

Concepts of Liberty in Mental Health Law

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1. Introduction

I want to discuss with you how we should think about the personal liberty, or freedom, of people with a serious mental illness, and why this matters for the design of our mental health laws.

I have tried to sum up my thinking over the years about the kind of mental health laws we should have and state these thoughts as an argument. The argument has a number of parts.

I am going to focus particularly on laws that authorise the use of compulsory psychiatric treatment outside hospital, under what is known as a Community Treatment Order (CTO).

A patient under such an order will usually be required to keep taking medication for their mental illness, and to accept visits at their residence from a community psychiatric nurse, who monitors their condition. If the patient refuses treatment, they may be returned to hospital for medication to be administered there.

Compulsory outpatient care of this kind is the major use of mental health law in Australia and NZ.

Currently, there are about 40,000 adult patients of our public psychiatric services in NZ. This is about 1% of the population. Somewhere between 2 and 3000 of these patients are under a CTO. That's about twice the number who are under involuntary treatment in hospital.

So CTOs are the high volume end of mental health law. That's why our research group has been studying them.

I am going to argue – somewhat against my legal training – that compulsory community treatment of this kind can promote as well as diminish the personal liberty of mentally ill people, and that it can therefore be justified.

Furthermore, I will argue it can be justified – under certain conditions – even in the most controversial and marginal kind of case: that is, when the mentally ill person does not pose a serious threat of harm to themselves or others.

I want to discuss this marginal kind of case because it best illustrates the distinct use we make of mental health laws in Australasia.

It illustrates our distinctive practices because patients who do not pose a serious threat of harm to themselves or others might not be considered suitable candidates for involuntary treatment in many other countries, especially in North America.

One reason we follow this different approach – perhaps – is because we have somewhat different views about liberty than they have in North America, or about what freedom means for people with a serious and continuing mental illness, like schizophrenia or bipolar disorder, who are the most likely candidates for a CTO.

2. Dangerousness criteria for involuntary treatment

We can use the law in Pennsylvania to illustrate the approach taken in some parts of the USA.

Under this approach, the right of mentally ill people to refuse psychiatric treatment is taken very seriously, unless they are ‘imminently dangerous’ to themselves or others.

Here is Pennsylvania’s standard for involuntary psychiatric treatment:

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The ‘dangerousness’ standard for involuntary psychiatric treatment

An example: Pennsylvania Mental Health Procedures Act, s 7301

‘when, as a result of mental illness ...

he poses a clear and present danger of harm to others or himself’;

and

this danger has existed ‘within the last 30 days’.

This is a rigorous standard. Not many people under CTOs in NZ would meet it, I think.

It could be said this is really a standard governing emergency hospitalisation, and perhaps a person who meets it ought to be treated in hospital, not in the community.

It is not really a standard designed to govern community-based treatment at all.

3. NZ's involuntary treatment criteria

Here, in contrast, is NZ's standard. Similar standards apply in Victoria and New South Wales.

To be treated involuntarily, you must have a 'mental disorder' in this special sense:

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NZ's criteria for compulsory treatment

'Mental disorder', in relation to any person, means 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.

This is a more detailed but broader standard for involuntary treatment. It would cover every patient committable in Pennsylvania and many more. I like it a lot, because it forces us to ask the right questions.

You will see it is in two main parts:

1. there is the definition of an abnormal state of mind; and
2. a list of consequences, or behaviours, one of which that state of mind must 'pose', under (a) and (b).

The person's state of mind must be 'characterised by' one of those recognised signs or symptoms of serious mental illness.

But it only needs to be 'intermittent', so fluctuating mental states can be covered.

With regard to the second part – the consequences of this abnormal state of mind – the key point for our purposes is that these consequences don't just cover people who have presented a clear and present danger within the last 30 days, as in Pennsylvania.

They cover a wider range of consequences, including serious dangers to the person's own health, not just dangers to their safety; and they cover 'seriously diminished capacity for self-care'.

These are broader notions than clear and present danger in the last 30 days. And this is deliberate, because NZ law covers involuntary treatment in the community as well as in hospital. So broader standards are required.

The main question I want to pose, then, is this: can this wider approach followed in NZ be justified, and on the strongest possible ground: that it promotes the personal liberty interests of the mentally ill?

3. Initial Summing up

My particular question is therefore this:

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Particular question

How can we justify the involuntary treatment of a mentally ill person who:

- **does not pose an imminent threat of serious harm to themselves or others; and**
- **is capable of living outside hospital?**

The strongest possible answer:

>>> because it can promote their liberty.

My more general questions, however, are these:

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Background Questions

- **What are community treatment orders?**
- **Do they limit or advance personal liberty?**
- **What is liberty for a person with a serious mental illness?**
- **How should the legislation be designed and used?**

5. The case of the dairy farmer

Let me give an example of a recent NZ case that sits right on the margins of the law that I'd like to look at in some depth.

The case concerns a 48 year old man from the Waikato, who is known to us only as TJF (*In the Matter of TJF*, MHRT No. 07/037, 27 April 2007).

He is under a CTO and required to accept continuing psychotropic medication, under threat of return to hospital.

He is unusual for a compulsory patient in some respects, because he's held down a job for the last 30 years and made a lot of money. He is a dairy farmer and probably makes more money than anyone in this room, even though he has a 30 year history of paranoid schizophrenia with delusions. Next year, he'll make even more.

He came before NZ's Mental Health Review Tribunal in April this year. This is a multi-disciplinary body that follows a statutory code of procedure and contains a lawyer, a psychiatrist and a lay member. It takes an inquisitorial approach.

Slide: NZ's definition of MD.

If TJF doesn't meet this legal standard, the tribunal must release him immediately from compulsory treatment. That's what independent review requires.

On the day of the hearing before the tribunal, TJF was immaculately dressed, reasonably well, lucid, living in his own home, and represented by a lawyer.

So how could we justify his continuing involuntary treatment?

Well, the uncontested evidence was that a few months earlier he was living in 'abject squalor' on his farm, gripped by paranoid delusions, and completely isolated from his parents and sister who were very distressed about it.

He had no social or recreational life and was constantly engaged in what are described as 'eccentric farming practices', like milking his cows in the middle of the night, and not taking them off the milking machines, causing them harm. This is a case about harm to cows.

He was also giving away large sums of money.

He had done 'no cleaning' in the farm house for many years. The toilet was completely blocked. But he was eating adequately, and was not malnourished, and was not at risk of serious injury or death.

So what should be done? Anything at all? Or should he be simply left alone?

Should we wait until he is at serious risk of harm before we intervene?

Should we let him fall and fall, until – perhaps – he is standing, homeless, on a street corner in Auckland (or in Chicago, with winter coming on).

Is that a sensible policy for a society to follow?

What led to intervention was the state of his milking shed. TJF wasn't cleaning out the shed properly after milking. The dairy company – Fonterra – repeatedly warned him about this, and they engaged consultants to work with him on dairy hygiene and monitor his standards. They were worried because his milk had become contaminated with penicillin before and it could contaminate their whole factory.

This help didn't make any difference. He was acutely unwell.

So Fonterra said they would stop taking his milk on Friday. That would be end of his income and his life as a dairy farmer.

Three days before that deadline, his parents, who were in their 70s, and a doctor, committed TJF to Waikato Hospital under the Mental Health Act.

His father then personally cleaned out the dairy shed, milked the cows, and saved the day with Fonterra. That was a pretty tough thing for a man in his 70s to have to do for his son: to commit him to the hospital and resume running the farm. I doubt he would do that lightly.

TJF then went through the compulsory assessment and treatment process under the Mental Health Act.

- the hospital psychiatrists repeatedly certified he met the involuntary treatment criteria;
- his family were consulted, as required;
- a private hearing was held before the Family Court; and
- a Judge then made an order for his involuntary treatment for up to 6 months.

His treatment then continued.

After a few months TJF was considered well enough to leave the hospital and go home and continue farming on medication under a CTO, to which he can be switched by the clinicians from involuntary inpatient care.

He then applied to the Tribunal for his release from compulsory status.

At the hearing, his lawyer pointed to his greatly improved condition and said he no longer had a seriously diminished capacity for self-care.

The psychiatrists said, however:

- TJF had suffered from schizophrenia since the age of 19;
- he had been hospitalised many times before;
- when unwell he became estranged from his family; he heard voices; and he had delusions about the neighbours;
- he had ‘confused and concrete thoughts’, ‘blunting of mood’, and many of the so-called negative symptoms of schizophrenia.

Nevertheless, with recent treatment by Risperidone his condition had markedly improved. Relations with his family had been re-established and he wanted this to continue.

The Tribunal questioned TJF in person and he agreed that treatment had greatly improved his mental health. But he said, in effect: ‘That was just an acute episode. It’s over. I don’t need medication any more. It slows me down. I just want to be left alone to go on being a dairy farmer.’

Let me pose the question, then: what would we say about the effect of involuntary treatment on this man’s liberty?

Does it make him more free or less free, do you think? Or both?

Should we only subject him to emergency hospitalisation when that is absolutely necessary, and then release him from control, and let him go off medication, even though he's lapsed into a paranoid psychosis many times before?

He is not currently posing a serious threat of harm to anyone, not even himself.

This is the problematic case at the margins of our mental health laws, and the kind that divides the mental health laws of Australasia from those in many parts of North America.

Should we require him to keep on taking medication, outside hospital, even by long-acting intra-muscular injections, without consent, if necessary?

That would be a very serious intrusion on his life.

But if we look at the whole history of his illness, and its recent consequences, not just his condition on the day of the hearing: would we say he has the capacity to determine his own freedom, or not?

His case is not unusual in most respects. He fits the profile of a typical person on a CTO. They tend to be used for a selected group of patients in the middle stages of a serious mental illness.

A recent review of the global literature found this:

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The typical profile of those on Community Treatment Orders

'Patients are typically males, around 40 years of age, with a long history of mental illness, previous admissions, suffering from a schizophrenia-like or serious affective illness, and likely to be displaying psychotic symptoms, especially delusions, at the time.'

**Churchill, Owen et al (2007)
International Experience of Using CTOs
London: Institute of Psychiatry**

So what are the precise powers that can be exercised over such patients?

This is the particular cluster of powers and duties provided by NZ law. The availability of these kinds of powers has given clinicians in Australasia the confidence to use our CTO regimes.

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Community Treatment Powers in NZ

- **the patient ‘shall accept treatment’: a duty**
- **the patient must accept visits and attend appointments**
- **the ‘level’ of their accommodation may be specified**
- **CMH teams may enter private premises ‘at reasonable times’, ‘for treatment purposes’**
- **swift recall to hospital by ‘responsible clinician’**
- **police assistance in entry and recall processes**
- **treatment in a hospital without consent**
- **no ‘forced medication’ in community settings**

These are the enforcement mechanisms the law provides.

Should we apply these powers to this dairy farmer, or the threat of their use?

Immanuel Kant said paternalism is ‘the most monstrous form of tyranny’. But even he made an exception for people who were ‘incapable of determining their own rational will’.

Can this dairy farmer determine his own rational will, do you think? How much of the time?

What does freedom mean in the special case of a person with a serious, continuing mental illness?

6. The meaning of freedom for the mentally ill

So let’s come to some thoughts on liberty.

I find it useful to work here with the two concepts of liberty famously expounded by Isaiah Berlin, in 1958, at the height of the Cold War.

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Two Concepts of Liberty (after Isaiah Berlin)

- **Negative liberty:**
the right to be left alone, or refuse treatment
- **Positive liberty:**
**capacity for self-governance,
self-directed activity, and
maintaining important relationships**

Berlin argued that two main ideas about personal liberty have dominated the western philosophical tradition:

- ideas about negative liberty: that is, our right to be left alone, and not to have external constraints imposed on us by other people; and

- ideas about positive liberty, by which he means our capacity for self-governance; to direct our own actions; to set goals and have some chance of meeting them, without being dominated by internal constraints that prevent that occurring.

The concept of negative liberty is deeply embedded in the common law tradition.

It is found:

- in the remedy of habeas corpus, to challenge a person's unlawful detention;
- in the civil action for trespass to the person;
- in the whole of the criminal law about interpersonal violence and property crime, which is to stop other people interfering with our lives;
- and it's found in human rights provisions, including, in NZ, the right to refuse treatment.

There is no more important concept than negative liberty in the history of our law.

It is called negative liberty because it prohibits others from interfering with us, and with our attempts to pursue our own ends, but it purports to say nothing about the ends we ought to pursue. That's for us to decide.

The great NZ jurist, John Salmond, endorsed this view in what is probably the most influential book on legal theory ever written in NZ: Salmond's *Jurisprudence*, written in complete isolation in Temuka in the 1890s – probably the best work on general jurisprudence ever written in Temuka.

One enjoys liberty, said Salmond, 'when the law allows to my will a sphere of unrestrained activity'.

Clearly that sphere is breached if other people force me to take medication without my consent.

The concept of positive liberty may be less familiar. Berlin says this about it:

'I wish to be an instrument of my own will, to be moved by reasons, not causes; a doer – deciding, self-directed and not acted upon as if I were a thing, incapable of playing a human role: that is, conceiving goals and policies of my own and realising them'.

He calls it: 'The freedom that consists in being one's own master': – the capacity for self-directed action.

Charles Taylor, the Canadian philosopher, says it is 'the exercise of control over one's own life', and internal barriers within a person count as obstacles to it.

This concept is not well-embedded in our legal traditions. Nor can it be readily captured in the language of enforceable rights.

There are echoes of it in NZ statutes that guarantee health and housing and education and social welfare entitlements, when those entitlements may be necessary to permit people to develop their capacities and pursue their goals.

But rarely would we talk, I think, of the right of an adult to be forced to exercise their capacities, or the right to receive involuntary treatment. These are not enforceable legal rights.

Nevertheless, in the health professions, the notion that we should try to enhance a person's capacity to achieve their own ends is a well-embedded therapeutic principle.

For health professionals – and patients' families – the main aim of treatment is often to re-establish the patient's capacity to function as they wish.

In our constitutional system it is open to Parliament – crucially – to endorse, in legislation, that alternative, therapeutic, intellectual tradition.

Even John Stuart Mill said he would permit others to intervene to promote the interests of those who are 'of limited understanding', which would include perhaps the seriously mentally ill.

In my view, both these concepts of liberty are relevant to involuntary treatment decisions under NZ law.

7. Involuntary patients' views of their freedom

What I'd like to do now is to show how both these concepts can be found embedded in comments made to us patients under CTOs whom we interviewed in our research, in Otago.

We tried to interview an entire cohort of patients who had been under a CTO in Otago in the previous 2 years. More agreed to be interviewed than refused. Eventually, we interviewed 42, including 8 Maori patients.

Many of these patients clearly felt highly coerced by the CTO.

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Coercion by the CTO: Patients' Views

**'I have to do what they say'.
 'Wham: they can put me straight back in!'
 A 'straight-jacket'; 'thumb-screws now on'.
 Under 'control, supervision, surveillance'.
 'Restricted, ordered, dictated to, pressured'.
 'It made me a second class citizen'.
 'It was mainly negative, but it saved my life'.**

Slide
Impact on ‘negative liberty’

Chi: ‘It didn’t help me. They forced me to take medication. I hated having my freedom taken away. There was a stigma always in the back of my mind. I was restricted in certain ways’.

Connor: ‘It was like a prison sentence. I could not go hunting in the forest with my sons. My psychiatrist is authoritarian. The injections impair my alertness and energy. They took away my gun licence’.

Fred: ‘It put me in a category hole and a little box’.

Isn’t that an eloquent statement about a sense of psychological confinement by the order.

These patients clearly felt their negative liberty – their right to be left alone – was reduced, as one would expect.

8. Less restrictive alternatives

That main thing that can be said for CTOs in this regard is that they may reduce a person’s exposure to even more restrictive alternatives than involuntary outpatient care.

Many former forensic patients, for instance, who had come under the Mental Health Act following involvement in the criminal justice system, spoke passionately of their preference for life under a CTO.

They said things like this, measuring their experiences against their former lives:

Slide
Compared to forensic care or prison

‘I was into marijuana, pills, sniffing glue, solvents, living the hard life. They would pick me up off the street and put me in a cell. I was just wandering around NZ doing nothing. It is a hard life out there. It saved my life’.

‘It’s better than the bashings, seclusions and jabs at [hospital X]’ (in the North Island).

‘That unit up there: it’s the same as being in prison but there are no uniformed officers’.

‘The real bad part of my life was in forensics’.

‘I’ve come straight from the lock-up place’.

‘Now I can come and go as I please, go outside, go for a walk, in the fresh air’.

They definitely found the CTO a less restrictive alternative.

9. Patients’ views on positive liberty

But my main argument is that we should go further and listen to what patients also say about the manner in which involuntary treatment may reduce internal barriers to achieving their ends found in their minds.

They expressed this in a number of related ways:

Slide Negative descriptions of prior mental state and its impact on self-governance

‘I was over the edge at the time’.
‘I was off the tracks’.
‘It is very confusing when you are ill and it is hard to relate to people. It all depends on how ill you are. It’s a cold hard world when you’re still very ill’.
‘I was distressed and depressed. Nothing mattered. I would have done something stupid’.
‘I was frightened of having delusions and hearing voices again’.

How much freedom does a person have who is ‘off the edge at the time’?

Slide Comments on enhanced access to treatment (as a means to achieve better mental health)

‘You know someone will keep in contact’.
‘It’s part of my personal risk management plan’.
‘You know if you flip out they’ll put you in hospital’.
‘You have care straight there’.
‘You move through the system in a tighter circle’.
‘If I was discharged it would take longer to get help’.
‘I like how it is worded, a community treatment order, because the people around you are helping you’.
Contra:
‘It’s easier for them. It cuts out the red tape’.

Many said that through receiving continuous care the burden of their mental illness was reduced and they achieved some stability and control over their life.

How much control do you have over your life when you are going through a repeated cycle of admissions to inpatient care?

My point is that these kinds of comments don't just go to matters of patient health, or patient welfare. They also go to matters of liberty – positive liberty.

It seems to me they're saying that by getting access to treatment – even involuntary treatment – they had experienced the removal of internal barriers to control of their life. And then they were able to achieve at least some of their aims.

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Overall Impact of CTO

Connor: 'It brought me back into society as a normal Dad. It lifted the burden of monitoring from my wife. It saved my marriage. It's good but there's handcuffs on it'.

Andrew: 'It saved my life. It got me off the streets. It helped me communicate with people'.

Dave: 'It was a step to freedom. It increased my independence from the hospital. It's better to be in the community. Now I have a job – unloading fish – but at least it's a job. It changed things to the point where I am 99% sure of myself'.

It gave him positive options.

10. Summing up

Let me try to sum this up and draw some conclusions on the law.

I think the ultimate task of mental health law in NZ is to create a legal structure within which the usual right of mentally ill people to refuse treatment can be weighed against the contribution involuntary treatment can also make to their capacity for self-regulation and to engage in meaningful occupation and personal relationships of their choice.

In short, several concepts of liberty, or ideas about liberty, may properly be deployed in mental health law.

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Relevant Concepts of Liberty

'Negative' liberty:

- the 'right to be left alone'

'Positive' liberty:

- the capacity to act, to set one's own goals
- to be 'moved by reasons, not causes'
- to maintain meaningful relationships of choice

Comparative liberty: – the CTO compared to

- hospital, forensic care, prison, the street

The temporal dimension: past, present, future liberty interests

So no party – neither lawyer nor psychiatrist – should claim to occupy the high moral ground of 'true' liberty on the patient's behalf, because there is no high ground of 'true' liberty to be found, only different and contestable concepts of liberty that may point to different conclusions in the same case.

If we try to construct a set of ethical principles, then, to justify involuntary treatment of people who pose no imminent threat of harm, those principles might look like this:

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**A justification for involuntary treatment
of patients not posing a clear threat of harm**

Necessary ethical conditions:

- **The person's capacity for self-governance is seriously diminished due to mental illness.**
- **Involuntary treatment would significantly advance their positive liberty.**
- **This would outweigh any reduction in their negative liberty.**

All these elements are necessary: the incapacity principle, and weighing up both major concepts of liberty, to reach a judgment, about which should take priority in the particular case.

I think we should be able to consider the whole course of the person's illness and their likely prognosis, in future, in making that decision.

I think NZ's legal criteria for involuntary treatment are reasonably consistent with these principles, *provided*:

- first, we do not intervene to promote a person's own health, or their levels of self-care, unless they have a seriously diminished capacity for self-governance;

- and, secondly, provided we weigh up the impact involuntary treatment will have on both their negative and positive liberty before we reach a decision.

I think NZ's legal criteria can be properly read in that light; and I think this is how such decisions are made in practice most of the time.

This approach respects the traditions of both law and psychiatry, and this was the intention of our Parliament when it adopted a multi-disciplinary approach to the design of the legislation, after listening to the views of patients, lawyers, the health professions, and families, all of whose views should be heard.

12. Wider consequences for mental health law

In the end, our thoughts about liberty will affect the whole design of our mental health laws: from whether one thinks a CTO regime is justified at all, down to the fine print of the law and how it is applied in individual cases.

If we put a very high value on the right of mentally ill people to refuse treatment:

- the law will tend to have tightly-drafted standards, based on current dangerousness;
- it will only authorise treatment for short periods of time;
- it will impose rigorous and frequent external review procedures on psychiatrists, that are very onerous;
- it will provide little extra authority to treat patients compared with the voluntary approach: no power of entry on to a private farm, for instance;
- and it will leave very little discretion in clinicians' hands.

So, let me put it to you: if you were a busy psychiatrist, and use of these powers was discretionary, not mandatory, as it is, under the law; and you have many patients claiming your time, including many prepared to accept voluntary treatment, who may be easier to treat but less unwell, would you make active use of that kind of scheme?

Or would you direct your attention elsewhere?

The answer seems pretty clear: to design the scheme in that legalistic way is to subvert it, because clinicians will not use it actively, and it will not then make a significant impact on the delivery of mental health services.

The great danger, in my view, if we let civil mental health law wither away like that, when the asylums are closed and will not be reopened, and the vast majority of mental health patients live in the community; and a small proportion remain very unwell over long periods of time; and when we live in rather punitive times, with rising rates of imprisonment; and 'the law loves a vacuum', as they say ...

... the great danger is that something worse will take the place of mental health law, and we will see greater use of the criminal law, and of secure forensic care, and greater suffering and stress on families, and greater homelessness among the mentally ill.

I don't think that would promote human liberty overall.

So I don't think we should let civil mental health law wither away.

I think we should grasp the nettle and enact reasonably flexible CTO schemes that clinicians will have the confidence to use.

11. The outcome in the dairy farmer case

So what did the tribunal decide in the dairy farmer case? They decided the CTO should continue.

They recognised TjF was now reasonably well, he opposed further medication, and his usual right to refuse treatment was being trumped.

They didn't think his squalid living conditions were sufficient, on their own, to justify involuntary treatment, because he'd lived like that for years and he hadn't been seriously harmed.

But they found his capacity for self-care was still seriously diminished, because, when he was unwell with paranoid delusions he lacked the capacity to make the decisions that were necessary to achieve the goals he set for himself when well:— to be a dairy farmer and have contact with his family.

These goals – of his – could not be met if he became unwell again, as he had, repeatedly, in the past.

In other words, without involuntary treatment, he would – in Isaiah Berlin's terms – lack positive liberty. Internal barriers in his mind would prevent him achieving his own goals. So his involuntary treatment was justified despite the restrictions that would also place on his life. So he should remain on the CTO.

This is typical of the preventive approach followed in NZ courts and tribunals in this kind of case.

I think it's justified, under the right conditions, in order to promote liberty, though I know some people will disagree.

It shows the distinct way in which we use mental health law in Australasia.

It reflects a humane form of liberalism, in my view, that is consistent with our political culture and our constitutional traditions.

I don't think either Immanuel Kant or John Stuart Mill would consider it a monstrous form of tyranny.

Nor should we.