case brought from New Zealand, the United Nations Human Rights Committee (UNHRC) also determined that detention based on risk predictions is consistent with human rights principles.[106] The UNHRC review of risk predictions in an indefinite detention context is relevant despite the case concerning the validity of the criminal sentence of preventive detention. The effect of preventive detention in New Zealand is to impose an indeterminate sentence on eligible

[98] *Thwaites*, above n 14: the findings of the Manitoba Court in regards to s 9 of the Canadian Charter of Rights and Freedoms 1982 can be usefully applied in New Zealand, as s 9 contains similar wording to s 22 of the NZBORA. Therefore, guidance can be gleaned from this authority concerning the concept of arbitrary detention.

[99] Ibid, at [34].

[100] Mental Health Act CCSM M 1998 c M-110 (Manitoba), s 15(1).

[101] *Thwaites*, above n 14, at [33].

[102] Ibid, at [34].

[103] *Waitemata Health*, above n 6, at [64]-[65] and [81].

[104] Jill Peay *Tribunals on Trial: A Study of Decision-Making under the Mental Health Act 1983* (Clarendon Press, Oxford, 1989) at 208.

[105] Susan Glazebrook "Risky Business: Predicting Recidivism" (2010) 17(1) Psychiatr Psycholog Law 88 at 88.

[106] *R v Rameka* (2003) 2 HRNZ 663 (UNHRC).

offenders, with a minimum parole period of five years[107] and liability to recall to prison for life if re-offending occurs upon release.[108] The offender must have committed a qualifying offence, when they were 18 or over, and must be likely to commit another offence if released.[109]

In *Rameka* it was argued by the applicants that this regime was based on an arbitrary risk assessment devoid of concrete evidence the offender will do harm.[110] The UNHRC was not persuaded. It instead held that so long as regular review of the patient confirmed he presented an ongoing threat then detention was legitimate.[111] The legislature had also provided a list of mandatory considerations which may indicate an ongoing threat, including the person's pattern of serious offending, the potential of serious harm to the community, the tendency to commit serious harm and the failure to address the cause of the offending.[112] Reports must be ascertained from at least two health assessors concerning the likelihood of the individual re-offending.[113] Such reports are considered valuable in the process of risk assessment as it is generally accepted that clinical predictions of dangerousness are increasingly becoming more accurate when carried out in a controlled manner, using reliable techniques, and are certainly much better than chance.[114]

Therefore, although risk assessment may appear to be inherently discretionary and unreliable, the UNHRC held that minimum standards can be established where the best available expert evidence is provided and subject to scrutiny by the courts.[115] This evidence is then compared with the guidelines and limits to be extracted from a proper reading of the functions and structure of the legislation.[116]

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[107] Sentencing Act 2002, s 87(1).

[108] Parole Act 2002, s 6(4)(d).

[109] Sentencing Act 2002, s 87(2): it is this criteria which satisfies the requirement that preventive detention only applies to a small and identifiable group of people.

[110] *R v Rameka*, above n 106.

[111] Ibid, at [7.3].

[112] Sentencing Act 2002, s 87(4).

[113] Ibid, s 88(1)(b).

[114] Paul Mullen "Assessing Risk of Interpersonal Violence in the Mentally Ill" (1997) 3 Adv Psychiatr Treat 166 at 166. See also Law Commission, above n 1, at [56] and Glazebrook, above n 105.

[115] Glazebrook, ibid, at 110.

[116] Dawson "Forensic Psychiatry", above n 95, at 115.

C Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (ID(CCR)A) is a good example of how the New Zealand Parliament has formulated a civil detention regime with clear substantive standards to avoid arbitrary detention. The ID(CCR)A was enacted because the exclusion of purely intellectually disabled people from the MH(CAT)A left a gap concerning the placement of such people when they committed an offence.[117]

The ID(CCR)A provides an alternative to prison, which some viewed as an inhumane option for people with substandard intellect, whereby intellectually disabled offenders are directed to care and rehabilitation facilities.[118] Section 7 defines "intellectual disability" by reference to reliable and universal scientific measures (i.e. the intelligence quotient and confidence intervals).[119] In conjunction, the person must display a maladaptive level of functioning as evidenced by a significant deficit in the ability for perform at least two common skills.[120] From these requirements a narrow class of people is indisputably established. In addition, the person's prior involvement in criminal activity legitimises their removal from society in the name of public safety.[121]

In this way the legislature has reduced the potential for detention being arbitrary as it has designated a clear and legitimate purpose, established specific requirements for eligibility, and minimised discretion by incorporating scientifically proven and universally accepted standards. In short, a clearly objective threshold has been established.

[117] MH(CAT)A, s 4.

[118] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 46(2): the initial detention period is for three years, although this may be extended which effectively makes the regime a form of indefinite civil detention.

[119] Ibid, s 7(3).

[120] Ibid, s 7(1)(b): the common skills are listed under s7(4) and includes communication, self-care, home living, social skills, use of community services, self-direction, health and safety, reading writing and arithmetic, and leisure and work.

[121] Ibid, s 11 states "a power under this Act ... must be guided by the principle that the care recipient should be treated so as to protect the health and safety ... of others".

D The Dilemma with DSPD

Complications arise when applying substantive standards to people with DSPD because the concept of DSPD is so ill-defined. The lack of consensus between psychiatrists as to the nature of DSPD means that psychiatric evidence is of tenuous value in establishing whether legal standards have been met.[122] Judicial overview of psychiatric evidence is of little benefit in such situations as judges or tribunal members are in no better position to analyse the conflicting evidence and literature.

Moreover, its vague nature means that if DSPD were to be considered a mental disorder then it could encapsulate an excessively broad group of people.[123] The danger exists that people will be detained based on anti-social behaviour alone, as the concept of DSPD draws a very fine line between anti-social behaviour *per se*, and anti-social behaviour caused by mental dysfunction.[124] The courts and even medical practitioners may lack the necessary skills to make such a fine distinction.[125] Therefore the boundaries of mental disorder may be extended beyond what Parliament intended, transforming legislation into a mechanism for controlling people who are socially dissident, rather than helping those who require medical attention.[126]

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[122] Gunn and Taylor, above n 10, at 861. Compare this to 'intellectual disability' which can be clearly indicated from an IQ score below 70 and the display of clear deficits in everyday functioning.

[123] Blackburn, above n 23, at 511.

[124] See *Re SJE,* above n 11, where Judge MacCormick sought to characterise a women's pyromaniac tendencies as an abnormal state of mind in order to differentiate her from the rest of the prison population. In coming to the conclusion that she did suffer from an abnormal state of mind Judge MacCormick adopted a lay interpretive approach to the criteria in the MH(CAT)A, with minimal reference to psychiatric opinion. Consequently it could be argued that the judgment did not show with sufficient certainty that commitment was being authorised on the basis of the patient's mental abnormality, rather than her deviant behaviour.

[125] Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital*,* above n 3, at [6.4.12]. See also evidence given by Dr Chaplow concerning RCH, in *Re RCH* MHRT 10/073, 26 August 2010 at [57], where he stated "his mental disorder is not evident to the casual observer, and it is a reasonable possibility it would also escape the attention of a psychiatrist who did not have proper training." This highlights the difficulty that even psychiatric professionals have when distinguishing between anti-social behaviour and behaviour caused by a personality disorder.

[126] Blackburn, above n 23, at 511.

The purpose of the MH(CAT)A may be further compromised as it is generally believed that DSPD patients are notoriously untreatable.[127] Hence it is questionable whether their detention under mental health legislation is suitable given that the primary purpose of such legislation is to treat and rehabilitate people.[128]

These difficulties are evidenced in the saga involving the patient RCH – who is currently committed under the MH(CAT)A.[129] RCH's primary diagnosis was ASPD and it was believed he presented a high risk to several women whom he had become infatuated with.[130] As the term of his prison sentence came close to expiring it was queried whether he could be committed under the MH(CAT)A.[131] Despite being found not mentally disordered in 2000,[132] the MHRT in 2003 (following direction from the Court of Appeal)[133] determined that he was mentally disordered, due to suffering from a disorder of cognition.[134] This change of direction shows there is psychiatric uncertainty about the concept of personality disorder and its relation with the definition of mental disorder. Moreover, despite the Court of Appeal's direction that commitment could not occur for the purpose of public protection alone,[135] sceptically one could conclude that the shift in attitude to RCH resulted from a desire to ensure his continual confinement. This would inappropriately elevate the public protection purpose of mental health legislation above its therapeutic purpose. This is also contrary to s 4 of the Act which disallows detention on the basis of criminal behaviour alone.[136]

Furthermore, the Court of Appeal required that a wide view of the legislative criteria be adopted.[137] The Court was effectively allowing a broader scope for discretionary opinion and more indeterminate limits on the extent of the legal criteria. Potentially this may

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[127] Hales, Yudofsky and Gabbard, above n 15, at 831.

[128] See Committee of Inquiry in to the Personality Disorder Unit, Ashworth Special Hospital, above n 3, at [6.10.11].

[129] The continuing status of RCH's CTO was recently confirmed by the MHRT in *Re RCH* (2010), above n 125.

[130] *Waitemata Health*, above n 6, at [26].

[131] *Waitemata Health*, above n 6, at [14].

[132] *Re RCH* MHRT NRT 772/00, 20 April 2000.

[133] *Waitemata Health*, above n 6.

[134] *Re RCH* MHRT NRT 02/0672, 27 February 2003.

[135] *Waitemata Health*, above n 6, at [81].

[136] MH(CAT)A, s 4(c).

[137] *Waitemata Health*, above n 6, at [72-73].

establish a precedent for an undesirably wide group of socially deviant people to fall within the MHS, many of whom may not benefit from therapeutic interventions.[138]

E Summary

Mental health legislation fulfils a critical role in society by ensuring that mentally disordered people who pose a threat are placed in secure institutions where their conditions can be managed and treated.[139] However, legislative powers cannot work outside the human rights framework.[140] It seems possible for a civil commitment regime to avoid the label of arbitrary detention so long as it applies only to a small group of people; identifiable legislative criteria can be applied in a clear and consistent manner; and where room for discretion exists, it is statutorily fettered and opinions are formed only after thorough assessment by qualified psychiatrists of the objective condition of the person and the risk they present. Importantly, standards must be interpreted in a way that gives effect to the overall purpose of the legislation.[141]

However the holes that exist in the understanding of personality disorder may be too vast to warrant its incorporation under the Act. To allow it may validate decisions made in ignorance of legal standards. Alternatively, standards may be manipulated in an inappropriate fashion to accommodate DSPD. This may subvert the purpose of mental health legislation and result in human rights abuses.

Nevertheless, instances do arise where people with DSPD have been committed under mental health legislation. Therefore, it is desirable to review the legal standards established by different jurisdictions to determine whether the legal standards do designate with sufficient clarity a discrete group of people with DSPD who may be appropriately detained and treated in the MHS.

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[138] Paul Appelbaum "Dangerous Severe Personality Disorders: England's Experiment in Using Psychiatry for Public Protection" (2005) 56(4) Law and Psychiatry 397 at 398.

[139] Fennell "The New Law", above n 63, at [1.3].

[140] See Lance Gable and Lawrence Gostin "Human Rights of Persons with Mental Disabilities: The European Convention of Human Rights" in L Gostin, P Bartlett, P Fennell, J McHale and R MacKay (eds) *Principles of Mental Health Law and Policy* (Oxford University Press, New York, 2010) at [3.09-3.12].

[141] *Waitemata Health*, above n 6, at [64]-[65] and [81].

IV The Former English Mental Health Act 1983

In contrast to its predecessor - the Mental Health Act 1959[142] - the MHA 1983 introduced a system of legal standards to ensure that detention would only occur when absolutely necessary.[143] The incorporation of these standards signified distance from the days when people could be detained for having a 'moral imbecility' but no mental abnormality.[144]

This chapter will explore the extent to which the definition of 'mental disorder' and the imposition of the legal standards under the MHA 1983 helped to clarify the proper placement of patients with DSPD. Particular focus will be directed towards the treatability test and its interaction with the definition of mental disorder.

A Definition of Mental Disorder

Pursuant to s 1(2) of the MHA 1983, mental disorder was defined as "mental illness, arrested or incomplete development of the mind, psychopathic disorder and any other disorder or disability of the mind."[145]

The central element for the purpose of this paper is the term psychopathic disorder or PPD. This is further defined as:[146]

> A persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

[142] Mental Health Act 1959 (UK) 7 and 8 Eliz II c 72.

[143] Philip Fennell "Mental Health Law: History, Policy and Regulation" in L Gostin, P Bartlett, P Fennell, J McHale and R Mackay (eds) *Principles of Mental Health Law and Policy* (Oxford University Press, New York, 2010) at [1.104]–[1.105].

[144] For example under the Mental Deficiency Act 1913 (UK) 3 and 5 Geo V c 23, it was possible that even unmarried women could be subject to civil detention because their behaviour was seen as undesirable and anti-social for having children out of wedlock.

[145] MHA 1983 (UK), s 1(2).

[146] Ibid, s 1(2).

PPD is a controversial psychiatric condition. The absence of any explicit reference to it in the DSM-IV-TR compounds its uncertainty. This lack of psychiatric agreement on terminology, combined with criticisms that a classification of PPD is "not a meaningful focus for theory and research, nor can it facilitate clinical communication and prediction[s]",[147] attests to the fact that PPD - as presented in the MHA 1983 - was primarily a legal construction.[148] Strictly speaking a medical diagnosis of PPD was not required to come with the legal ambit of the sub-category.[149]

Interpreted through a legal lens, the phrase 'abnormally aggressive or seriously irresponsible conduct' would seem to encapsulate the type of behaviour exhibited by most violent offenders. No obvious measure existed to distinguish 'normal offenders', who engaged in such conduct, from mentally disordered offenders. Thus commitment becomes a 'lottery'.[150] On this basis the legislature could be criticised for attempting to medicalise morality,[151] by re-categorising criminal activity from being a social problem to being a medical problem.

Arguably this problem was resolved because the adverse conduct had to be linked to "a persistent disorder or disability of the mind." Yet little clarity can be gleaned from this qualifier. No guidance was proffered in the legislation as to what amounted to a "disorder or disability of the mind". The courts, lacking the necessary expertise, had to rely almost exclusively on ambiguous and inconclusive psychiatric evidence for determination.

Nevertheless, psychiatric expertise proved no better at demarcating the presence of such a mental disturbance.[152] This failure was associated with two key deficits in the construct of the definition. First, medical confusion surrounding the concept of PPD led to difficulties pinpointing the type of 'disorder or disability' which was indicative of it. Some have argued that there is sufficient agreement as to the common traits of PPD – distinct from its

[147] Blackburn, above n 23, at 511.

[148] See Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, above n 3, at [6.2.2].

[149] *B, R (on the application of) v Ashworth Hospital Authority* [2005] 2 WLR 695, [2005] UKHL 20 at [20].

[150] Hoggett, above n 45, at 35.

[151] The Butler Report, above n 50, at [5.20].

[152] Hoggett, above n 45, at 36.

manifestations.[153] Even if this were so, the absence of PPD from any authoritative diagnostic manual[154] meant there was no objective measure preventing the courts using it to commit people with recidivist criminal mentalities but who suffered no clinically recognised mental abnormality. The failure to specify what amounted to a legal psychopath caused increasing confusion for the courts and clinicians, and the legal standard fell far short of being a coherent definition against which detention could be easily justified.[155]

The second deficit in the construct of the disorder is that it is essentially circular: anti-social behaviour is evidence of a mental disorder, yet the mental disorder purports to explain why the anti-social behaviour occurs.[156] A circular definition of this sort is likely to lead to arbitrary detention.[157] This issue was aptly discussed in the case of *R v Mental Health Review Tribunal ex p. Clatworthy* where an applicant - committed under the PPD category - was seeking a review of the decision not to discharge him.[158] His responsible medical officer stated that he could not deduce any evidence of mental disorder apart from his sexual offending.[159] However s 1(3) of the Act excluded a finding of mental disorder by reason of sexual deviancy alone.[160] On the basis that no mental abnormality could be evidenced without reference to sexual deviancy, the court quashed the tribunal's decision not to discharge.[161]

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[153] See Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, above n 3, at [6.4.10]–[6.4.11]; Hare, above n 59, at 7: Hare, the leading authority on psychopathy in North America, argues that "... clinical descriptions of psychopathy make some sort of reference to his egocentricity, lack of empathy...lack of shame or guilt, inability to profit from experience and a lack of appropriate motivation."

[154] The major diagnostic manuals are the DSM-IV-TR, above n 18, and the International Classification of Diseases, Tenth Edition (ICD-10): World Health Organisation *International Classification of Diseases* (10th ed, World Health Organisation, Geneva, 2004).

[155] See Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, above n 3, at [6.2.2].

[156] The Butler Report, above n 50, at [5.20].

[157] Law Commission, above n 1, at [308].

[158] *R v Mental Health Review Tribunal Ex p. Clatworthy* [1985] 3 All ER 699 (QB).

[159] Ibid, at 702.

[160] MHA 1983 (UK), s 1(3).

[161] *Clatworthy*, above n 158, at 702. See also *Grey v UK* (34377/02) ECHR 23 January 2002 (ECtHR) where Dr Lomax could not find evidence of a mental disorder sufficient to base a finding of PPD despite acknowledging the presence of repugnant personality traits.

It is also important to note the stigma which attaches to PPD. To the lay person a 'psychopath' may be deemed inherently 'evil'.[162] To mental health practitioners PPD connotes that the patient is troublesome and untreatable.[163] These presumptions make patients categorised with PPD "a highly vulnerable group",[164] so the label may cause more harm than good.[165]

In sum, the category of PPD provided inadequate justification for detention under the MHS. The courts and tribunals primarily committed a patient based either on psychiatric evidence that the person was a 'psychopath',[166] or, alternatively, simply on evidence the person was a recidivist offender.[167] Yet neither of these in isolation amounts to adequate justification for commitment. The former because PPD was a legal construct and not to be determined on the basis of unsettled psychiatric theories; and the latter because it failed to delineate a group of people apart from the general prison population.

B Role of Additional Legal Standards

A possible solution to the problem of this ill-defined concept was to argue that the incorporation of further legal standards narrowed the class of people who should be subject to the MHA 1983. Four additional standards existed: the mental disorder had to be of a nature or degree making it appropriate to receive treatment via hospitalisation;[168] detention had to be necessary to ensure the health and safety of the patient or the public;[169] detention was the only

[162] John Gunn "What's in a Name: A Psychopath Smells just as Sweetly!" (1993) 3 Crim Behav Ment Health iii at iv.

[163] Hoggett, above n 45, at 36.

[164] Dawson "Forensic Psychiatry", above n 95, at 101.

[165] Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, above n 3, at [6.3.7].

[166] See *Grey v UK*, above n 161, and *Morley v UK* (16084/03) ECHR 28 March 2002 (ECtHR) where the European Court of Human Rights made a finding of PPD solely on the basis of psychiatric evidence with little discussion of the definition as a legal construct.

[167] See Peay, above n 104, at 110, for a discussion on the principal criteria for establishing a finding of PPD.

[168] MHA 1983 (UK), s 3(2)(a): this standard ensured that the mental disturbance was of sufficient type and severity to warrant commitment. 'Nature' referred to the character of the mental disorder – its aetiology, prognosis and any features individual to the patient. 'Degree' assessed the potency of the disorder to ensure that commitment was proportionate in light of the current symptoms of the individual's disorder.

[169] Ibid, s 3(2)(c).

means of providing treatment;[170] and in the case of PPD and mental impairment, treatment had to be "likely to alleviate or prevent a worsening of his condition" (the treatability test).[171]

The first three standards will not be discussed as the absence of litigation surrounding the phrases suggests they do not contribute significantly to the debate surrounding the commitment of people with DSPD.[172] The fourth standard has been a point of contention in many borderline commitment cases.

1 The 'treatability test'

(a) What is treatment?

Akin to personality disorders, PPDs are firmly engrained and inflexible dispositions. It follows that "the notion of 'cure' is not appropriate and total personality change is not a realistic aim."[173] Therefore 'treatment' must be interpreted in a wider sense.

Although not a case involving mental disorder, the judgment in *Airedale Hospital Trustees v Bland* provides some guidance concerning the notion of treatment.[174] In the case a distinction was made between medical 'treatment', which are procedures carried out using medical expertise, and medical 'care', such as feeding or bathing.[175] However, the distinction was blurred in the legal test of treatment, and, unanimously, the House of Lords held that the entire therapeutic regime endured by the patient constituted medical treatment.[176]

This conclusion is reflected in the broad definition of 'medical treatment' provided in the MHA 1983 which "includes nursing, and also includes care, habilitation and rehabilitation

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[170] Ibid, s 3(2)(c): this standard reflected the principle that a patient should be treated under the least restrictive means. It acknowledged the weight of the negative stigma and the potential resentment arising from inpatient orders. It was a clear signal to decision-makers that commitment was only to be used as a last resort.

[171] Ibid, s 3(2)(b).

[172] Peter Bartlett "Civil Confinement" in L Gostin, P Bartlett, P Fennell, J McHale and R Mackay (eds) *Principles of Mental Health Law and Policy* (Oxford University Press, New York, 2010) at [12.17].

[173] Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, above n 3, at [6.8.14].

[174] *Airedale Hospital Trustees v Bland* [1992] UKHL 5. The case concerned whether artificial feeding of a person in a terminally vegetative state amounted to treatment.

[175] Ibid, at 4.

[176] Ibid.

under medical supervision".[177] This sub-section was designed to reflect the burgeoning judicial view, adopted in cases such as *B v Croyden Health Authority* that although medical treatment must be strictly *for* the mental disorder, this can include interventions targeted at remedying the underlying cause of the disorder, as well as interventions targeted at managing the consequences of the disorder.[178] However, treatment for concurrent medical conditions unrelated to the mental disorder cannot be authorised under the MHA 1983.[179]

The scope of 'medical treatment' was widened even further by the Scottish courts in *Reid v Secretary of State* where Lord Hope accepted Dr White's submission that treatment could reasonably include "the structured setting of the State Hospital in a supervised environment."[180] This interpretation was applied in *DW v Rampton Hospital Authority* in evidence given by the patient's responsible medical officer who stated that the hospital setting kept the patient busy, helped him gain an interest in Occupational Therapy Programmes and promoted more socially acceptable behaviours - all at least helped prevent the worsening of his condition.[181] These conditions were enough for Elias J to substantiate the presence of 'medical treatment'.[182]

Controversially Lord Hope also remarked in *Reid* that 'medical treatment' is "sufficient to include all manner of treatment the purpose of which may extend from cure to containment."[183] Such a capacious conclusion came under heavy criticism from Allen J in *Ruddle v Secretary of State for Scotland*.[184] Allen J conceded that a structured hospital setting

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[177] MHA 1983 (UK), s 145, definition of "medical treatment," para (1).

[178] *B v Croyden Health Authority* [1995] 1 All ER (CA) at 687H -688A. See also *Reid v Secretary of State* [1999] 2 AC 512, [1999] 2 WLR 28, [1999] 1 All ER (HL) at 514F.

[179] *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819 (Fam). This case involved a chronic schizophrenic who had developed a gangrenous leg that doctors believed it was in his best interests to amputate. However, the patient refused and because he retained mental capacity the state lacked the necessary powers to intervene. No move was taken in the case to authorise the removal of the leg under the MHA 1983, even though C was subject to the Act. This indicates that 'medical treatment' in the Act was not intended to be read so widely as to include interventions for physical problems that arise concurrently with the mental disorder, unless the physical problem can be framed as a consequence of the mental disorder.

[180] *Reid,* above n 178, at 497C.

[181] *DW v Rampton Hospital Authority* [2001] EWHC 134 (Admin) at [27]-[31].

[182] Ibid, at [33]

[183] *Reid*, above n 178, at 495C.

[184] *Ruddle v the Secretary of State for Scotland* [1999] ScotSC 24 (Sheriff Ct).

was capable of amounting to treatment under s 125 of the Scottish Mental Health Act 1984,[185] in situations where the patient may benefit from it.[186] However, he distinguished between the aspects of detention which advantaged the condition of the patient, and those aspects which merely removed opportunities for the patient's condition to manifest itself in a harmful manner.[187] The former aspects would amount to treatment, but the latter were more appropriately regarded as aspects of containment.[188] Specific to the case, Allen J held that physically denying the patient access to drugs and alcohol did indeed benefit him. However no evidence could be gathered that hospitalisation was reducing his propensity towards such substances and so any advantage from detention could equally be achieved in prison.[189] Therefore no evidence of medical treatment existed.

Such reasoning supports the therapeutic ethos that civil commitment in forensic hospitals is for the primary purpose of addressing the medical needs of the patient, not public protection – although this may be a secondary consideration.[190]

Allen J's conclusions have received variable support within the United Kingdom courts. Some courts have determined that a hospital environment *is* treatment if it removes the stressors which may cause undesirable behaviour to arise.[191] This is more akin to the reasoning given by Lord Hope in *Reid.* Nevertheless, even where Allen J's distinction between containment and treatment has been accepted, *Ruddle* largely remains a rogue decision in its finding that no medical treatment at all could be extracted from the hospital setting.[192] This indicates that

[185] MHA 1983 (UK), s 125. It was noted by Lord Clyde in *Reid v Secretary of State*, above n 178, at 498B, that there is no material difference between the Scottish and English mental health statutes, and so the views of the English and Scottish courts are interchangeable.

[186] *Ruddle v the Secretary of State for Scotland*, above n 184, at [9.2].

[187] Ibid, at [10.3].

[188] Ibid.

[189] Ibid.

[190] Ceri Evans "Ethical Issues in Forensic Psychiatry" in W Brookbanks and S Simpson (eds) *Psychiatry and the Law* (Lexis Nexis, Wellington, 2007) at [2.6.1].

[191] *P v Mental Health Review Tribunal for the East Midlands and North East Regions* [2002] EWCA CIV 697 at [45].

[192] See *R v Secretary of State for Scotland* [1998] SLT 162 (Scot); *R v Mersey Mental Health Review Tribunal, ex p Dillon* (1987) TLR, 13 April 1987 (DC): these cases distinguished containment from treatment, but nevertheless concluded that the structured hospital environments went beyond containment and conferred benefit on the patient.

in principle the courts wish to avoid containment without therapeutic benefit, but practically the courts are determined to find a smidgen of therapeutic benefit to justify detention.

(b) The treatability test

When formulating the MHA 1983, concessions were made by the legislature reflecting the general medical pessimism that 'psychopaths' were not amenable to treatment.[193] The treatability test was implemented to distinguish people whose disorders were treatable and whose detention under the MHA 1983 was therefore appropriate, from those whose conditions were not treatable, signifying that detention under the MHA 1983 would be futile and unjustified.[194] In other words the treatability test was a means of preventing the indefinite detention of patients whose conditions were unlikely to improve.[195] This reflected the understanding that there existed two types of people with DSPD: those who were amenable to treatment and those who were not. Thus the test would appease civil libertarians seeking to avoid the use of the MHA as a back door for social control.

This reasoning for the test is convincing but its application was lamentable. Predominantly, this was because 'medical treatment' was defined so broadly that the threshold for satisfying the treatability test was correspondingly low. As Richard Jones opined "it is difficult to imagine the circumstances that would cause a patient to fail it."[196] This rendered the treatability test merely a superficial formality, as opposed to an effective safeguard.

Despite Jones' predictions, the *Ruddle* case did illustrate a scenario where the broad net of the treatability test failed to capture a patient's condition. This decision sparked panic from the both the English and Scottish Parliaments which feared *Ruddle* would set a precedent for the immediate release of many dangerous mentally disordered offenders. As an emergency measure, the Scottish Parliament enacted the Mental Health (Public Safety and Appeals)

[193] (19 January 1982) 426 GBPD HL 564.

[194] Ibid, 565.

[195] Neil Munro "Treatment in Hospitals" in L Gostin, P Bartlett, P Fennell, J McHale and R Mackay (eds) *Principles of Mental Health Law and Policy* (Oxford University Press, New York, 2010) at 486.

[196] Richard Jones *Mental Health Act Manual* (10th ed, Thompson/Sweet and Maxwell, London, 2006) at [1-051].

(Scotland) Act 1999 which prevented discharge of a patient if detention was "necessary for the protection of the public from serious harm".[197]

In England, however, it remained that proposed patients could actively sabotage treatment provided, thereby ensuring that the treatability test was not satisfied and continued detention could not be justified. As pointed out by Jones: "the treatability test [was] a perverse incentive for people to not comply with treatment."[198] This is especially relevant when considering DSPD patients whose difficult personality prompts unwillingness to change and resistance to treatment programmes. Following similar lines of reasoning, clinicians wishing to avoid the occupation of wards by disruptive and challenging PPD patients could easily make a case that they were not amenable to treatment.

As it stood, the treatability test proved incompetent at demarcating patients who should be detained from those who should not. The United Kingdom courts and tribunals displayed an outcome orientated approach where decisions were based on whether detention would be best for society, rather than whether detention of the patient conformed with the purpose of the MHA 1983. The panicked reaction to *Ruddle* is indicative of the fact that it was not designed to have any teeth.

C Summary

The MHA 1983 framework offered no cogent measures to ensure the group of patients subject to its provisions aligned with the therapeutic aim of the Act. Primarily, this was due to a circular definition of PPD from which it was legally and clinically impossible to extract a narrow class of people. Thus the definition was rendered meaningless, opening up excessive discretion for the courts and the potential for abuse of the MHS. The treatability test proved largely valueless as it was interpreted in a manner highly reflective of public safety policies, rather than concerns about therapeutic benefit.

In sum, it is plausible that many of the cases of PPD subject to the MHA 1983 involved arbitrary decisions, using imprecise criteria which were often given superficial consideration.

[197] Mental Health (Public Safety and Appeals)(Scotland) Act 1999: this was the first enactment to be passed by the Scottish Parliament after its creation on July 1 1999.

[198] Richard Jones *Mental Health Act Manual* (11th ed, Thompson/Sweet and Maxwell, London, 2008) at [1-051].

Such a flimsy framework is not satisfactory when civil liberties should only be removed in precise circumstances under clear conditions. This is especially so given the mental fragility and vulnerability of the people at stake.

V The Current English Mental Health Act 1983 as amended by the Mental Health Act 2007

At the turn of the millennium increasing political debate arose in England over the management of people with DSPD.[199] This resulted from public outcry over events such as the Michael Stone murders and cases such as *Ruddle.*[200] Numerous proposals for reform were advanced, including the introduction of a separate civil detention regime for people with DSPD.[201] However, it was decided by the United Kingdom Parliament that amendments to the MHA 1983 would be enough to resolve the dilemmas plaguing management of people with DSPD.[202]

This chapter examines the effectiveness of these amendments in achieving this aim. As with the previous chapter, the central focus of discussion will be on the treatability test and the definition of mental disorder, which were both substantially altered through the amendments.[203]

A Definition of Mental Disorder

Under the MHA 2007 mental disorder is defined as 'any disorder or disability of the mind'.[204] The intended purpose of this broad definition was to increase clinical discretion when interpreting the meaning of mental disorder.[205] Consequently, it would be simpler for clinicians to use, and it would avoid having to place disorders within one of the four

[199] Fennell "The New Law", above n 63, at [1.16]–[1.17].

[200] Ibid, at [1.17].

[201] See Department of Health and Home Office, above n 2; Dangerous People with Severe Personality Disorder Bill 1999.

[202] (10 January 2007) 688 GBPD HL 299-301.

[203] Philip Fennell "The Statutory Definition of Mental Disorder" in L Gostin, P Bartlett, P Fennell, J McHale and R MacKay (eds) *Principles of Mental Health Law and Policy* (Oxford University Press, New York, 2010) at [2.01].

[204] MHA 1983, s 1(2) as amended by the MHA 2007, s 1(2).

[205] Department of Health and Home Office *Reforming the Mental Health Act Part 1: The New Legal Framework* (CM 5016-I Department of Health and Home Office 2000) at [3.3].

restrictive categories listed in the MHA 1983.[206] In particular removal of the term PPD was considered desirable because, as the Butler Committee had expressed previously it was "no longer a useful or meaningful concept".[207]

What is apparent from this new approach to 'mental disorder' is that it relies extensively on clinical evidence for meaning. This is affirmed in the Code of Practice for the MHA 2007 (Code of Practice) which states that determination of a mental disorder will be made "in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability."[208] Support for this approach can be seen in *Winterwerp v Netherlands* where the European Court of Human Rights (ECtHR) held it was impossible to provide a definitive interpretation because a flexible legal definition was required to accommodate for the rapidly evolving framework of modern psychiatry.[209] Increased psychiatric input should also emphasise the treatability and clinical needs of the patient to ensure that the MHA 2007 is used for the purposes of providing treatment, and not solely for security reasons.

However, a definition where the meaning is almost exclusively extracted through expert psychiatric opinion harbours the potential for abuse for a number of reasons.[210] First, it may be used by psychiatrists to test their own medical theories and certify the presence of a mental disorder where one would traditionally not have existed.[211] Second, in relation to DSPD the cause-effect relationship between a mental dysfunction and the aggressive or irresponsible conduct no longer needs to be established as it did under the former legislation - even though on many occasions this was only done superficially.[212] This may further blur the line between mental disorder and social deviancy as well as broaden the scope of the Act considerably, as it may allow for a diagnosis of DSPD based on the presence of anti-social behaviour alone.[213] Third, reviewability is also limited, with patients facing an uphill battle disputing the

[206] (15 November 2006) 687 GBPD HL 657.

[207] The Butler Report, above n 50, at [5.23].

[208] Department of Health *Code of Practice: Mental Health Act 1983* (Department of Health 2008) at [3.2].

[209] *Winterwerp v Netherlands* (1979) 2 EHRR 387, [1979] ECHR 4 (ECtHR) at 37. See also *Anderson and Ors v The Scottish Ministers and Anor* [2000] Scot CS336 (16 June 2002) (IH(1 Div)) at [31].

[210] Sylvia Bell "Defining Mental Disorder" in W Brookbanks and S Simpson (eds) *Psychiatry and the Law* (LexisNexis, Wellington, 2007) at 56.

[211] Jones, "Manual 11th ed", above n 198, at [1-021].

[212] Fennell "The Statutory Definition", above n 203, at [2.82].

[213] Ibid, at [2.82].

presence of a mental disorder against the weight of psychiatric expertise.[214] Hence patient rights may be prejudiced where determination of the legal standard is delegated to one profession.[215]

Alternatively, heavy reliance on psychiatric discretion may suggest Parliament intended the Act to apply only to clinically recognisable disorders, such as schizophrenia or depression. However, if this were so then it would be contrary to the policies driving the amendments which – as discussed above – were to increase protection for the public from the criminal activities of the mentally disordered.[216] The very recent case of *R (on the application of SP) v Secretary of State for Justice,* where the High Court authorised a transfer order of a patient diagnosed with ASPD, indicates that such a narrow reading has not been adopted.[217]

It is apparent then that the undefined approach to the term mental disorder results in a large amount of discretion being conferred on psychiatrists.[218] As evidenced by the Canadian authority discussed in Chapter Three, heavy reliance on psychiatric discretion without statutory limitations opens the door to arbitrary detention. However, like the previous MHA 1983, the legislation limits clinical discretion through the presence of additional standards, which will be discussed further below.

B The Role of Additional Standards

The four legal standards found in the MHA 1983 have been retained in the MHA 2007, with the treatability test being the only one to have been substantially altered. Accordingly, it is again the only standard to require further analysis.

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[214] Philip Bean *Mental Disorder and Community Safety* (Palgrave, New York, 2001) at 10.

[215] John Dawson "Psychopathology and Civil Commitment Criteria" (1996) 4 Med L Rev 68. But compare the findings of Jill Peay who argues that even under the MHA 1983 it was the opinion of psychiatrists which was the most influential within the decision-making process and generally the view of the responsible medical officer was accepted by courts and tribunals (Peay, above n 104, at 137). If Peay is correct then it is unlikely that decisions will substantially be altered through the use of an undefined definition of mental disorder, as the weight given to psychiatric opinion is unlikely to substantially change.

[216] Fennell "The Statutory Definition", above n 203, at [2.05].

[217] *R (on the application of SP) v Secretary of State for Justice* (2010) WLR 442412, [2010] EWHC 1124 (Admin).

[218] Fennell "The Statutory Definition", above n 203, at [2.17]

1 The treatability test

(a) What is treatment?

"Medical treatment" as defined in s 145(1) of the MHA 2007 "includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care."[219] It is also stated in s 145(4) that the purpose of medical treatment "is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations."[220] The combination of these two subsections shows the United Kingdom Parliament supported the wide interpretation of medical treatment adopted in *Croyden Health* and *Reid.* Therefore, s 145(4) was not designed to bring about interpretative change; rather it was designed to reflect the case law developments.

Nevertheless, uncertainty exists as to what could be considered a 'symptom or manifestation' of a mental disorder. It was argued by Mr Bryant, the Minister of the United Kingdom Parliament who initially proposed the s 145(4) amendment, that it would only encapsulate manifestations that were directly related to the mental disorder.[221]

However, case law established prior to the 2007 amendments indicates that an indirect consequence of the disorder might also be considered a symptom or manifestation. In *Tameside and Glossop Acute Services NHS Trust v CH (a patient)* the Court held a Caesarean section amounted to medical treatment under the MHA 1983, because avoiding the death of the patient's child would help to treat her mental state.[222] The MHA 1983 was similarly used in *Croyden Health* to authorise naso-gastric feeding of a patient whose PPD had manifested in self harm by refusing to eat, even though this would not directly lessen the psychopathic tendencies.[223]

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[219] MHA 1983, s 145(1) as amended by the MHA 2007, s 7(2) definition of 'medical treatment'.

[220] MHA 1983, s 145(4) as amended by the MHA 2007, s 7(3).

[221] Jones "Manual 11th ed", above n 198, at [1-1306].

[222] *Tameside and Glossop Acute Services NHS Trust v CH (a patient)* [1996] 1 FLR 762, 31 BMLR 93, [1996] FAM Law 535 (Fam) at [21].

[223] *Croyden Health*, above n 178.

Nevertheless, it may be inappropriate to extend the scope of treatment this far as it substantially undermines the wishes of the patient and their right to self determination. Moreover, this would further stretch the scope of the treatability test so it may be satisfied where a person is amenable to interventions for physical disabilities, yet it is still believed their mental state cannot be altered. This would substantially compromise the purpose of the Act which is not designed to manage psychical ailments, as well as widen the class of people subject to the Act. Where a situation is fatal or a severe reduction in the patient's health is likely the doctrine of necessity may be more appropriately drawn upon.[224] Nonetheless, because *Tameside* and *Croyden* allowed treatment for indirect consequences of the mental disorder under the MHA 1983 it is likely that this trend will continue under the MHA 2007.

(b) The treatability test

(i) 'Available'

The current treatability test stipulates "appropriate medical treatment is available for him."[225] A patient's refusal to co-operate will not defeat this test because of the requirement that treatment need only be 'available'.[226] Availability necessitates that the intervention be possible in the present, and not just theoretical or implementable after a lengthy delay.[227] In addition a clinician must be ready and willing to oversee the course of treatment.[228]

[224] The doctrine of necessity is a common law principle where a medical professional may treat a patient who is lacking competence, if it is in their best interests and it is necessary to save their life, or improve or prevent the worsening of their mental or physical health. See *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649 (Fam) at 664.

[225] MHA 1983 s 3(2)(d), as amended by MHA 2007, s 4(2).

[226] Jones "Manual 11th ed", above n 198, at [1-052].

[227] Department of Health, above n 208, at [6.13].

[228] This qualification arises from the case of *R v Ealing District Health Authority, ex p Fox* [1993] WLR 373, [1993] 3 All ER 170 (HC) where the English High Court determined that courts, tribunals and district health authorities do not have the power to force a clinician to treat a patient in a way that is contrary to their professional and ethical judgement.

(ii) 'Appropriate medical treatment'

Pursuant to s 3(4) "appropriate medical treatment" is a reference to "to medical treatment which is appropriate in his case taking into account the nature and degree of mental disorder and all other circumstances of his case."[229]

The requirement that the "circumstances of his case" must be accounted for indicates that to some extent consideration of the individual circumstances of the patient is required. Following this individualistic approach Jones has argued that an intervention will only be 'appropriate' when it can be seen to have some therapeutic benefit for the patient.[230] Similarly, Peter Bartlett argues that if it is the clinician's view that insufficient benefits exist to justify treatment, then it is unlikely that the treatment will be appropriate.[231]

In contrast, the Code of Practice affirms that where clinicians propose a treatment they only need a credible belief that it will have therapeutic benefit.[232] This is antithetical to both Bartlett and Jones' assessment, and the requirement under the former test that evidence had to be presented that the treatment was likely to have therapeutic benefit.[233] This subtle difference is indicated by the shift in the wording from "treatment is *likely* to alleviate ..."[234] to "treatment the *purpose* of which is to alleviate...."[235] In short it does not need to be known in advance whether the treatment will work.[236] Therefore, while many clinicians may establish appropriateness in the manner advanced by Bartlett and Jones, there is no indication that it must be done in this way. In fact the legislature seems to want to discourage analysis of the potential for therapeutic benefit in individual cases, and instead focus on whether the proposed intervention is designed and intended to have a therapeutic benefit. The advantage of this approach is that it still manages to separate therapeutic interventions from interventions

[229] MHA 1983 s 3(4), as amended by MHA 2007, s 4(3).

[230] Jones "Manual 11th ed", above n 198, at [1-050].

[231] Bartlett, above n 172, at [2.98]. See also the view established in *Ruddle v the Secretary of State for Scotland*, above n 184, at [9.3] where the Court stated "[p]sychiatrists would not generally consider it appropriate to detain a person with uncomplicated ASPD if no specific medical treatment would be likely to be effective".

[232] Bartlett, ibid, at [12.37].

[233] Jones "Manual 11th ed", above n 198, at [1-050].

[234] MHA 1983, s 3(2)(b) (my emphasis added).

[235] MHA 1983, s 145(4) as amended by the MHA 2007, s 7(3) (my emphasis added).

[236] Department of Health, above n 208, at [6.4].

purely contrived to ensure containment, yet it avoids debates about efficacy of treatment in individual cases, about which it may not be possible to draw definite conclusions.[237]

Nevertheless, a further consequence of this shift is that the current treatability test enjoys a lower threshold than its predecessor. If no positive change is affected in the person then the test is not defeated because the intervention was only proposed with the intention that it has therapeutic benefit.[238] An increasing proportion of psychiatric wards may be filled with patients for whom nothing can be done[239] - contrary to the therapeutic ethos of psychiatrists and at the expense of the limited resources of the MHS.[240] Therefore, it is unlikely to be effective at delineating the appropriate class of people who should be subject to the Act, nor adequate at upholding the therapeutic purpose of the Act.

(iii) European human rights law and its effect on the treatability test

The absence of treatment will not necessarily lead to arbitrary detention in accordance with wider European human rights law. In *Winterwerp v Netherlands*[241] the applicant argued he was being detained contrary to the European Convention on Human Rights (the Convention).[242] He contended that Art 5(1)(e) of the Convention, which authorises the detention of "persons of unsound mind", was breached because the applicant was not currently receiving appropriate treatment.[243] The ECtHR did not support this proposition, as it could not be established that Art 5(1)(e) included a right to treatment.[244] The more recent case of *Hutchinson Reid v United Kingdom*, bought to the ECtHR from Scotland, not only confirmed *Winterwerp* but in addition stated that detention of "persons of unsound mind" is

[237] Fennell "The Statutory Definition", above n 203, at [2.100].

[238] Fennell "The New Law", above n 63, at [2.18].

[239] Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, above n 3, at [1.38.2].

[240] Evans, above n 190, at 28.

[241] *Winterwerp v Netherland*, above n 209.

[242] European Convention on Human Rights (formerly European Convention for the Protection of Human Rights and Fundamental Freedoms) (opened for signature 4 November 1950, entered into force 3 September 1953): the Convention allows for cases to be brought before the ECtHR where potentially a human rights abuse has occurred in breach of one or more of the articles of the Convention. The decision of the ECtHR is binding on member states and where a violation has occurred then states are mandatorily obliged to amend their laws to remedy the breach.

[243] *Winterwerp v Netherland*, above n 209, at [51].

[244] Ibid.

justifiable solely on the basis containment is necessary to remove the threat the individual poses to the public.[245] All that is necessary is a finding that the person has a mental disorder and poses such a risk.[246]

Nevertheless, the United Kingdom Parliament did not intend English law to reflect such a draconian position.[247] This is evidenced by the fact that although Parliament had indicated that the treatability test might be removed through the proposed amendments in the MHA 2007, this did not occur.[248] Rather it sought to ensure commitment is used as a means of helping patients within a human rights context, as well as protecting the public.

(iv) Overall effect of the treatability test

Overall, however, the decision to retain the treatability test along with the additional amendments appears to be a move to appease civil libertarians rather than a genuine attempt to enhance the therapeutic purposes of the legislation. This is because the preservation of a broad definition of treatment suggests it would be almost impossible for treatment not to be 'available' so long as there is room in a psychiatric facility. This view was reflected in *R (on the application of SP)*, where Burnett J concluded that:[249]

> Rampton Hospital was prepared to offer a place for assessment and treatment and also confirmed the availability of a bed. It does not seem to me to be necessary to require the doctor to set out in greater detail the precise nature of the treatment which is available to be given at Rampton.

The only grounds for denying availability would be if psychiatrists refused commitment, but it is likely that some clinician can be found to take in the 'hard cases' such as people with DSPD. The precise meaning of 'appropriate treatment' may remain somewhat uncertain, but

[245] *Hutchinson Reid v United Kingdom* [2003] 37 EHRR 211, [2003] ECHR 94 (ECtHR) at [51]. This case reflects the policies underlying the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003 that discharge may be prevented solely on the basis the person is still dangerous, even if it cannot be shown they are amenable to treatment.

[246] Ibid.

[247] Jones "Manual 10th ed", above n 196, at [1-050].

[248] Appelbaum, above n 138, at 397-398.

[249] *R (on the application of SP) v Secretary of State for Justice* (2010) WL 442412, [2010] EWHC 1124 (Admin) at 26.

Parliament's removal of the requirement for evidence of probable therapeutic benefit in the individualised case, may allow for ineffective or substandard courses of treatment to be authorised.

C Summary

By introducing the 2007 amendments, the United Kingdom Parliament has created a contradictory piece of legislation. On the one hand it reflects a policy strongly in favour of public protection. Heightened public safety may result from an undefined definition of mental disorder that is capable of including a broad range of disorders, and a treatability test which requires only that treatment could benefit the patient, not that it will do so.[250] Combined, these features will allow a greater number of 'hard cases' to be committed under the MHA 2007 than under the MHA 1983.[251]

On the other hand the legislature seems to want to ensure that commitment is intended to provide therapeutic benefit and is not exclusively for the purpose of public protection, through retention of a treatability test and the other three legal standards.[252]

However, the United Kingdom Parliament has failed to achieve a proper balance between these two purposes. Ultimately, the policy of public protection has prevailed because the legal standards can be interpreted so broadly as to be almost worthless. The definition of mental disorder allows for an excessive amount of clinical discretion, without clear terms for review by courts or tribunals. The intention that the treatability test will protect civil liberties by ensuring placement in hospitals is for a therapeutic purpose has not been affected in case law. The courts have established such a low threshold that anyone could be accurately described as treatable, thus providing justification for their detention under the MHS. This raises the potential that individuals will be detained arbitrarily, exclusively for the purposes of security rather than therapeutic benefit.[253] In sum, the MHA 2007 is ineffective at protecting patients from arbitrary detention, as it cannot be said commitment rests upon any clear substantive standards, nor a clearly defined purpose.

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[250] Fennell "The New Law", above n 63, at [3.54].

[251] Ibid, at [2.20].

[252] *Savage v South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681 (HL) at 694-685.

[253] *Thwaites*, above n 14, at [41].

VI The Current New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992

The implementation of the MH(CAT)A in 1992 marked a shift from paternalistic legislation where powers were enforced for the patient's 'own good' to a regime which more strongly recognised the rights of patients.[254] This resulted partly from the civil libertarian movement of the late 1980's and early 1990's that culminated in the enactment of the NZBORA and Human Rights Act 1993. By weaving in the theme of human rights, Parliament has made decisions concerning civil commitment less medically orientated and more legalistic. The extent to which this reduces the 'lottery effect' and prevents arbitrary detention is explored in the discussion below.

In this chapter the definition of mental disorder in the New Zealand Act will be critiqued, with particular focus on the complexities surrounding the terms 'disorder of volition' and 'disorder of cognition'. Next the concept of an implicit treatability test will be examined, targeting the extent to which it is applied by New Zealand courts. The chapter will conclude with a discussion linking the primary features of the MH(CAT)A with the interpretative recommendations made by Nigel Dunlop, principal convenor of New Zealand's MHRT.

A Definition of Mental Disorder

'Mental disorder' is defined in s 2 of the MH(CAT)A as:[255]

> An abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it -
>
> (a) Poses a serious danger to the health or safety of that person or of others; or
> (b) Seriously diminishes the capacity of that person to take care of himself or herself.

[254] Warren Brookbanks "Mental Health Law" in PDG Skegg and R Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) 357 at 358.

[255] MH(CAT)A, s 2(1), definition of 'mental disorder'.

The definition is constructed in two distinct parts. The first limb requires the individual to have an 'abnormal state of mind' characterised by delusions, or by a disorder of mood or perception or volition or cognition – collectively described by Elias CJ in *Waitemata Health* as the 'phenomenological consequences' of mental disorder.[256] This model of listing disorders of mental function has also been described as the 'psychopathological' approach.[257] The second limb, beginning after the word cognition, describes the consequences of an 'abnormal state of mind' – incapacity for self-care and serious threats of harm.

The key feature of the psychopathological format is that it aims to avoid debates over diagnostic terminology by determining the presence of the major signs and symptoms of mental disturbance, rather than requiring the diagnosis of a specific illness.[258] This is desirable as a means of facilitating mutual comprehension between psychiatrists, the judiciary and lay-people, as even the former groups are capable of recognising certain psychiatric signs indicating severe deviance from the norm.[259]

Yet psychiatric input is still critically necessary for accurate identification of the phenomenological consequences.[260] Psychiatric evidence is drawn upon to identify individuals with mental dysfunction, as opposed to those who simply display an extreme of usual behaviour, in order to reduce the likelihood that commitment is based purely on socially deviant behaviour.[261]

However, Carney and Beumont argue that it is a fallacy to suggest that the psychopathological approach will create more precision in the law, as opposed to a diagnostic model.[262] They contend that assessment of psychopathology merely shifts the difficulty in establishing diagnostic certainties to difficulty in establishing phenomenological certainties.[263] In addition some clinicians argue that increased reliance on legalism hinders prompt treatment, patient management, and undermines

[256] *Waitemata Health*, above n 6, at [71].

[257] Dawson "Psychopathology", above n 215, at 63. The psychopathological approach has also been adopted by two Australian states: New South Wales in the Mental Health Act 2007 (NSW) and Victoria in the Mental Health Act 1986 (Vic).

[258] Dawson, ibid.

[259] Ibid, at 75.

[260] *Waitemata Health,* above n 6, at [68].

[261] Dawson "Psychopathology", above n 215, at 79.

[262] Pierre Beumont and Terry Carney "Can psychiatric terminology be translated into legal regulation? The Anorexia nervosa example" (2004) 38(10) Aust and New Zeal J Psychiatr 819 at 821 - 822.

[263] Ibid.

professional discretion and judgement.[264] Nevertheless, this intrusion on the smooth operation of psychiatry is justified to ensure patient rights when personal liberties are removed in such a substantial way. Further, patient rights can only be assured where an objective threshold sets parameters around the discretion of clinicians.[265] Arguably this threshold is well established by a psychopathological approach as it provides the judiciary with a basis on which to further define deficits in mental function by a process of interpretation. Thus specifying more accurately the class of people appropriately covered by the Act.

It is possible that some people with DSPD fall within the definition of mental disorder.[266] However the inclusion is not automatic, rather it is dependent upon a finding of at least one of the 'phenomenological consequences'.[267] 'Volition' and 'cognition' are the two terms frequently applied to the commitment of people with DSPD, yet it is these terms which have caused the most interpretive debate. Both will be discussed below, along with other features of the definition.

1 The first limb

(a) 'Abnormal state of mind'

The phrase 'abnormal state of mind' does not contribute extensively to the determination of whether a mental disorder is present.[268] Nevertheless, in relation to DSPD, two crucial considerations require acknowledgment. First, the phrase reiterates that a marked deviance from the norm must be evident – not just an extreme of usual conduct.[269] Second, because the deficit is the individual's lifelong way of being, and so is normal for them, Parliament might have envisioned that DSPD falls outside the ambit of the Act.[270] However, case law has asserted that the notion of abnormality here is to be determined objectively: that is, by reference to what is normal in society

[264] Ibid, at 825.

[265] Carney, Tait and Beaupert, above n 76, at 338-339.

[266] Bell and Brookbanks, above n 43, at [3.2.1].

[267] Brookbanks, above n 254, at 365.

[268] Stephen McCarthy and Sandy Simpson "The Statutory Definition of Mental Disorder – Running a Case under the Mental Health Act 1992 and Related Legislation (paper presented to the New Zealand Law Society, Auckland, May-June 1996) at 3.

[269] Ibid.

[270] Ibid.

as a whole, not what is normal for the individual.[271] Moreover, a blanket exclusion of DSPD cannot be assumed because if this had been Parliament's intention it could have explicitly said this, as with intellectual disabilities.[272]

(b) 'Continuous or intermittent nature'

Determining whether a disorder is of a continuous or intermittent nature is a contentious feature of the Act.[273] A detailed analysis of this debate goes beyond the scope of this paper but this phrase acknowledges the fluctuating course a mental disorder may take.[274] Therefore, if a person appears well, but is likely to relapse if discharged, the commitment order may be extended until the potential for relapse is reduced.[275]

(c) 'Disorder of volition'

'Disorder of volition' is not a concept commonly used or understood by mental health professionals.[276] It follows that interpretation of this phrase cannot rely too heavily on psychiatric evidence.[277] Consequently, courts and tribunals have resorted to lay definitions, citing volition as "the exercise of the will or the power of willing".[278] The use of lay definitions has been criticised for ignoring the crucial role psychiatrists play in demarcating those who are mentally disordered

[271] *Re PT* MHRT NRT 601/98, 1 July 1998, at 6. For a discussion on the debate between the subjective and objective use of 'abnormal state of mind' see Bell and Brookbanks, above n 43, at [2.3].

[272] MH(CAT)A, s 4(e).

[273] See *Re RCH* [2002] NZFLR 413 (MHRT-NRT) at [105] for an outline of the contentious questions which the courts must deal with concerning the phrase. For general discussion see Bell and Brookbanks, above n 43, at [2.4].

[274] McCarthy and Simpson, above n 268, at 4.

[275] Ibid.

[276] Christopher Ruthe "Volition-the rotten apple" (1997) 2 BFLJ 129 at 131; *Re AC* MHRT SRT 52/94, 9 February 1995 at 10.

[277] *Re JC,* above n 11, at 765: evidence from reputable psychiatrist Dr Gunn showed that 'volition' was a difficult concept which could not be determined on psychiatric evidence alone.

[278] Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (2000) at [1.2.7].

from those who are socially unusual.[279] However, because psychiatric or legal definitions are not readily available for this term, a dictionary definition may be desirable if it can be applied consistently and clearly.

Nonetheless, a lay definition must accord with the purpose of the Act.[280] The law assumes that an individual has the right to free choice, and is responsible for the consequences.[281] So presumably Parliament incorporated disorder of volition to apply to situations where an individual is no longer in control of free choice,[282] such as when a patient displays catatonic excitement or extreme withdrawal.[283]

However, debate exists as to whether a deficiency in impulse control equates with an absence of free-choice. Disorder of volition might be widened to include 'impulses not resisted', even if it should be confined to 'irresistible impulses'.[284] The danger of including impulses not resisted is that most criminal activity can be explained by an absence of self control and impulsive behaviour. Therefore, widening the term in this way may blur the distinction between socially deviant and mentally disordered behaviour.

The courts and MHRTs have allowed for the inclusion of deficiencies in impulse control but have refused to debate the subtleties of it.[285] Rather, alongside psychiatric observations of the patient's behaviour, they have considered contextual factors such as treatability of the condition, the compulsory nature of treatment, the potential for loss of liberty, and the understandings of mental health professionals, to determine whether a condition could be legally framed as a disorder of volition.[286] The combination of these contextual factors, considered alongside the overall legislative

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[279] See Brenda Hoggett's discussion on the case of *W v L* [1974] QB 711 where the English Court of Appeal applied a lay definition of the meaning of 'mental illness.' In her view the lay "man-must-be mad" test paid insufficient regard to the views of the psychiatric profession and did not adequately justify why some people should be under the MHS but others should not: Hoggett, above n 45, at 32-33.

[280] *Re AC,* above n 276, at 13.

[281] Ministry of Health*,* above n 278, at [1.2.7].

[282] Ibid.

[283] Ibid.

[284] Examples of 'impulses not resisted' include conditions such as kleptomania, pyromania, pathological gambling and paedophilia. These conditions are usually excluded from the MH(CAT)A as they are deemed to be products of free-will: See Brookbanks, above n 254, at 367.

[285] *Re PT,* above n 271, at 6.

[286] *Re AC*, above n 276 at 13-14.

purpose, will help to formulate an interpretation consistent with the intentions of Parliament.[287] Such reasoning emphasises that decisions concerning the presence of mental disorder is "as much a legal/social matter as a medical one".[288]

A further contextual factor oft mentioned is the need for public protection. A wide interpretation of disorder of volition is frequently adopted where the second limb criteria have been strongly satisfied and there is an established need to protect the public from the individual. For example, in both *Unknown 56/93*[289] and *Re SJE*[290] a disorder of volition arose from the pyromaniac tendencies of the individuals. Public safety therefore was considered relevant to determining the presence of a mental disorder. However, it must be ensured that antisocial behaviour stems from mental abnormality, such as reduced impulse control and not simply a lapse in moral judgment.[291] Psychiatric evidence will be critical in making this difficult distinction.

The advantage of the term disorder of volition is that it has the potential to act as a categorical test for the commitment of people with DSPD.[292] It signals that people who offend due to deficits in impulse control should not necessarily be deprived of the opportunity for treatment.[293] This is supported in numerous instances where people with personality disorder have been committed under the rubric of the disorder of volition.[294]

In short the approach that the MHRT has taken to the interpretation of disorder of volition reflects Parliament's intent that the scope of 'mental disorder' may extend somewhat beyond the usual clinical understanding of 'mental illness'. This is evident in the use of lay approaches to interpretation and the use of contextual factors to identify whether a particular volitional deficit should come within the ambit of the Act.

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[287] *Re AC*, above n 276, at 9.

[288] *Re JC*, above n 11, at 765.

[289] *[Unknown]* MHRT SRT 56/93, 24 November 1993.

[290] *Re SJE*, above n 11.

[291] See *Re RCH* (2010), above n 125, at [42] where the MHRT stated in summary of a previous Tribunal's decision concerning RCH that "disorders of volition are concerned with irresistible impulses involving loss of free will. By contrast, the Tribunal said, the Applicant's behaviour is characterised by careful, considered and planned actions, albeit often antisocial ones."

[292] Dawson "Psychopathology", above n 215, at 81

[293] Ruthe, above n 276, at 129.

[294] See *Re J* MHRT SRT 28/93, (exact date unknown); *Re JC*, above n 11; *Re RR*, above n 11; *Re SJE*, above n 11.

(d) 'Disorder of cognition'

As with volition, a wider lay definition is sometimes utilised by courts and tribunals to interpret disorder of cognition.[295] In *Re RCH,* the MHRT applied the Concise Oxford Dictionary definition, stating cognition is "the mental action or process of acquiring knowledge through thought, experience and the senses; a perception, sensation or intuition resulting from this".[296] Interestingly, the MHRT noted that the application of that definition did not preclude the use of alternative definitions in other cases.[297] Such a statement is surprising given the requirement for the law to be consistently applied according to predetermined standards with no discrepancy between like cases. To change the definition from case to case may be arbitrary.

Nevertheless, some guidance has been provided which serves to limit the discretionary use of the term. Cognition in lay terms can be defined as a noun (a thought) or a verb (a process of thinking).[298] However, the Ministry of Health has stipulated that the term only includes cognitive deficits in thought processes.[299] If thought content alone was included then potentially people could be committed for holding beliefs or opinions contrary to societal norms.[300] This could be antithetical to rights guaranteed in the NZBORA.[301]

This reasoning was affirmed by Simpson and McCarthy, who assert that disorder of cognition should not be extended to include abnormal thought content but should incorporate the clinical idea

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[295] *Re RCH* (2002), above n 273, at [80] and [108].

[296] Ibid, at [80] and [108]: by adopting this lay definition the MHRT determined that RCH's impaired ability to construct knowledge through thought and experience constituted a 'disorder of cognition'.

[297] Ibid.

[298] Bell and Brookbanks, above n 43, at [2.9.1].

[299] Ministry of Health, above n 278, at [1.2.7].

[300] But see *JAH v the Medical Superintendent of Rozelle Hospital* (1986) NSWSC 7322 (Aus) where it was held by the New South Wales Supreme Court that a defining characteristic of anorexia nervosa was 'a fear of being fat and an overvalued idea about the desirability of being thin.' Although this case was decided under mental health legislation based on a diagnostic model, it shows that the New South Wales Supreme Court was willing to find that the 'thought content' itself was an aspect of the mental disorder. Reference to a deficient 'thought process' was not required. This view is also somewhat supported by the obiter statement made by Elias CJ in *Waitemata Health*, above n 6, at [72]: "The suggestion that the definition cannot have been intended to apply to a 'view of the world' arising from such cause and of such severity is not immediately attractive."

[301] The rights contained in the NZBORA which could be afflicted by extending the disorder of cognition to incorporate 'thoughts' include freedom of thought, conscience and religion (s13), freedom of expression (s14), freedom from discrimination (s19) and freedom for minorities (s20).

of 'formal thought disorder', referring to the "disorganised and increasingly illogical thought process".[302] However, following the lead of the Court of Appeal,[303] the MHRT have not felt constrained to this narrow interpretation.[304]

Rather a wider interpretation has been favoured extending to evidence of 'cognitive distortions', such as obsessive ruminations. This is seen in the case of *Re PDG* where one expert clinical witness[305] argued that a convicted sex offender should be distinguished from other offenders and made subject to the MH(CAT)A because he displayed an inability to cognitively engage with others that prevented his ability to overcome his destructive thought pattern.[306] Similarly in the most recent decision involving RCH, the MHRT concluded:[307]

> ... his thinking about women and his relationships and sexual conduct towards them remains so distorted as to be regarded as a disorder of cognition in terms of the mental disorder definition.

However, the uninhibited and deviant sexual thoughts of paedophiles or rapists generally do not constitute a disorder of cognition.[308] This is because it is difficult to identify where there exists a disturbed thought process and not simply a collection of deviant thoughts. As noted by Simpson and McCarthy, unfettered discretion by psychiatrists and an unrestrained interpretive analysis from the courts and tribunals may bring offenders into the MHS that would more appropriately fit the CJS.[309] It follows that disorder of cognition is best narrowed to thought processes and 'cognitive distortions' will only be considered when they can be assertively linked with a disordered thought pattern.

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[302] McCarthy and Simpson, above n 268, at 8-9.

[303] *Waitemata Health*, above n 6, at [72].

[304] *Re RCH* (2002), above n 273, at [108].

[305] It is interesting to note that the expert witness was Dr Simpson one of the commentators that advocated a narrow definition excluding cognitive distortions from the definition of disorder of cognition. In contrast, in this instance he seems to be taking a very wide approach to the definition. This indicates the difficulty in grounding a clear definition for cognition and how easy it is to manipulate the term from case by case.

[306] *Re PDG* MHRT NRT 465/97, 22 August 1997 at 4.

[307] *Re RCH* (2010), above n 125, at [110].

[308] McCarthy and Simpson, above n 268, at 8-9.

[309] Ibid, at 9.

2 *The Second Limb*

The second limb of the definition will not be a critical focus of this paper because the threats posed to others by people with DSPD is not in dispute. However a brief overview is necessary to gain a holistic understanding of the definition.

The purpose of the second limb is to ensure there is a link between the presence of a mental disorder and a legitimate personal or public interest in ordering commitment.[310] Use of the terms 'health' and 'safety' have been interpreted broadly to include psychological and physical components.[311] 'Serious danger' occurs when there is an imminent risk that will have significant consequences.[312]

Most patients are committed due to danger to themselves or a diminished capacity for care.[313] Although DSPD patients frequently pose a threat to others, they may also represent a threat to themselves and maintain inadequate levels of self–care. Serious danger to the patient's own health and safety will commonly include situations where the patient displays suicidal tendencies, self-harming behaviours or refuses to accept treatment.

A diminished capacity for care incorporates broader considerations of the patient's wellbeing, beyond psychological health and safety, such as the individual's ability to manage accommodation and money.[314] However it does not cover situations where a person chooses an alternative lifestyle which may be socially unconventional, inconvenient or uncomfortable.[315] Hence judgements should be based on both subjective and objective considerations – the court should take account of the

[310] Bell and Brookbanks, above n 43, at [2.2].

[311] *Re IC* [1996] NZFLR 562 (MHRT-SRT) at 575; *Re RWD* [1995] NZFLR 28 (DC) at 39; *Re T* [1995] NZFLR 351 (DC) at 355.

[312] *Re RWD*, ibid, at 44; *Re E* [1994] NZFLR 328 (DC) at 332. As discussed in Chapter Three, the process of predicting dangerousness must be done professionally, using controlled and reliable techniques. Conclusions must be clearly relayed to decision makers, along with any limitations to these findings: see Glazebrook above n 105.

[313] M Dixon, F Ocybode and C Branningan "Formal Justifications for Compulsory Psychiatric Detention" (2000) 40 Med Sci Law 319 at 323.

[314] Ministry of Health, above n 278, at [1.2.3].

[315] Ibid, at [1.2.3].

individual's circumstances and background when determining whether an objective bystander would find the person's capacity for care acceptable.[316]

B Does the New Zealand Legislation have a Treatability Test?

1 What is treatment?

The MH(CAT)A does not explicitly define 'treatment for mental disorder'. However, as in the United Kingdom, an expansive approach to treatment for mental disorder has been adopted in New Zealand. In the definitive case, *Capital Coast Health v R,* Judge Frater stated:[317]

> I do not see 'treatment' as a narrow concept. In the mental health context it must include all the remedies which mental health professionals ... have available to them to manage mental illness.

He reiterated that treatment must be *for* the disorder but this included rehabilitating the person fully back into the community and minimising relapses.[318] It was concluded that the patient, whose disorder was marked by social rigidity and isolation, would continue to benefit from the social interaction experienced in the hospital.[319] This mirrors the finding in *Rampton* and *Reid* that the hospital milieu forms part of the patient's entire treatment regime.

Nevertheless, while the English approach explicitly allows for treatment of symptoms and manifestations, it is unclear where the line is drawn in New Zealand. Direct manifestations such as treatment for aggression in DSPD patients would probably be authorised through the MH(CAT)A, as reduction in such tendencies would help manage the disorder.

Controversy arises where there is an indirect manifestation of the disorder, for example where the disorder includes sexual promiscuity resulting in pregnancy where an abortion or Caesarean section

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[316] *Re C* DC Auckland CAT 132/99, 28 August 2000, at 9-10.

[317] *Capital Coast Health v R* [1995] 13 FRNZ 294 at 300.

[318] Ibid.

[319] Ibid, at 301. See also *Re RCH* (2003), above n 134, at [20] where evidence was given by Dr Wyness noting the benefits of the structured hospital environment as a form of treatment for RCH. This was despite concessions that it is difficult to distinguish between mere containment and the therapeutic benefit gained from the hospital milieu.

may be required. As mentioned in Chapter Five the English courts have accommodated indirect consequences, such as pregnancy or naso-gastric feeding, when interpreting the scope of 'medical treatment'.[320]

In the New Zealand case of *R v M* an application was made under the Protection of Personal and Property Rights Act 1998 (PPPR)[321] for a Caesarean section for a woman committed under the MH(CAT)A.[322] The fact treatment did not simply proceed under the MH(CAT)A reflects a conservative approach to the definition of treatment.[323] This was despite acknowledgement that her pregnancy was a barrier to management of her mental disorder.[324] The benefit of this conservative approach is that it reduces the potential for abuse of the MH(CAT)A as a paternalistic tool for overriding the right to refuse medical treatment.[325] It also respects Parliament's intentions for the use of the PPPR as the appropriate vehicle for authorising the general medical treatment of those who lack competence.

In short, a clear nexus must still be established between the mental disorder and the medical condition for which the treatment is proposed. In this way the New Zealand courts and tribunals have restricted the scope of treatment in comparison with their English counterparts.

2 The treatability test

There is no explicit treatability test in the MH(CAT)A comparable to that found in the MHA 1983 and the MHA 2007. Nevertheless courts and MHRTs in New Zealand have repeatedly emphasised that a patient must have a treatable disorder to justify commitment.[326] This is supported by the long title which reiterates, amongst other things, that the purpose of the Act is to refine the

[320] *Tameside*, above n 222, at [21].

[321] Protection of Personal and Property Rights Act 1998: this Act authorises the making of 'personal order' for the court to exercise jurisdiction over the affairs of a person in situations where a person is lacking competence in certain areas (s 10). Specifically s10(1)(f) can allow for an order designating that medical treatment or advice be provided for the person.

[322] *R v M* [2005] NZFLR 1095 (FC).

[323] Ibid, at [5].

[324] Ibid, at [24].

[325] The right to refuse medical treatment is confirmed under s11 NZBORA.

[326] See *Re AC*, above n 276; *Re RR*, above n 11; *Re DG* [2003] NZFLR 87 (MHRT-SRT).

circumstances in which a person may be subject to treatment.[327] Furthermore s 57 states that a person subject to a CTO must accept treatment;[328] s 66 provides that a patient has the right to treatment;[329] and s 30(1) states that an inpatient order is 'for the purposes of treatment.'[330] Commitment of a patient for whom no treatment could be given might be contrary to the intent of these sections.

This legislative intent was confirmed in *Re AC* where the MHRT stated "[i]f the disorder of volition is not treatable such a disorder must be deemed to fall outside the provisions of the legislation."[331] Similarly, in *Re RR* a holistic reading of the Act necessitated that "the existence of a therapeutic regime is essential".[332]

Essentially the courts and MHRTs have looked to the whole statutory framework and have adopted a purposive approach to the application of MH(CAT)A. Such a reading is validated under s 5(1) Interpretation Act 1999 which reads "[t]he meaning of an enactment must be ascertained from its text and in the light of its purpose."[333] This holistic explication of the Act assertively highlights treatment as being a central issue to the determination of a mental disorder. Therefore, if the issue of treatability was simply ignored or unaccounted for in a particular case this would disregard the purposive approach which has been well developed in precedent.[334] An appeal or review of a decision could ensue based on incorrect application of the legislation.

Nevertheless, if there is to be judicial recognition of a treatability test then its requirements must be clearly established. In *Re DG* the MHRT determined the threshold for satisfying the requirement of treatability is the presence of "minimally efficacious treatment".[335] This threshold is met when the positive effects of the treatment outweigh its negative effects, resulting in an intervention which is

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[327] MH(CAT)A, long title. See also *Waitemata Health*, above n 6, at [78] Elias CJ stated "[s]ection 4 makes explicit what is clear from the long title and terms of the Act. It is concerned with the assessment and treatment of those suffering from mental disorder."

[328] MH(CAT)A, s 57.

[329] MH(CAT)A, s 66.

[330] MH(CAT)A, s 30(1).

[331] *Re AC*, above n 276, at 14.

[332] *Re RR*, above n 11, at 15.

[333] Interpretation Act 1999, s 5(1).

[334] See *Waitemata Health,*, above n 6; *Re DG*, above n 326; *Re AC*, above n 276, at 14; *Re RR*, above n 11, at 15; *Re DMR* MHRT SRT 48/02, 25 July 2002.

[335] *Re DG*, above n 326, at [56].

in the 'best interests' of the patient.[336] The MHRT saw the benefits of applying this 'best interest' principle as twofold: first, it prevents an excessively expansionistic use of the term treatment by ensuring that an intervention is strictly focused on better managing the patient's disorder; and second, it avoids the implementation of interventions which would be contrary to the ethical and professional standards of mental health practitioners.[337] This would suggest that interventions which are purely designed to ensure the containment of a patient do not meet the treatability threshold akin to the recommendations propounded by Allen J in the English case of *Ruddle*.[338]

This balancing process also pays regard to the rights of the patient as it accounts for a wide range of considerations including adverse symptoms, the patient's willingness to comply,[339] and predictions of long term efficiency (as opposed to immediate or short-term benefits). In *Re DG* the 'best interests' principle was not satisfied because the adverse effects of medication and the patient's unwillingness to take it outweighed its benefits.[340] It is evident then that a treatability test, which is grounded in the wider framework of the statute, can help to distinguish a class of people who should properly be subject to the Act, as well as ensure that commitment aligns with the therapeutic purpose of the Act.

[336] Ibid, at [41].

[337] Ibid.

[338] Contrast the reasoning given by the MHRT in *Re J*, above n 294, at 19 and 21, where it was noted that the sole reason for the abeyance of the patient's symptom was because of his confinement in the "stress-free cocoon" of a closed institution. This reasoning would conform to the conclusion reached by Lord Hope in *Reid* that aspects of containment could constitute treatment. However *Re J* was a very early MHRT decision and since then the MHRT have taken a narrower view to the scope of treatment under the Act as indicated by *Re DG*.

[339] In *Re DMR*, above n 334, at 5 the patient's right to refuse medical treatment was given special regard in determining whether a CTO was justifiable in the circumstances. This was because the long title to the Act affirmed the purpose of the Act is to ensure patient's rights and in addition, s 6 of the NZBORA necessitates an interpretation consistent with the NZBORA.

[340] *Re DG*, above n 326, at [49].

C Nigel Dunlop's Analysis

Dunlop argues that underlying the interpretation of the MH(CAT)A are crucial policy and value judgements.[341] It is these judegments that transform determinations about mental disorder from a mechanical exercise requiring satisfaction of both limbs, to being one which acknowledges and emulates policy choices. These policy choices, coined by Dunlop as 'issues of justification', explain why society chooses to detain mentally disordered people.[342] This shifts the critical question from being 'does the person have a mental disorder' to 'should the person be regarded as having a mental disorder *in law?*'[343] As Dunlop suggests, the statutory words do not exclude the need to take other issues into account when making a determination of mental disorder.[344] These issues of justification are not to be applied as separate tests, rather they will influence the interpretation and application of the provisions of the Act.[345] Thus there is 'dynamic interplay' between the statutory words and the external issues of justification.[346] For example, the importance of treatability concerns is reflected in *Re KMD* where the MHRT stated:[347]

> ... the issues of whether or not treatment is necessary or desirable and the efficacy of such treatment is one of the many contextual factors which assists clinicians and the Tribunal reaching a view as to whether or not a patient is mentally disordered.

It follows that where treatability is doubtful the range of conditions encapsulated by the term mental disorder is likely to shrink. Alternatively, where the individual poses a severe risk to the public the scope of mental disorder may widen. This reasoning is indubitably clear in cases where disorder of volition has been extended to include disorders such as pyromania.[348]

Seemingly this approach would allow many extra-statutory considerations to impact upon decision-making, transforming committal hearings into an arbitrary process. This is avoided if justifications are only considered where it can be shown they align with the purpose and underlying policies of the Act. This was evidenced in *Unknown 672/99* where the MHRT concluded that detention was not contrary to s 22 NZBORA because "[t]he applicant is plainly

[341] Nigel Dunlop "Compulsory Psychiatric Treatment and 'Mental Disorder'" (2006) 5 NZLJ 225 at 225.

[342] Ibid, at 226-227.

[343] Ibid, at 226.

[344] Ibid, at 226-227.

[345] Ibid, at 227.

[346] Ibid, at 228.

[347] *Re KMD* MHRT 04/139, 27 April 2004 at [3].

[348] See *[Unknown]*, above n 289; *Re SJE*, above n 11.

in need of treatment and full time supervision".[349] Therefore issues of justification, such as need for treatment and public protection, clearly influence decision-making.

This suggests that decisions do not rest solely on a literal reading of the precise texts of isolated statutory provisions. Instead, important contextual issues can be extracted from the entire statutory scheme, which can be considered in conjunction with the salient criteria. The requirement that such issues of justification accord with the overall purpose of the Act allows them to be overtly noted in decisions, promoting transparent decision-making and allowing for review of decisions at a later time. In this way a treatability test can be legitimately applied without necessarily grounding it in a single explicit statutory provision.

D Summary

The psychopathological approach to the definition of mental disorder highlights the disorders of mental function that Parliament has identified as requiring the removal of the person from society, when found in combination with the necessary risks. The benefit of this approach is that it intentionally circumvents the pitfalls surrounding the diagnostic difficulties concerning DSPD.[350] Nevertheless, the possibility for arbitrary decision-making is not entirely eliminated as uncertainty remains regarding the definition of disorder of volition and disorder of cognition. A broad interpretation of these terms may incorrectly characterise socially deviant behaviours as stemming from mental disorder. This mis-categorisation is highly likely in relation to DSPD patients because it is difficult to distinguish what behaviour stems from mental dysfunction (if any) and what stems from moral dysfunction.[351]

Nevertheless, the New Zealand legislation includes legal standards to ensure detention is for correct purposes. These standards are not precisely nor explicitly stated, rather they are gleaned from a purposeful and holistic reading of the Act. By taking this approach a treatability test can be found in the Act which has proven effective at distinguishing the appropriate class of people who should be subject to the MHS, as the case of *Re DG* highlights.

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[349] *[Unknown]* MHRT NRT 672/99, 5 March 1999 at 7.

[350] *Re J*, above n 294, at 14.

[351] See Blackburn, above n 23, at 11, where Blackburn states that the concept of ASPD or PPD is "little more than a moral judgement masquerading as a clinical diagnosis."

An element of arbitrariness may still remain if it is uncertain what considerations will be taken into account and what weight of importance they will carry. Therefore while these legal standards are important they may not always establish an identifiable objective threshold for intervention of a completely foolproof kind.

VII Conclusion

A problem was posed at the beginning of this paper asking how the law could be used to protect the public from the harm caused by people with DSPD. It was considered that detention of such people could occur through the MHS or CJS, yet uncertainty existed as to the circumstances that would favour the use of one system over the other, resulting in a placement 'lottery'. The particular focus of this paper was to assess whether proper use could be made of the MHS to civilly detain these people. Legislative attempts to reconcile the competing imperatives of public safety and patient rights proved imperfect. This was fuelled by the inconclusive state of knowledge about DSPD which hindered the ability to reliably recognise these people in the field of psychiatry or law. In the absence of any clear marker of mental abnormality, the drive for public safety was often the decisive point in the determination of whether a person with DSPD was mentally disordered. This suggests that arbitrary detention may be inevitable in the absence of sufficient legal standards to counter-balance this overriding public safety concern. In conclusion it cannot be said that precise legal standards have been identified which would always avoid the arbitrary detention of people with DSPD within the MHS.

All three of the legislative frameworks examined contain blemishes allowing for arbitrary decision-making. Under the MHA 1983 this prospect arose because of the indeterminate nature of the term PPD. PPD was an inherently circular and ill-defined concept which was largely based on the presence of anti-social behaviour, rather than a recognisable mental malfunction. Therefore use of the term became the subject of criticism by those who viewed its presence as exclusively furthering social and security purposes, rather than being reflective of a true psychiatric disturbance.

The United Kingdom Parliament, recognising that PPD was essentially "a mythical entity",[352] removed the category in its 2007 amendments. It replaced it, however, with an undefined and broad definition of mental disorder, which relies heavily on clinical opinion for its application. This is problematic given that clinical opinion concerning the status of DSPD is uncertain and controversial, and cannot alone provide a valid foundation for removing rights and liberties. The courts and tribunals cannot effectively review such decisions or readily

[352] Ibid, at 511.

inject more specificity to the definition when Parliament has left it deliberately undefined; nor are they able to refute medical opinions as they lack the necessary expertise and experience. Essentially, the current English approach suffers from the absence of a clear objective threshold against which a legal determination of mental disorder can be made.

Under both the former and current English models it was anticipated that the potential for individuals to enter the MHS on the basis of deviant and dangerous behaviour alone would be reduced through the enactment of a treatability test. However, this test was interpreted so broadly as to be meaningless and thus it was innocuous as a tool for distinguishing mentally disordered offenders from the wider criminal population. Noticeably a clear political policy of public safety has caused the reading down of the treatability test.

It was seen that disorder of volition and disorder of cognition within the New Zealand framework may also have been ineffective tools at making such a distinction, as the precise limits of these phrases remain unclear. The saga of RCH highlights how the use of lay definitions and an underlying theme of public protection resulted in a broad interpretation of these terms which could be used to describe the musings of many offenders. Moreover, interpretive fluctuations may result in inconsistent meanings being applied in similar cases, which is seemingly contrary to the requirement that decisions be made against identifiable legal standards.

Nevertheless, while the New Zealand model does not eliminate the prospect of arbitrary detention altogether, it minimises this risk to a greater extent than both English models for a number of reasons. First, it does not rely on fluctuating diagnostic debates which may give rise to inconsistencies between cases. Second, it lists specific disorders of mental function which permit the courts and tribunals to actively engage in the interpretative process and further refine the meaning of contentious terms in case law. Third, issues of justification may be extracted from a holistic reading of the Act and applied throughout the interpretive process to distil the group of people who Parliament has identified as being appropriately subject to the legislation. In contrast the English courts and tribunals do not explicitly adopt a purposeful approach and instead depend on the strict application of statutory wording. However, as cautioned by Judge MacCormick in *Re SJE:*[353]

[353] *Re SJE*, above n 11, at 11.

> While it can promote greater consistency if terms are precisely defined, that can also have the effect of being unduly restrictive, in precedent terms, when applied to different but similar sets of facts...

Moreover, attempts to ground decisions in strict statutory wording may mean a range of considerations are ignored in judgments. This may mean the actual reasons for decisions are not clearly stipulated which limits the reviewability and transparency of the committal process.

In sum, it is my belief that legislative reform in New Zealand is unlikely to immediately resolve the issues surrounding DSPD. At best it is desirable to nurture the discourse between lawyers, psychiatrists, politicians and patients in an endeavour to understand more about the DSPD phenomenon within a legal context. Currently, the New Zealand model facilitates this discussion as it engages an inter-disciplinary range of skills and allows for relevant contextual considerations to overtly influence decision-making. Therefore, conclusions about the presence of 'mental disorder' consider all circumstances of a patient's case. It would be advisable for England to explore the possibility for legislative changes based on the New Zealand model.[354] Particularly it would be fortuitous to avoid the delegation of the interpretation of mental disorder wholly to the psychiatric profession as this is antithetical to the concept's role as a legal gatekeeper to civil commitment. Moreover, the English courts and tribunals could adopt a more purposive reading of the Act in order to explicate crucial policy factors when defining the term mental disorder. This would advance the discourse and hopefully result in a more comprehensive legal threshold to protect the civil liberties of patients. However, it is critically necessary that both the New Zealand and English courts and tribunals bear in mind the primary purpose of managing and treating dangerous people with mental disorder throughout this dialogue to ensure the MHS is not used as a back door for indefinite detention of socially deviant individuals.

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[354] It is poignant to observe that it was in the Butler Report - a report commissioned by the United Kingdom Parliament - that the psychopathological approach was first proposed as a means for reformulating the legal test of insanity. The recommendations of the Butler Report were not accepted by the United Kingdom Parliament, however it would be advisable that these recommendations are reviewed in light of the continuing problem caused by people with DSPD in England, and the ineffective way in which the current English legislation appears to manage it: The Butler Report, above n 50, at [18.14]–[18.36].

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