

**“Early Mental Health Intervention with Young people –  
Is the Mental Health Act a Help or a Hindrance”**

**Capital Coast District Health Board Conference**

**Mercure Hotel, Wellington**

**1.30 p.m. 22 June 2009**

**Principal Family Court Judge Peter Boshier**

**Introduction**

I am delighted to have been invited to speak to you today on the vexed question of whether the Mental Health (Compulsory Assessment and Treatment) Act 1992 is a help or a hindrance in the treatment of young people.

In my initial briefing notes, it was explained to me that you work with young people aged 13 – 25 years, who experience their first episode of psychosis. I think your primary goal is to detect young people who are in the early stages of a psychotic illness, and provide them with thorough and effective assessment and treatment. Your underlying principles include early detection and intervention, recovery approach, engagement, family/caregiver involvement, developmental focus, providing optimal interventions for psychosis and minimising secondary trauma and disability.

Unquestionably, applying these principles will be an enormous challenge for you.

Obviously, I will talk to you today from the perspective of a Family Court Judge, and I am one of the older vintage who has worked under both the 1992 Act and its predecessor. Each year, Family Court Judges undertake an enormous number of mental health hearings. For instance, last year, we considered 5,853 applications for compulsory assessment and treatment.<sup>1</sup> That amounts to 6.7% of our total workload.<sup>2</sup> Many of these applications involved young people that you are concerned with.

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<sup>1</sup> Statistics provided by the Ministry of Justice.

<sup>2</sup> Statistics provided by the Ministry of Justice.

And it is not just the Family Court which is concerned with young people who present with mental health and behavioural issues. There is a select group of young people who offend, who appear in the Youth Court and have an often complex interface of intellectual, behavioural and mental health issues. For both you, and the justice system, it is well worth our time discussing how we deal with these young and often vulnerable members of our society.

Mental illness is not just something that happens to adults; statistics worldwide have indicated that in any one year approximately 10 percent of children and adolescents will exhibit signs of psychiatric disorder, of whom one percent will be in urgent need.<sup>3</sup> In a recent New Zealand Mental Health Survey the median age of onset for anxiety disorders was 13 years and 18 years for substance abuse disorders.<sup>4</sup> Mental illness clearly affects all ages. Many of the mental health disorders experienced by children and young people can be managed by primary services and supportive social systems, and do not need the intervention of specialist mental health services.<sup>5</sup> But where they do, and compulsory care is necessary, this can be provided under the Mental Health (Compulsory Assessment and Treatment) Act 1992 ('the Act').

As a general rule, the Act provides a young person with the same guarantees and protections as an adult but, recognising the particular vulnerability of children, has built in extra safeguards to ensure their rights are protected to the greatest degree possible, particularly with regards to consent.

But is this helpful? Is compulsory care actually beneficial for a young person with mental illness? Can all young people who need to access help, obtain assistance? Does the Act provide a help or a hindrance when dealing with young people with mental health disorders? This paper will attempt to examine these issues from a judicial perspective.

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<sup>3</sup> Sylvia A Bell and Warren J Brookbanks, *Mental Health Law in New Zealand* (New Zealand: Brooker's Ltd, 1998), 223.

<sup>4</sup> Mark A Oakley Brown and others, "Lifetime prevalence and projected lifetime risk of DSM-IV disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey." *Australian and New Zealand Journal of Psychiatry*, 40 (2006) : 865-874

<sup>5</sup> Ministry of Health, *New Futures A strategic framework for specialist mental health services for children and young people in New Zealand*, (New Zealand: Ministry of Health, 1998), 9.

## **How the Act is a help to young people**

When either children or young people are suffering neurosis or psychosis disorders, and are in need of compulsory care, the Act provides a very comprehensive means of addressing their health either pursuant to a community treatment order or an inpatient order. Even when criminal offending is involved, the Act works well to address rehabilitation and protect the community whilst taking into account some of the unique needs of children and young people in Part 8.<sup>6</sup> There is now good evidence that early intervention for major psychotic illnesses in adolescence is much more effective than letting the illness grumble on, and where this can only be achieved through compulsory care the Act can be of assistance.

### *Assessment and Treatment Provisions*

The assessment and treatment provisions of the Act apply irrespective of the patient's age, and a number of extra requirements are imposed in Part 8 of the Act in recognition of the additional vulnerability of children and young people. In terms of the assessment procedure "wherever practicable" the assessment examination of a young person should be carried out by a psychiatrist with expertise in child psychiatry.<sup>7</sup>

This requirement is intended to prevent the misdiagnosis of young people who may simply be challenging adolescents rather than mentally disordered, that is, suffering from the "abnormal state of mind" that is adolescence. Whilst it may not always achieve its purpose since it is based on the assumption that there are an adequate number of practitioners specialising in child psychiatry to meet demands,<sup>8</sup> this is not a failing of the Act, rather of our ability to resource it.

The Act makes a strident effort to involve family, but as I indicate a little later, I doubt that the provisions go far enough.

Once a preliminary assessment has been undertaken, if a medical practitioner considers that there are reasonable grounds for believing that the patient is mentally disordered and that further assessment and treatment is desirable, a copy of the

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<sup>6</sup> Of the Act.

<sup>7</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s.86.

<sup>8</sup> Sylvia A Bell and Warren J Brookbanks, *Mental Health Law in New Zealand* (New Zealand: Brooker's Ltd, 1998), 225.

certificate and statement of the recipients' rights must be given to the patient's principal caregiver.<sup>9</sup> Similar provisions apply to s.12 and s.14 in the subsequent procedure when we undertake either a review of the patient's condition pursuant to s.16, or an examination pursuant to s.18.<sup>10</sup> The patient's principal caregiver is entitled to be present throughout the hearing except as the Judge may otherwise order,<sup>11</sup> and s.20(3) of the Act entitles a patient's principal caregiver to be heard by the court when an application for a compulsory treatment order is being heard. These are but examples of the extent to which the Act seeks to involve principal caregivers. s.29(6), s.35(2) and s.37 of the Act are further examples of the continuing involvement and of course, there are other examples as well.

s.2 of the Act defines the principal caregiver as:

"In relation to any patient ... the friend of the patient or the member of the patient's family group or whanau who is most evidently and directly concerned with the oversight of the patient's welfare".

I doubt that one can criticise the intention of the legislation to involve families of mentally ill young people. In probability, the Act could and should go further in ensuring that there is wider support.

### *Consent Provisions*

The Act also operates to assist young people with mental health disorders through s.87 which states:

"Notwithstanding anything in s36 of the Care of Children Act 2004 or any other enactment or rule of law to the contrary, in respect of a patient who has attained the age of 16 years, the consent of a parent or guardian to any assessment or treatment for mental disorder shall not be sufficient consent for the purposes of the Act."

This allows a young person over the age of 16 years to have a voice in their treatment in the same way that an adult would. Consequently, a young person who is a proposed patient or patient may refuse consent to any form of treatment for a mental disorder except when undergoing assessment pursuant to section 11 or

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<sup>9</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s.10(4)(a)(iv) and s.10(4)(b).

<sup>10</sup> All references to sections in this sentence refer to the Mental Health (Compulsory Assessment and Treatment) Act 1992.

<sup>11</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s.19(6).

section 13 or during the first month of the currency of a compulsory treatment order.<sup>12</sup> In such circumstances they are entitled to a 'second opinion' on the treatment from an independent psychiatrist appointed for that purpose by the Mental Health Review Tribunal, as if they were of full age.

By giving young people the ability to consent, situations involving the 'informal' admission of young people by the substituted consent of their parents and guardians are avoided. It gives those who might not otherwise have a voice a voice, thereby affording young people the best possible balance between protection and liberty.

Whilst s.87 does not address the issue of consent where a patient is under 16, at common law a child under 16 can consent to medical treatment if they have sufficient intelligence and understanding. As a general principle, a parent's right to decide whether a child under 16 will have medical treatment ends when the child is able to understand what is involved. This will be a question of fact. Until the child is considered to have capacity, the parental right to decide continues unless there are exceptional circumstances such as parental neglect, abandonment or emergency.<sup>13</sup> Again this provides the appropriate balance between protection and liberty for a young person. The Act and the law in general are cognisant of the importance of offering a young person a voice and s.87 is particularly helpful in providing this.

So, let me sum up where we are at so far as the strong points of the Act are concerned. Firstly, it enables early intervention to occur and requires it, when there is evidence of mental disorder. In times where health resources become stretched, these directive aspects of legislation are important for they require the State to act, and to perform. Secondly, there is a recognition of the rights of young vulnerable patients and of the need for consent to be obtained, where treatment is ongoing. Thirdly, the Act recognises the need to advise those closest to young patients, with a degree of precision, as to what the perceived nature of the mental illness is and what the proposed treatment is.

But, there can be problems in how we go about the process.

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<sup>12</sup> Or when treatment is urgent in accordance with Mental Health (Compulsory Assessment and Treatment) Act 1992, s.62.

<sup>13</sup> Brooker's Ltd, "Brookers Family Law Commentary to the Mental Health (Compulsory Assessment and Treatment) Act, s.87", <http://www.brookersonline.co.nz/databases/modus/lawpart/statutes/ACT-NZL-PUB-Y.1992-46~BDY~PT.8~S.87?sid=edosc0e00r6d0et0j3jah7hdeqxc4q7&hli=0&sp=statutes&si=57359> (accessed June 17, 2009).

## **How the Act can be a hindrance to young people**

### *The iatrogenic effect of compulsory care for adolescents*

Ultimately the Act does not provide any actual treatment which is not available elsewhere. All the Act does is provide legal authority for the compulsory nature of the treatment. Unfortunately though, the negative consequences of compelling treatment can be greater than the positive benefits that can be derived from the provision of the treatment.

Much has been made of the potential iatrogenic effects of compulsory care on a young person that results from the exercise of an adult versus young person power dynamic. Any application by an adult for the compulsory care of a young person which is to be decided in front of a Judge (who is necessarily an adult) carries with it hints of paternalism, something which most adolescents, especially those who are feeling out of control and vulnerable resent.

This means that if an application is made for a young person with a mental disorder, they then need to cope not only with the disorder, but also the perceived stigma of being a patient under the Act and the paternalistic overtones which accompany the making of that order.

When they are then compelled to receive treatment the power struggle that they are going to have with adults as they go through their adolescent phase is going to be much more focused and more difficult than that experienced by their peers who do not have to also learn how to cope with an illness. This can mean that young people who are depressed are even more catatonic and those who are volatile are even more intense. When we look at the effect of an illness on a child or young person therefore, I would suggest we not only have to look at the primary complications that occur as a direct consequence of the illness, but also at the secondary complications that may occur as a result of committing a young person to compulsory care.

It is absolutely vital that consideration is given to this not only by the Judge when hearing the application, but by the applicant when considering whether the filing of an application is actually in the best interests of the young person. If it is not, utilising the compulsory provisions of the Act may well prove to be a hindrance rather than a help in the long run.

It may be helpful to set out how it is that mental health hearings are conducted by Judges. In almost all cases, we travel to mental health facilities and conduct examinations and hearings in hospitals or community centres. This is in direct contrast to the balance of our court work where, for instance, in the criminal justice system, we require everyone else to come to us.

The Act has been at pains to endeavour to make the process as user friendly as possible. For instance, s.16(3), which applies upon reviews, and which is identical to s.18(3), which applies to examinations, provides that:

“(3) Before examining the patient, the Judge shall, (wherever and so far as practicable) –

- a. Identify himself or herself to the patient; and
- b. Explain to the patient the purpose of the visit; and
- c. Discuss with the patient the patient’s situation, the proposed course of assessment and treatment, and the patient’s views on these matters.”

All mental health hearings are conducted in an essentially inquisitorial fashion. But of course the fact is we are Judges, and the setting is formal. The power imbalance is demonstrable. Irrespective of the attempt at making the environment less formal, and in ensuring that the Judge first explains the process, it must, on any view of the matter, be daunting for a young vulnerable patient to be placed in this position.

### *Behavioural Disorders*

Whilst the use of compulsory care *per se* has to be considered in terms of whether the positive benefits that can be achieved through compulsory care outweigh the negative iatrogenic effects of that care for those with neurosis or psychosis disorders, the Act seems to be a great hindrance for those young people suffering from solely behavioural disorders.

s.4 is one of the most important sections of the Act for it limits circumstances in which the Act can be invoked. It provides that its procedures shall not be invoked in respect of any person by reason only of:

- a. That person’s political, religious or cultural beliefs; or
- b. That person’s sexual preferences; or
- c. That person’s criminal or delinquent behaviour; or
- d. Substance abuse; or
- e. Intellectual disability.

This in turn is reflected in the District Health Board National Service Specification Framework (2008) for Mental Health and Alcohol and other Drugs Specialist services which states that “Vote: Health” funding does not cover services for people whose needs are solely due to:

- Sexual abuse;
- Violence and anger;
- Intellectual disability (including post-head injury);
- Learning difficulties;
- Criminal activities (anti-social behaviours);
- Conduct disorder; or
- Nicotine addition.

I acknowledge that members of the health profession have some reservations about accepting behavioural disorders as mental illness due to the aetiology and diagnosis of such disorders. Those with behavioural disorders might be viewed as “bad” as their antisocial or maladaptive behaviour is the result of unusual personality traits rather than mental disturbance or malfunction.<sup>14</sup> Whilst I certainly would not attempt to suggest that I have a better understanding of the nature of mental illness than you, I would suggest that a broader interpretation of the legal term “mental disorder”, such that behavioural disorders were included, may be beneficial.

This is not such a radical thought. Indeed in the original draft of the Mental Health Bill (before it became the Mental Health (Compulsory Assessment and Treatment) Act 1992) a definition of mental disorder was included which would have applied to people under the age of 17. It would have considered the young person to be mentally disordered if their behaviour indicated:

An abnormal state of mind characterised by delusions or by disorders of mood or perception or volition or cognition or by disturbance of conduct or behaviour of such a degree that it poses a serious danger to the health or safety of that person or others; or the mental or emotional development of that person. (Emphasis added).

The need for this extra limb to the definition of mental disorder was explained by the fact that acute mental illness in young people does not manifest itself in the same

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<sup>14</sup> Sylvia Bell, “Defining Mental Disorder,” in *Psychiatry and the Law: Clinical and Legal Issues*, ed. Warren Brookbanks and others (New Zealand: Brooker’s Ltd, 1996), 82.

way as it does in adults. Young people are less likely to verbalise and more prone to act out any delusions.<sup>15</sup>

Those in favour of an extended explicit definition dispelled counter arguments by saying that the Act would not be misused by way of social control<sup>16</sup> since the exclusions in clause 4 of the Bill (later s.4 of the Act) did not allow the assessment and treatment provisions to be invoked by reason of any of the criteria listed in that section, if one of them was the sole presenting factor.

As we now know, the proposed extended definition was not included within the legislation. The emphasis on disturbed behaviour raised concerns at the time that the law might be used as a means of social control. But it gives us an insight into what the legislators were thinking at the time. Perhaps it is not too far a stretch to say there was the view that, particularly in adolescents, there is a need to create a responsible avenue within the Act for compulsory care of those who have an extreme disturbance of conduct or behaviour.

As it is, the definition within the Mental Health Bill was not included. With the current funding it therefore becomes extremely hard (and expensive) for young people to gain access to “behavioural” therapy. Debate in New Zealand, and internationally, has often focused on the split in responsibility for the care (or treatment) of such children and young people. Many children and young people with serious behavioural problems will be managed appropriately outside specialist mental health services with consultation/liaison as necessary. But there are times, where more intensive care may be necessary,<sup>17</sup> and in a very few cases the use of the Act might be beneficial.

### **Overlaps in Intervention**

I have spent a good deal of time on definitions and I have done so deliberately because for the unsuspecting, treatment of young people can be fraught. Potentially, there are three Acts which must always be borne in mind when a young person is so mentally affected that intervention seems required, and those Acts are:

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<sup>15</sup> Sylvia A Bell and Warren J Brookbanks, *Mental Health Law in New Zealand* (New Zealand: Brooker’s Ltd, 1998), 224.

<sup>16</sup> Ibid.

<sup>17</sup> Ministry of Health, *New Futures A strategic framework for specialist mental health services for children and young people in New Zealand*, (New Zealand: Ministry of Health , 1998), 29.

- i. The Mental Health (Compulsory Assessment and Treatment) Act 1992
- ii. The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- iii. The Children Young Persons & Their Families Act 1989

For young people who offend, and they may either be in the Youth Court if they are aged between 14 and 17, or the District Court if they are older; the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 may apply if there is an intellectual disability. However, in my experience, if mental health services are excluded because of the definition contained in s.4 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, available facilities for the treatment of young intellectually disabled people are few.

The same is so for young people who are in need of care or protection because, for instance, they have severe conduct disorders. Unless mental health services can be engaged, the Department of Child Youth and Family services sometimes struggles to cope with the challenge of such disturbed young people.

Fortunately, the Ministries of Social Development and Health have recognised that these are fundamentally important issues to grapple with and Chief Executives are currently working on protocols to make treatment easier. But up until now, it has been a nightmare for Family and Youth Court Judges to find appropriate intervention and treatment options for young people who present with complex needs. The strict definitions in the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 have not necessarily helped young people who are in need of state assistance.

## **Conclusion**

So what can we conclude? Is the Act a help or a hindrance? I believe the answer is it is both. The Act is a robust and helpful piece of legislation for the very few children and young people that come within its jurisdiction. If a young person with a psychosis or neurosis disorder is in need of compulsory care, the Act is a help. It provides, where practicable, for the involvement of a psychiatrist practising in the field of child psychiatry in the assessment examination<sup>18</sup> and in any review tribunal.<sup>19</sup>

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<sup>18</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s.86.

<sup>19</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s.89.

Whilst the Act would have been more helpful if it had required this in every instance, in its current form it is still helpful.

It also recognises the importance of providing young people with a voice in the procedure through the provisions pertaining to consent. In doing so it finds the right balance between protection and liberty.

However, there are elements of the Act, which mean for some, it is more of a hindrance. Iatrogenic effects from the imposition of compulsory care by adult figures on a mentally ill young person can do more harm than good. This always needs to be borne in mind. We also need to consider whether the exclusion of behaviour disorders (in particular conduct disorder) is really meeting the needs of the young person. If a definition is too narrow people who need treatment may be excluded, while a definition that is too broad can result in the in appropriate detention of people who are unlikely to benefit from treatment.<sup>20</sup>

My final comment is this. I have referred to the requirement to notify principal caregivers when young people are undergoing assessment and treatment. But I have to say that actual involvement of families and wider families has at times, been disappointing. I have wondered, whether the family group conference model, so successfully employed by the Children Young Persons & Their Families Act 1989, could not be better used in mental health treatment. There are occasions when, as a Judge sitting in hearings, I would have loved to have had parents and wider family present and involved. In cases involving Maori, the overriding principles of whanau and whanaunatanga might have enabled a wider and more holistic approach to be taken.

Fortunately, mental health services benefit from wonderful people like you. Inevitably, you go the second mile in doing your utmost to support and encourage young people who have mental health problems. However, systemically, we must continue to strive to make our approach even more user friendly, easier to access and to draw on family and community resource, for it is there, that ultimately, the best chance for recovery may lie.

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<sup>20</sup> Sylvia Bell, "Defining Mental Disorder," in *Psychiatry and the Law*, ed. Warren Brookbanks and Dr Alexander Simpson (New Zealand, LexisNexis NZ Limited, 2007), 41.