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Concepts of Liberty in Mental Health Law

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1. Introduction

This lecture concerns 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. A particular focus will be 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 accept medication for their mental illness and receive visits at their residence from a community psychiatric nurse who will monitor their condition. If the patient refuses treatment, they may be returned to hospital for medication to be administered there. This is a very significant intrusion on a person's life.

Compulsory outpatient care of this kind is the major use of mental health law in Australia and New Zealand. Currently, there are about 40,000 adult patients of New Zealand's public psychiatric services. This is about one per cent of the population. Somewhere between 2000 and 3000 of these patients are under a CTO.¹ This is about twice the number of patients who are under involuntary hospital care. So CTOs are the high volume end of mental health law. That is why we study 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 interests 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

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¹ Office of the Director of Mental Health. *Annual Report 2005* (2006), Ministry of Health, Wellington.

suitable candidates for involuntary treatment in many other countries, especially in North America, even though they might be considered suitable candidates here. One reason why we follow this different approach in Australasia might be because we have somewhat different views about liberty than they have in North America, or different views 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. Different criteria for involuntary treatment

We can use the law in Pennsylvania to illustrate the approach taken in some parts of the United States of America. 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. Pennsylvania follows this kind of 'dangerousness' standard for involuntary psychiatric treatment:

Pennsylvania Mental Health Procedures Act, section 7301

A person may be placed under involuntary psychiatric treatment:

'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. Many people under compulsory outpatient treatment in New Zealand would not meet it. It might be considered a standard designed primarily to specify the conditions for emergency hospitalisation, and that a person who meets it should be treated in a hospital, and not in the community. It is not really a standard designed to cover community-based treatment at all.

The broader legal standard for compulsory treatment followed in New Zealand is set out below. Similar standards apply in Victoria² and New South Wales.³ To be treated without consent, in New Zealand, a person must have a 'mental disorder' in the following special sense:

New Zealand's criteria for compulsory psychiatric treatment under section 2 Mental Health (Compulsory Assessment and Treatment) Act 1992

'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

² Mental Health Act 1986 (Victoria).

³ Mental Health Act 1990 (NSW).

- (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. It has two main parts. There is a definition of an abnormal state of mind, and then a list of consequences, or behaviours, which the state of mind must 'pose'.

To meet the first part of the definition, a person's state of mind must be 'characterised by' one of the listed signs or symptoms of serious mental illness. But this only needs to be 'intermittent', so fluctuating mental states can be covered.

With regard to the second part, the consequences of the abnormal state of mind, under (a) and (b), the key point for our purposes is that the listed consequences do not cover only people who have presented a clear and present danger within the last 30 days, as in Pennsylvania. The New Zealand standard covers a wider range of consequences of mental disorder, including serious dangers to the person's own health and seriously diminished capacity for self-care. These are broader notions than clear and present danger. And this is deliberate, because New Zealand law covers involuntary treatment in the community as well as in hospital. So a broader legal standard is required.

The main question I wish to pose is: can this broader New Zealand approach be justified, and on the strongest possible ground, that it promotes the personal liberty interests of the mentally ill? Can we justify the involuntary treatment of a person who does not pose an imminent threat of serious harm to themselves or others, and is capable of living outside hospital, on the ground that involuntary treatment can promote their freedom? I will argue that this can be justified, under certain conditions.

In the background sit several more general questions: what are community treatment orders; how do they limit or advance personal liberty; and how should the legislation be designed and used? I will address these questions as we proceed.

3. The case of the dairy farmer

First, let us consider a recent case that sits right on the margins of the law that I wish to examine in some depth. The case concerns a 48 year old man from the Waikato, who is known to us as TJF.⁴ When his case came before New Zealand's Mental Health Review Tribunal (MHRT), he was living at home under a CTO and required to accept continuing psychotropic medication, under the threat of return to hospital care.

TJF is unusual for a compulsory patient in some respects. He has a 30 year history of paranoid schizophrenia with delusions, but he has also held down a job for many years. He is a dairy farmer and has made a

⁴ *In the Matter of TJF*, MHRT No. 07/037, 27 April 2007.

lot of money.

The MHRT that considered his case is a multi-disciplinary body, containing a lawyer, a psychiatrist and a lay member. It follows a statutory code of procedure and takes an inquisitorial approach. Its primary job is to consider whether compulsory psychiatric patients continue to meet the statutory definition of a 'mentally disordered person': that is, whether they meet the civil commitment criteria established by the Act. If TJF does not meet those criteria he must be immediately released by the tribunal from compulsory treatment. That is what a system of independent review demands.

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. How could we possibly justify continuing his involuntary treatment?

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 partly 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, not malnourished, and not at risk of serious injury or death.

So what should be done? Anything? Or should he simply be left alone? Should we wait until he is at serious risk of harm before we intervene, and let him fall and fall, until – perhaps – he is standing homeless on a street corner in Auckland (or in Chicago, with the winter coming on). Is that a sensible policy for a society to follow?

What led to intervention in his case was the dreadful state of his milking shed. He was not 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 to monitor his standards. They were worried because his milk had become contaminated with penicillin before and it could contaminate their entire factory. But the help they provided made no difference. TJF 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 legislation. 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: to commit his son, again, to the hospital and resume running the farm. I doubt he would do that lightly.

TJF then went through the compulsory assessment process under the Act. The hospital psychiatrists repeatedly certified that 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.

After a few months TJF was considered well enough to leave 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 release from compulsory status. At the hearing, his lawyer pointed to his greatly improved condition and said TJF no longer had a seriously diminished capacity for self-care.

The psychiatrists said, however, that 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, heard voices, had delusions about the neighbours, and 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 TJF said he wanted that to continue.

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

The question I want to pose, then, is this: how should we describe the effect of involuntary treatment on this man's liberty? Does it make him more free, or less free, or both? Should we subject him only to emergency hospitalisation when that is absolutely necessary, and then release him from further control when he leaves hospital, and let him go off medication, even though he has 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 of case that divides the mental health laws of Australasia from those in many parts of North America. Should we require him to keep taking medication, outside hospital, even by long-acting intramuscular injection, 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. These orders 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 that the typical profile of a person on a CTO was as follows:⁵

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.

4. Community treatment powers

A CTO provides a particular cluster of powers and duties that apply to an involuntary outpatient. The availability of these powers has given clinicians in Australasia the confidence to use actively our CTO regimes. The particular cluster of powers and duties provided in New Zealand may be summarised as follows:⁶

- The patient 'shall ... accept treatment' for their mental disorder.⁷ This is expressed in terms of a duty imposed on the patient, although logically this may also entail the conferral of a correlative power on health professionals to provide the treatment without consent.⁸
- The patient must accept visits and attend appointments with health professionals.⁹
- The 'level' of the patient's accommodation (or the degree of support that must be available) may be specified, in practice, as a condition of their community tenure, even if not the precise address at which they must live.
- The members of community mental health teams are empowered to enter private premises 'at reasonable times', 'for treatment purposes'.¹⁰
- The patient may be swiftly recalled to hospital by direction of their Responsible Clinician.¹¹
- Police assistance is available in the entry and recall processes, if required.¹²
- The patient may be treated in hospital without consent,¹³ but there is no express power to restrain or detain the patient in order to administer 'forced medication' in community settings.

⁵ R Churchill, G Owen, S Singh, M Hotopf, *International Experiences of Using Community Treatment Orders* (2007), Institute of Psychiatry, London.

⁶ See J Dawson, *Community Treatment Orders: International Comparisons* (2005), Otago University Print, Dunedin; J Dawson, 'Fault-lines in community treatment order legislation' (2006) 29 *International Journal of Law and Psychiatry* 482.

⁷ Mental Health (Compulsory Assessment and Treatment) Act 1992, s 29(1).

⁸ *Re MJO SRT 20/98*, 2/4/98.

⁹ *Supra* n 7.

¹⁰ *Id.*

¹¹ *Id.*

¹² *Supra* n 7, ss 40, 41.

¹³ *Supra* n 7, Part V.

This is the important cluster of enforcement mechanisms that the law provides. So, should we apply these powers to this dairy farmer, or the threat of their use? Immanuel Kant said paternalism was the greatest conceivable despotism.¹⁴ But even he made an exception for people who were incapable of determining their own rational will. Can this dairy farmer determine his rational will? How much of the time? What does freedom mean in the special case of a person with a serious, continuing mental illness?

5. The meaning of freedom for the mentally ill

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: that is, negative and positive liberty.¹⁵ Berlin argued that these two ideas about personal liberty have dominated the western philosophical tradition. Negative liberty concerns our right to be left alone, and not to have external constraints imposed on us by other people. This translates, in this context, into a right to refuse psychiatric treatment. Positive liberty concerns our capacity for self-governance, or self-directed activity, our ability to set goals and have some chance of meeting them, and to maintain important relationships, without being dominated by internal constraints that prevent this 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 people interfering in our lives; and it is found in human rights provisions, including, in New Zealand, the right to refuse treatment.¹⁶

There is no more important concept than negative liberty in the history of our law. It is called negative liberty because it prohibits other people interfering in our lives, and with our attempts to pursue our own ends, while purporting to say nothing about the ends we should pursue. That is for us to decide.

The great New Zealand jurist, John Salmond, endorsed this view in what is probably the most influential book on legal theory ever written in New Zealand, *Salmond's Jurisprudence*, produced 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'.¹⁷ Clearly that sphere is breached if other people force me to take medication without

¹⁴ I Kant, *Groundwork of the Metaphysics of Morals*, (M Gregor trans. and ed., 1998), Cambridge University Press, Cambridge.

¹⁵ I Berlin, *Two Concepts of Liberty* (1958), Clarendon, Oxford.

¹⁶ New Zealand Bill of Rights Act 1990, s 11.

¹⁷ A Frame, *Salmond: Southern Jurist*, (1995) Victoria University Press, Wellington.

my consent.

The concept of positive liberty may be less familiar. Berlin says this about it:¹⁸

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’:¹⁹ that is, the capacity for self-direction. Charles Taylor, the Canadian philosopher, says it is ‘the exercise of control over one’s own life’,²⁰ 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 of the right of an adult to be forced to exercise their capacities, or of a right to receive involuntary treatment. These are not the stuff of 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 were not ‘of ordinary understanding’,²¹ which might include those with a serious mental illness.

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

6. Involuntary patients’ views about negative liberty

Both concepts are also implicit in the comments made to us by patients under CTOs whom we interviewed in our research.²² We tried to

¹⁸ Supra n 15 at 16.

¹⁹ Id.

²⁰ C Taylor, ‘What’s wrong with negative liberty?’ in *The Idea of Freedom* (A Ryan ed, 1979), Oxford University Press, Oxford, at 177.

²¹ J Mill, *On Liberty* (D Spitz ed, 1975), Norton, New York, at 70.

²² See A Gibbs, J Dawson, C Ansley, R Mullen, ‘How patients in New Zealand view Community Treatment Orders’ (2005) 14 *Journal of Mental Health* 357; A Gibbs, J Dawson, R Mullen, ‘Community Treatment Orders for people with serious mental illness: a New Zealand study’ (2006) 36 *British Journal of Social Work* 1085; J Dawson, R Mullen, ‘Insight and use of community treatment orders’ (2008) 17 *Journal of Mental Health* 269.

interview an entire cohort of patients who had been under a CTO in Otago in the previous two years. More agreed to be interviewed than refused. Eventually, we interviewed 42, including eight Maori patients. Many clearly felt highly coerced by the CTO.

Coercion by the CTO: patients' views

'I have to do what they say'.

'Wham: they can put me straight back in!'

It was a 'straight-jacket'.

'Thumb-screws now on'.

I was under 'control, supervision, surveillance'.

I was 'restricted, ordered, dictated to, pressured'.

'It made me a second class citizen'.

'It was mainly negative, but it saved my life'.

'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'.

'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'.

'It put me in a category hole and a little box'.

Clearly these patients consider their right to be left alone was compromised, as one would expect. The last comment captures particularly the sense of psychological confinement that may be experienced by someone under a CTO.

The main thing that can be said *in favour* of 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 legislation following involvement in the criminal justice system, spoke passionately of their preference for life under a CTO. They measured their experiences against the prior pattern of their life.

CTO compared to forensic care or imprisonment

'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 New Zealand 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]'.

'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'.

These patients definitely found the CTO less restrictive than those other options.

7. Patients' views on positive liberty

My main argument, however, is that we should go further and listen to what patients also say about the manner in which involuntary treatment may reduce internal barriers, in their own minds, to achieving their ends. They expressed this in a number of related ways:

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'.

Many also suggested that consistent treatment had improved their mental health.

Comments on enhanced access to treatment as a means to 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 involuntary patients said that through the receipt of continuous care the burden of their illness was reduced and they achieved some degree of 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 comments go not only to matters of patient health, or patient welfare. They also go to matters of liberty – positive liberty.

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

Overall Impact of CTO

‘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’.

‘It saved my life. It got me off the streets. It helped me communicate with people’.

‘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’.

Compulsory treatment gave them positive options. In a sense, that may seem paradoxical, they were forced to be free.

8. An ethical framework for the use of CTOs

The ultimate task of mental health law, in my view, is to create a structure within which the usual right of mentally ill people to refuse treatment can be weighed against the contribution that involuntary treatment can also make to their capacity for self-regulation and their ability to engage in meaningful occupation and personal relationships of choice. In short, several concepts of liberty, or ideas about freedom, may properly be deployed in mental health law. These may be summarised as follows:

Relevant Concepts of Liberty

‘Negative’ liberty:

- the ‘right to be left alone’.

‘Positive’ liberty:

- the capacity to act, to set and meet 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 psychiatric treatment of people who pose no imminent threat of harm, those principles might look like this:

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, which distinguishes candidates for involuntary treatment from other adults, and the weighing up of both major concepts of liberty, to reach a judgment as to which should take priority in the particular case. I think we should be able to consider the whole course of a person’s illness and their likely prognosis in making that decision. New Zealand’s legal criteria for involuntary treatment can be properly read and applied in that light, and I think this is how involuntary treatment decisions are made most of the time.

This approach respects the traditions of both law and psychiatry, and that was the intention of our Parliament when it adopted a multi-disciplinary approach to the design of New Zealand’s mental health legislation, after listening to the views of patients, lawyers, the health professions, and patients’ families – all of whom should be heard.

9. The consequences for mental health law

In the end, our thoughts about liberty will affect the whole design of our mental health laws: from whether we think 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 be left alone and 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.

In that situation, is it likely that busy psychiatrists, who have some discretion as to whether they will use these powers, will make active use of an under-powered and over-regulated scheme? There are many calls on psychiatrists' time, and they may simply direct their attention elsewhere, to patients who *will* accept voluntary treatment, and who may be easier to treat, even if they are less unwell. In short, to design a CTO scheme in that legalistic way is to subvert it, because clinicians will not use it actively, and then it will not make any significant difference to the delivery of mental health care.

The great danger, 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 for 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 do not think that would promote human liberty overall. So we should not let civil mental health law wither away. We should grasp the nettle. We should enact and support reasonably flexible CTO schemes that clinicians will have the confidence to use.

10. The outcome for the dairy farmer

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 did not think his squalid living conditions were sufficient, on their own, to justify involuntary treatment because he had lived like that for years and not been seriously harmed. But they found his capacity for self-care was still seriously diminished, because, when 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 to have contact with his family. Those goals – of his – could not be met if he became unwell again, as he had, repeatedly, in the past.

Without involuntary treatment, in other words, 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 this would also place on his life. He should therefore remain on the CTO.

This is typical of the preventive approach followed in New Zealand courts and tribunals in this kind of case. I think it is justified, under the right conditions, in order to promote liberty, although I know some people disagree. It shows the distinct way in which we use mental health laws in Australia and New Zealand. It reflects a humane form of liberalism, in my view, one that is consistent with our political culture and constitutional traditions. I do not think either Immanuel Kant or John Stuart Mill would consider it a monstrous form of tyranny. And nor should we.

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