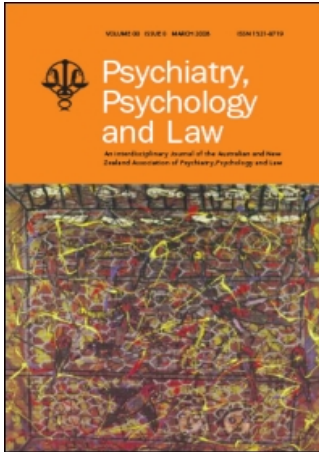


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Judging Nursing Practice: Implications of Habeas Corpus Rulings for Mental Health Nurses in New Zealand

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The *Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ)* introduced a number of statutory roles now undertaken by mental health nurses. One of these roles is that of Duly Authorized Officer (DAO). The DAO is responsible for the procedural requirements necessary to facilitate compulsory assessment. Under section 9(2)(d) the DAO is required to ensure that the purpose of the assessment and the requirements of the notice of assessment are explained to the proposed patient in the presence of a member of the proposed patient's family, or a caregiver or other person concerned with the welfare of the proposed patient. Three recent court decisions under the *Habeas Corpus Act 2001 (NZ)* have challenged existing DAO practices in arranging the presence of a third party. This article outlines these cases and discusses their implications for nursing practice in the role of DAO. Further research focused on unravelling the complexities associated with the DAO role is suggested.

Key words: compulsory treatment, habeas corpus, mental health law, mental health nursing, statutory roles.

In 1992 the *Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ)* (MH(CAT) Act) became law in New Zealand, replacing the *Mental Health Act 1969 (NZ)*. The intent of the MH(CAT) Act was to "redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric

assessment and treatment, to define the rights of such persons and to provide better protection for those rights, and generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder" (*Mental Health (Compulsory Assessment and Treatment) Act, 1992, p. 3*). The intent

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of the MH(CAT) Act is to balance the interests of a person suffering from mental disorder with the interests of the wider society, while at the same time ensuring adequate checks and balances are in place that protect individual civil liberties (Ministry of Health, 2000a, p. 6).

The MH(CAT) Act also signalled a general move away from reliance on medical authority in decision-making concerning compulsory assessment and treatment. Correspondingly there are a number of statutory roles undertaken by other health professionals. One such role is that of the Duly Authorized Officer (DAO). The DAO role is usually undertaken by mental health nurses and involves being the public face of the legislation. Nurses practising as DAOs provide general information, advice and practical assistance as to how the MH(CAT) Act operates, information about the services available and also assist in transporting patients to where assessments are to take place (Ministry of Health, 2000a). DAOs are responsible for maintaining the procedural requirements necessary to bring about a preliminary assessment by a medical practitioner; these are discussed below. Most nurses acting as DAOs are employed in multidisciplinary community mental health teams where the DAO role is an occasional component of their clinical work.

The MH(CAT) Act outlines several procedures for assessment and review that must be upheld before a compulsory treatment order can be made. Under section 8A of the MH(CAT) Act, the committal process is commenced by an application made to the Director of Area Mental Health Services for the assessment of the person who is believed to be mentally disordered. The application must be accompanied by a medical certificate (section 8B) completed by a medical practitioner who has examined the patient within 3 days prior to the application. The medical practitioner must state on the certificate that there are reasonable grounds to believe that the person they examined is mentally disordered. At this stage the person becomes a "proposed patient". Proposed patient status ends when a medical practitioner records under section 10 of the Act that the person will or will not become a patient. Most DAO practice takes place in the context of mental health emergencies. A person should therefore, be a proposed patient only for a matter of hours, something recognized in the requirement under section 9(1) that the arrangements for an assess-

ment examination are made "forthwith". Once the application and medical certificate are received by the Director of Area Mental Health Services arrangements for assessment under section 9 of the Act can take place.

The procedural requirements of section 9 of the MH(CAT) Act are particularly important to the DAO role. Section 9 requires the DAO, acting under the authority of the Director of Area Mental Health Services, to make arrangements for the proposed patient to undergo assessment by a medical practitioner. Specifically, the DAO must nominate the person by whom the assessment examination is to be conducted; determine the time and place at which it is to be conducted; and give the proposed patient a written notice of the circumstances and details of the assessment. Under section 9(2)(d) the DAO must ensure that the purpose of the assessment examination and the requirements of the notice given are explained to the proposed patient "in the presence of a member of the proposed patient's family, or a caregiver in relation to the proposed patient or other person concerned with the welfare of the patient.

Subsequent to section 9, a medical practitioner must certify whether there are reasonable grounds for believing the person is mentally disordered. If so, the person will undergo a first period of assessment and treatment, which can last up to 5 days. The certifying medical practitioner names a responsible clinician who, at the expiration of those 5 days, reassesses the patient and may determine that a further assessment is needed. The second period of assessment and treatment can last up to 14 days. If following this period of assessment and treatment the responsible clinician is still of the opinion that the patient is not fit to be released, a compulsory treatment order application must be prepared that is then usually heard by a Family Court judge.

Three recent court decisions on applications for writs of habeas corpus highlight the importance of ensuring that the procedural requirement of section 9(2)(d) is upheld. Habeas corpus law allows detainees to challenge the validity of their detention if they feel they are being unlawfully detained. These applications for a writ of habeas corpus under the *Habeas Corpus Act 2001* focused on alleged illegal detention of complainants based on non-compliance with section 9(2)(d). The rulings challenged existing DAO practice in meeting the requirements of this section.

The following section reviews these recent cases in which the DAO's role of ensuring the procedural requirements of section 9(2)(d) has been subject to legal challenge. Although the characteristics of each case differ, the court decisions exposed the clinical and legal complexity of the statutory role of the DAO. Specifically, this article addresses how these decisions have highlighted four significant issues for DAOs: that assuming statutory roles may expose nursing practice to intense legal scrutiny; that the exact nature and purpose of the third party under section 9(2)(d) is ambiguous; that there are significant pragmatic difficulties in achieving these procedural requirements; and that the importance of the other checks and balances that follow section 9 should be emphasized. Further research focused on unravelling the clinical and legal complexity of nursing practice within the statutory role of DAOs is also suggested.

Case Law

Case 1: Keenan v The Director of Mental Health Services

In *Keenan* (*Keenan v The Director of Mental Health Services, Otago District Health Board, 2006*) an application for a writ of habeas corpus was made under the Habeas Corpus Act 2001 (NZ). In this case a nurse applied under section 8A for compulsory assessment for a person under his long-term care. Because there was an existing therapeutic relationship between the nurse and the person, the nurse accompanied the DAO to the person's residence to initiate the compulsory assessment. At the residence there was no one else available who was suitable to be considered a caregiver or a person concerned with the welfare of the proposed patient. Additionally, the proposed patient's parents were not available. The proposed patient was accompanied by the nurse and DAO to a public hospital where the notice of assessment was subsequently given. The nurse who had applied for the compulsory assessment acted as the third party, within the definition of "a person concerned with the welfare of the patient". Following presentation of the notice of assessment, the proposed patient was assessed under section 9 of the MH(CAT) Act.

The allegation of illegal detention was based on the applicant's argument that the correct procedure

was not followed in that the explanation was not given in the presence of either a family member or other person concerned with his welfare.

The judgement emphasized that it is important that the third party is independent of the clinical team facilitating the process of compulsory assessment. To achieve this degree of independence, the third party should be either a family member, or a caregiver of a voluntary or professional character, or a suitably qualified volunteer. This person's role is to listen to the explanation and to provide clarification, reassurance and support in moving toward compulsory assessment. In this case the Court found that the nurse who applied for compulsory assessment was not sufficiently independent.

Judge Fogarty concluded that although there was no deliberate breach of section 9(2)(d), there was an error of law tainting the compulsory assessment with "illegality" (para 13). Therefore, a successful writ of habeas corpus was issued with the Court allowing for a new application to proceed with the required third person present.

Case 2: Chu v District Court of Wellington and Director of Area Mental Health Services

Central to the application of a writ of habeas corpus in *Chu* (*Chu v District Court of Wellington and Director of Area Mental Health Services, 2006*) was again the irregularities in fulfilling the obligations under section 9(2)(d) of the MH(CAT) Act. The case involved a person who appeared in court on charges of burglary, theft, aggravated assault and unlawful trespass. The person was remanded in custody. On the day of his court appearance he was considered to require assessment under the MHA(CAT) Act. This was conveyed to the judge in chambers.

Following the application, the court liaison nurse saw the person in the police holding cells with police officers. The nurse presented a written notice and verbal explanation as required by section 9(2)(d). District Court procedures prohibit family members from being present in court holding cells. Therefore, no family member or caregiver was present, even though a family member was present in the court building at the time. The nurse concerned discussed what had taken place with the person's lawyer. At another location in the court building the family member was kept informed of the application for assessment.

In his determination, Judge Fogarty did not accept that the person could not have been escorted with police assistance to a locality providing a more “dignified environment” (para 15), whereby the explanation could have been given in the presence of the family member:

...it seems to me that if the mindset of the persons discharging these duties, and/or of the police, is such that the District Court business and District Court procedures and practices are more important than the therapeutic processes of the Mental Health legislation so that the latter has to bend to the former, we are in a very poor state of affairs in this country (para 10).

Consequently, the writ of habeas corpus was granted and the compulsory assessment no longer applied. The outcome of the criminal prosecution was that the person was bailed to a mental health unit to allow for steps to be undertaken to engage the person in voluntary treatment, while the conditions of bail applied.

Case 3: Sestan v Director of Area Mental Health Services

The same argument articulated in the first two cases was applied in *Sestan* (*Sestan v Waitemata District Health Board*, 2006). But this case was significantly different from the other two because the patient expressly refused to have a third party present. The application for a writ again relied on the argument that the DAO did not comply with the obligation to present the notice of assessment in the presence of an appropriate third party.

In *Sestan* it was clear that although the statutory requirement for an appropriate third party was not met, attempts were made by the nurse concerned to comply with section 9(2)(d). The nurse contacted the patient’s mother and asked if a family member would like to be present to be the third party and support the proposed patient. The mother declined on the basis that the process engendered fear in her; at times she had been afraid of her son. The nurse then asked the mother if there was anyone else the patient would like to have present. However, she could not think of anyone suitable.

The nurse then asked the proposed patient if she could contact anyone else given the family’s reluctance. He stated that he understood the family’s reluctance but also could not think of a suitable person, despite the nurse offering to ring

someone on his behalf. Furthermore, this situation occurred late at night, and the proposed patient stated that he wished to proceed forthwith without a third party present. In court, the nurse stated that she was aware of her obligations under section 9(2)(d). Nevertheless in accordance with the proposed patient’s wishes, the notice of assessment was presented without a third party present.

The Court concluded that the requirement under section 9(2)(d) of the MH(CAT) Act was not adhered to because there was no third party present at the time of the explanation (para 15). This breach related to the DAO’s role of ensuring that a third party to the explanation shall be arranged. However, in ruling that procedural irregularities did not negate the rest of the process of compulsory assessment, the Judge declined the application for the writ of habeas corpus. The irregularity was seen in relation “to the background process of assessment” (para 45) rather than the assessment itself, which was conducted appropriately. The Court acknowledged that section 66 of the MH(CAT) Act states that a person subject to the Act is entitled to medical treatment. Over-ruling the subsequent compulsory status of the person could have caused unnecessary delays in treatment.

This breach was not viewed as being “trivial” because it was stated that in the absence of the family, other options could have been explored, for example, the use of lawyers, social workers or other professional persons. But the nurse was exonerated with the judge conceding that the difficulties encountered warranted “some sympathy” (para 52). The judge accepted that if the process was not quickly progressed the person might have inflicted harm upon himself or others.

The decision was unsuccessfully appealed (*Sestan V Director of Area Mental Health Services Waitemata District Health Board*, 2006), when the Court of Appeal ruled that the facts of this case were distinguishable from *Chu* in that the DAO had attempted to comply with the statutory provisions of section 9(2)(d). The appellant’s family member would not witness and the appellant stated that despite not having a support person, he wanted to continue with the process. Although the use of a trained volunteer was suggested as an alternative support person the Court stated that it was “inappropriate” to find subsequent orders under the MH(CAT) Act automatically invalid (para 51). Further, the Court discussed issues of privacy when forcing a trained

volunteer as a support person onto a proposed patient:

If a person refuses to have a support person present, to what lengths are DAOs expected to go to comply with the requirement? Ultimately, efforts to force a support person on the proposed patient will lead to a breach of the patient's right to privacy. To bring a stranger from a list of support people into the room against the patient's will could result in the patient understanding less of the process than to allow the patient to refuse the presence of a support person (para 54).

In conclusion, the Court of Appeal held that the statutory framework allows for several checks and balances throughout the period of assessment and after the compulsory treatment order has been made. Any variances or deviations from the statutory requirements, the Court argued, should be considered within the context of the statute rather than "a blinkered focus on isolated provisions" (para 89). Additionally, non-compliance with a specific provision does not mean total invalidity of all subsequent actions.

In 2007 *Sestan* sought leave to appeal the decision of the Court of Appeal (*Sestan V The Director of Area Mental Health Services Waitemata District Health Board*, 2007). But at the time of this court sitting the appellant was no longer under the compulsory treatment and therefore, the writ of habeas corpus could not be granted. Instead the Supreme Court held that the applicant's questions would be "more appropriately addressed by way of a judicial review proceeding which counsel has indicated as the likely course" (para 2).

The Supreme Court decision in *Sestan* has been discussed recently by the New Zealand Law Commission (2007), who have been mandated by the New Zealand Ministry of Justice to review procedural aspects under the Habeas Corpus Act 2001 (NZ). Specifically citing the above cases in their discussion piece, the Commission stated:

Experience with the Act since it came into force suggests it has largely achieved its objective of providing an effective procedure for dealing with habeas corpus applications. However some practical problems have emerged including the misuse of the procedure by some applicants to obtain a priority hearing on matters that should be brought by some other procedure such as

judicial review (*New Zealand Law Commission*, 2007, p. 1).

With the New Zealand Law Commission's review of procedural aspects of the habeas corpus procedure under way, it is important that the breaches of section 9(2)(d) of the MH(CAT) Act are discussed and the role of DAOs in meeting this statutory requirement debated.

Discussion

The basis for illegal detention argued in each of the three cases outlined above was fundamentally very different. In *Keenan* the nurse who acted as third party perceived himself to be a person concerned with the welfare of the patient. But the judge held that the third party had to be independent of both the application for compulsory assessment, and the clinical team initiating the assessment process. This means that a third party cannot be a clinical "colleague" of the DAO; this does not include a nurse acting in a professional capacity. The requirement of section 9(2)(d) was not met in *Chu* because of the constraints of the environment in which the assessment was taking place. Although a potential third party was available, District Court procedures prevented a family member from entering the holding cell where the proposed patient was located. In the most complex of the cases, *Sestan*, the nurse made several attempts to access a third party with no success. The proposed patient accepted this and specifically requested to proceed with section 9(2)(d) without a third party present. The application for a writ of habeas corpus was not successful.

All three cases have highlighted the ambiguity and practical difficulties surrounding the procedural requirements of section 9(2)(d). In particular, there are four discussion points that emerge from the case law presented above. These are the legal scrutiny of statutory roles, the purpose of the third party under section 9(2)(d), the pragmatic difficulties in meeting this procedural requirement, and the role of other checks and balances provided subsequent to section 9 under the MH(CAT) Act.

Legal Scrutiny of Statutory Roles

Although very different, all three cases illustrate that legal roles, such as the DAO, are subject to

legal scrutiny in a way that clinical roles usually are not. This is clearly articulated in the New Zealand Ministry of Health guidelines for the MH(CAT) Act:

A clinician, Duly Authorized Officer (DAO), police officer, or any other person should be able to justify his or her actions in terms of the powers conferred by the Act (Ministry of Health, 2000b, p. 3).

In every case, therefore, the nurse acting as a DAO has to document and be able to justify their actions to a level that their decision can be upheld under scrutiny in court.

Under section 63 the MH(CAT) Act proposed patients are protected by the rights given under Part VI, although in practice there is little time or opportunity to access many of these rights, for example the right to consult a lawyer. For this reason nurses who work with people in crisis are expected to pay close attention to ensuring that the process — from first crisis response to compulsory assessment — is conducted fairly and impartially in accordance with the procedural requirements necessary to bring about compulsory assessment. Nurses should be guided not only by their professional ethical frameworks but also by mental health legislation and common law to ensure the fairness of the crisis process and the eventual decisions to implement compulsory assessment.

The DAO has juxtaposed roles during mental health emergencies, where the legal requirements of the DAO role have been described as conflicting with nurses' therapeutic/advocacy role (Street & Walsh, 1994). Nurses' statutory status as DAOs require them to comply with the legal requirements of this role, such as the procedural aspects of section 9(2)(d), while professional expectations require the development of therapeutic relationships based on negotiation and mutual trust.

Little is understood about the extent to which these roles are complementary or in conflict. The Street and Walsh (1994) study indicated that the loss of the advocacy role and disruption of therapeutic relationships as a result of the statutory role was a source of immense dissatisfaction for many DAOs in New Zealand. *Sestan* illustrated the tension experienced by the nurse in legitimately trying to balance the need to meet the statutory requirement to have someone present,

within a nursing ethical framework that promotes the person's decision-making right to exercise his autonomy regarding his wish to proceed "forthwith" without someone being present. There is the need to clarify the decision-making process that takes place in balancing statutory and clinical obligations.

Purpose of the Third Party

The three cases also exemplified the ambiguity surrounding the nature and purpose of the third party. The New Zealand Ministry of Health guidelines to the MH(CAT) Act suggest that in cases of ambiguity, authoritative interpretation should be settled in Court. If we take a guide from *Keenan*, Judge Fogarty held that a third party must be independent from the clinical team facilitating the process of compulsory assessment and treatment. To be independent, the third person should be either a family member, a caregiver of a voluntary or professional character from outside of the clinical team, or a suitably qualified volunteer. But there remains some ambiguity as to when a "caregiver of a voluntary or professional capacity" is independent. The nurse who acted as the third party in *Keenan* had a long-term therapeutic relationship with the proposed patient and would arguably have an interest in his welfare. To ensure fairness, however, Judge Fogarty held that by applying for compulsory assessment the nurse was inextricably part of the clinical team facilitating a coercive process where the individual may lose their liberty. The nurse could not, in this situation, be considered independent enough from the process to ensure unbiased advice and clarification of the process to the proposed patient.

In cases where no family is available, it was suggested in *Keenan* that trained volunteers, such as a member of the Salvation Army, could be used by DAOs to ensure a third party is present. This person could potentially act as a third party without the proposed patient's consent. Although this would ensure that the literal interpretation of section 9(2)(d) of the MH(CAT) Act is adhered to, it is debatable whether bringing a stranger into this stage of the committal process would enhance the safety and wellbeing of the individual or the clinical staff. In *Sestan* the Court of Appeal held that in some cases forcing a trained volunteer to act in the capacity of the third party would breach the proposed patient's right to privacy. Rather

than allowing for explanation and understanding of the process, the Court of Appeal found that the proposed patient would learn less of the process than if they were to refuse the presence of a support person.

The Ministry of Health guidelines suggest that in situations where the MH(CAT) Act “can be interpreted in two ways, literally or purposively (i.e., in a manner more consistent with its purpose), then the purposive interpretation should be preferred” (Ministry of Health, 2000b, p. 3). Taken with the decision in *Sestan*, this would suggest that in some situations having no third party present may be more appropriate than introducing a stranger as a third party.

Pragmatic difficulties with Achieving Legal Requirements

The decisions discussed above highlight a number of circumstances in which these legal requirements are pragmatically difficult to uphold. For instance, in *Sestan* section 9 (2)(d) was required late at night, when it was difficult to contact and engage with the person(s) required to act as third party. In *Chu* section 9(2)(d) was complicated by the environmental context in which the section 9(2)(d) certificate was presented. The decision highlighted the constraints on the process imposed by District Court procedures prohibiting family access to court holding cells for this purpose.

DAOs may need to initiate section 9(2)(d) in a variety of locations including a person’s home, supportive accommodation, police holding cells, emergency departments or inpatient services. Little is understood about the pathway of people through these locations or the unique difficulties they present to fulfilling the section 9(2)(d) requirements or in upholding other rights under mental health and related legislation.

People in mental health crisis present a challenge to service providers because they may be distressed, volatile and/or incoherent. Clinical presentation may be compounded by risk to self or others. In the case of section 9(2)(d) the statutory tasks of the DAO must be undertaken “forthwith” and the circumstances may provide only a small window of opportunity in which to act. This does not negate the legal requirements of the MH(CAT) Act, but may

shift the balance of interpretation from literal to purposive.

The clinical complexity of mental health emergencies may be further accentuated by the involvement of multiple interested parties with diverse motivations and conflicting interests, including family/whanau, health professionals, and the police. Cultural and/or interpreting needs can add to this clinical complexity.

The cases highlighted may be the “tip of the iceberg” in demonstrating the pragmatic difficulties involved in ensuring that rights are upheld in fraught circumstances such as mental health emergencies. Research is required to elicit these difficulties in order that the circumstances are anticipated and proactively addressed.

Other Checks and Balances under the MH(CAT) Act

The intent of the MH(CAT) Act is to balance the interests of a person suffering from mental disorder with the interests of society, while at the same time ensuring that adequate checks and balances are in place to protect individual civil liberties (Ministry of Health, 2000a, p. 6). Section 9(2)(d) is one procedural requirement of many contained within the statute that ensure that the journey to compulsory treatment is justifiable and fair. In addition to the presence of the third party, the medical practitioner conducting the assessment under section 9, and the responsible clinician are each obliged to consult with the family of the proposed patient. In addition, during the first and second periods of assessment and treatment there is a right under section 16 to seek review by a Family Court judge. Finally, an application for a compulsory treatment order application is heard by a Family Court judge. At all of these stages the patient can be released or continue with the compulsory assessment and treatment process. But it should be noted that several other procedural requirements of the MH (CAT) Act have also been identified as potentially problematic (Cull & Robinson, 2003; Farrow, McKenna, & O’Brien, 2002; Lakeman, 1998; Mason, 1994; O’Brien & Karunaharan, 1995).

The consideration of breaches specific to section 9(2)(d) in isolation from the complete statute within the context of habeas corpus law could be seen as inappropriate. Indeed, this was confirmed by the Court of Appeal decision in *Sestan* followed by the Supreme Court suggesting

that a "judicial review proceeding" which could evaluate the MH(CAT) Act provisions in their entirety may be more appropriate. Recently the New Zealand Law Commission has also suggested that some legal practitioners may be utilizing habeas corpus procedures for reasons counter to its intent.

There is a risk that nurses in their roles as DAOs are being subject to legal scrutiny under an inappropriate legal procedure that does little to clarify ambiguities surrounding interpretation of the procedural requirements of the MH(CAT) Act. It is clear from the discussion above that there is still uncertainty around the purpose of the third party; who can act as the third party; and what DAOs should do in cases in which locating a third party is unachievable. If nurses are to use case law as a guide to their practice, the judgements under the habeas corpus procedure do not achieve this.

Conclusion

The court decisions discussed in this article expose the clinical and legal complexity of nursing practice within the statutory role of DAO. Under section 9 of the MH(CAT) Act the DAO has to arrange for a formal assessment, give notification to the person of the requirement for assessment, explain the purpose and processes of assessment, ensure that a suitable support person is present and arrange if necessary to transport the person to the place of assessment. This occurs at the same time as managing the clinical complexity of the patient's presentation.

The rulings were diverse and give little direction to DAO practice. So far, apart from a guideline provided by the New Zealand College of Mental Health Nurses, there is no national guideline to direct nurses in their practice as DAOs. Some Directors of Area Mental Health Services have guidelines for practice in their individual districts but these are not consistent across the country.

Further research is required that explores the implications for mental health services of adopting a literal interpretation of the MH(CAT) Act, and the effect this has on the procedural and clinical outcomes for proposed patients. Failure to develop an understanding of these complex issues may result in the law inappropriately scrutinising clinical practice or conversely, health

professionals subverting the law in pursuing their perception of "commonsense need" in meeting the clinical imperative of patient safety (Appelbaum, 1994). Either way, the outcome might be to negate the intent of the legal requirement to assist the proposed patient to move toward compulsory assessment in a manner that is fair and just.

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