Litigating Historic Mental Health Claims

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Abstract: **This paper considers the use of procedural protections such as statutes of limitation and statutory immunities in the litigation of historic mental health claims in New Zealand. Following comparison with similar litigation in Australia and Canada, it is argued that defendants should utilise available limitation defences in historic mental health litigation and the Courts should be more willing to engage with limitation arguments at an interlocutory stage rather than waiting until the substantive hearing.**

Key Words: **mental health; litigation; statutes of limitation; historic claims.**

1. INTRODUCTION

This paper examines the litigation of historic mental health claims. These are civil or disciplinary proceedings brought more than six years, and usually more than a decade, after the event alleged. There have been massive changes in societal expectations, and clinical and legal standards for mental health care over the last 70 years. In civil litigation, statutes of limitations and other statutory immunities are intended to protect defendants from changing norms and laws. Courts also have the power to stay or strike out proceedings to prevent an abuse of process, for example if a claim is so old that it cannot be fairly defended. This paper examines the success with which defendants in New Zealand have used procedural protections in historic claims. The developing approach of the New Zealand courts is contrasted with the earlier experiences of Canada (the sterilisation cases) and Australia (the Chelmsford 'deep sleep therapy' cases). It is argued that:

Defendants, including institutional defendants such as government or church organisations, should utilise available limitation defences in historic mental health litigation. Limitation defences are not merely "technical defences".

Courts should be more willing to engage with limitation defences and statutory immunities at an interlocutory stage rather than waiting until the substantive hearing.

2. HISTORIC MENTAL HEALTH CLAIMS IN GENERAL

Broadly speaking, historic mental health claims span four main categories.

First, allegations of an act that at the time was criminal or tortious (for example, a staff member physically or sexually assaulting a patient). Second, allegations regarding a treatment or practice that was not illegal or unethical at the time but is now considered to be such, including for the reason that it is of little or no therapeutic value. For example, widespread use of electro-convulsive therapy ("ECT") or sterilisation of patients. Third, allegations regarding the standard of care given where such conditions reflected practices of that time. Such claims generally relate to the nature of institutional care (such as the conditions of the facilities, overcrowding) and behavioural management practices (such as seclusion). Fourth, claims that the treatment was negligently provided, essentially a medical negligence claim. Claims in the second and third categories are most vulnerable to the effect of the effluxion of time, but all historic mental health claims have inherent difficulties.

Currently in New Zealand, more than 240 former psychiatric patients are progressing individual civil claims against the New Zealand government relating to their treatment in state psychiatric hospitals, primarily from the 1950s-1970s. The events complained of run across all the categories of claims set out above.
In 2001 the New Zealand government settled 183 claims arising out of treatment in the children and adolescent unit of Lake Alice Hospital. The Lake Alice claimants and the current claimants are distinguishable on a number of bases. The Lake Alice settlement related to a specific unit of one institution over a short period of time. The allegations primarily concerned the use of ECT and the drug paraldehyde as punishment (instigated by one doctor) and latterly, sexual and physical assaults. The current claims span almost four decades, every state psychiatric hospital in the country and countless alleged abusers.

Of the current claims, only two have so far been substantively heard. In Knight v Crown Health Funding Agency, the trial judge found that the alleged sexual assaults by nurses in the late 1960s and early 1970s had not been proved and the defendant's Limitation Act defence was upheld. In J v Crown Health Funding Agency, the trial judge found that Mrs J had not proved her allegations of a sexual assault by nurses, assaults by identified nurses, or that ECT was used or threatened as punishment, but accepted that there had been low-level physical assaults on her by unidentified junior staff members and that she had witnessed assaults on other patients. His Honour said that he would have awarded Mrs J low-level damages as a result of the distress she suffered, but that the Limitation Act defence applied. The other claims remain to be heard.

New Zealand is not alone in dealing with the litigation of historic mental health claims, although

internationally these are not as common as historic child welfare/residential school claims. There was significant litigation in Australia from 1980 to 1997 against private practitioners involved in 'deep sleep therapy' at Chelmsford Private Hospital between 1963 and 1979. There has been litigation in Canada during the last decade against the provincial governments of Alberta and British Columbia relating to the sterilisation of mentally ill patients under provincial eugenics statutes from 1940-1972. The issues faced by all of these courts are addressed below.

3. ISSUES IN LITIGATING HISTORIC CLAIMS

The issues for a court considering a claim so long after the event are many and varied, and can be only briefly summarised here. The most obvious problem is the deterioration or destruction of evidence. Witnesses may have died or become impossible to trace; their ability to accurately recall events, perhaps up to 50 years later, also comes into question. Arguably, this is of greater detriment to the plaintiff as he or she bears the burden of proof in the proceeding. However, an institutional defendant may be put at a greater disadvantage, for amongst other things, the plaintiff will have greater recall of events they consider traumatic and will craft the claim as to the matters they recall. The actual tortfeasors may have died or may not be identifiable, which may be why the claim is brought against the institutional defendant, their employer. Where the allegation comes within the first category (acts that were criminal or tortious at the time) it is unlikely there will be any record of the event, unless a contemporaneous complaint was made. This makes it difficult for the institutional defendant to offer any defence other than a bare denial. As a result both parties are likely to rely on "similar fact" evidence to prove the likelihood (or not) of an event happening. Such evidence is of lower value to the Court than direct evidence, may increase the length of the trial and lessen the effectiveness of the Court (in that it may not be able to determine some disputes).

Second, there is the problem of changing norms and developing clinical knowledge over time, which is particularly a problem in the mental health sphere. Fifty years ago, the lack of chemical restraint methods and the institutional setting of mental health care required more forceful methods of nursing; knowledge of psychiatric illness was much more rudimentary and there were few anti-psychotic or tranquillising drugs available. Some previously used treatments (which could be painful or had negative side-effects) are now considered to be of little or no therapeutic value. Changing community attitudes to mental illness over the last 70 years are well documented as are reflected in the mental health statutes over that time. The need for informed consent

was not widely recognised until the late 1980s in New Zealand, and there were no counterparts for present-day legal instruments such as the New Zealand Bill of Rights Act 1993 and the Code of Health and Disability Services Consumers' Rights 1996.

Third, the Court faces greater difficulty in assessing the evidence in historic claims. In particular, it can be difficult for the Court to determine the motives of alleged tortfeasors (ie was the treatment given to punish or treat, did the assault occur in the course of legitimately restraining a patient). It can also be difficult to gauge the effect of the act on the plaintiff as against other events in their life (for example where the plaintiff claims damages for the impact on their earning potential), and in light of their psychiatric history.

4. PROCEDURAL PROTECTIONS

In New Zealand a defendant has two primary procedural protections to historic mental health claims. First, the limitation statute bars recovery on a personal injury claim brought more than six years after the cause of action accrued. Second, mental health legislation between 1911 and 1992 contained a statutory immunity for an act done pursuant to the legislation, unless it was done in bad faith or without reasonable care, the leave of the Court is required to file a proceeding challenging the act, and there is a six-month limitation period. The extent to which the immunity and leave provisions of the mental health legislation apply to the current litigation is under appeal.

These procedural protections have not prevented the historic claims progressing in New Zealand. Two exceptions defer commencement of the limitation period. First, for limited categories of claims, namely sexual offending, the limitation period will be extended if the plaintiff could not reasonably discover that they had a cause of action for which they could sue earlier (for example, because they were not able to link the event with the psychiatric injury suffered). Second, the limitation period will be extended if the plaintiff was under a disability that prevented him or her bringing their claim earlier.

It is sometimes argued by plaintiffs' counsel and advocates that institutional defendants such as the Crown and church organisations should not rely on the limitation defence in historic claims as this is a "technical defence". However, the limitation defence exists to protect defendants (and to a lesser degree, the Court system and public interest) from the difficulties and inefficiencies of litigating historic claims (set out above). Further, a government defendant is publicly accountable for responsible expenditure of public taxes and I argue this includes utilising available defences against legal proceedings.

In New Zealand, the defendant's limitation defence has been successful

at the substantive hearings in the mental health claims decided to date. In the first historic sterilisation claim in Canada, a limitation defence was not relied on and the plaintiff's claim succeeded. After approximately 700 other claims were filed against the Alberta provincial government, it entered into a settlement with almost 900 other claimants who had been surgically sterilised under the aegis of the former Alberta Eugenics Board. Eighteen claimants brought a similar claim against the provincial government of British Columbia regarding their sterilisation while in psychiatric hospitals between 1940 and 1968. The provincial government successfully relied on the limitation defence at trial. However, this was overturned on appeal when the British Columbia Court of Appeal held that the sterilisation was a sexual assault, taking it outside the relevant statutory limitation period. Some of the defendants in the Chelmsford litigation did not rely upon limitation defences; interlocutory decisions indicated that awards of damages were likely.

The ability of an institutional defendant to gain relief from the procedural protections has been severely compromised by the approach of the Courts to date. In practice defendants are not able to utilise these protections as other than a defence at the substantial trial. Three examples can be highlighted here.

First, the New Zealand courts have stated that limitation defences should not be determined at an interlocutory stage where this will subject the plaintiff to a "mini-trial" (for example as to when the plaintiff was able to "reasonably discover" their cause of action), holding that the Court's ultimate decision on a plaintiff's cognitive capacity must depend on a full testing of all the evidence at the substantive hearing. The plaintiff must only raise a prima facie case (for example by filing an affidavit alleging they could not reasonably discover the claim earlier) for leave under the Limitation Act or mental health immunities to be adjourned, without prejudice to the defendant's ability to rely on either defence at the substantive hearing. To strike out the claim at the interlocutory stage on either ground, the defendant must establish that the application for leave is clearly so untenable that it cannot succeed. Further, the Courts have criticised the Crown for bringing such interlocutory applications and encouraged it to consent to adjourning determination of whether the Limitation Act and immunities bar the claim until the substantive hearing. Various judges have also complimented or "rewarded" the defendant for not relying on limitation defences. For example, in the Alberta sterilisation case, the Judge considered the provincial government's decision not to rely on the available limitation defence was in the nature of an apology, and thus did not award punitive damages when the plaintiff's claim succeeded.

Second, the scope of the mental health immunity provisions is a matter of fierce

debate between plaintiffs' advocates and the Crown. As stated earlier, aspects of the immunity and leave provisions are on appeal. To date the Court has struck out pleadings where the allegations relate to treatments (ECT, seclusion etc) covered by the immunity. However, where the pleading is amended to complain that the treatment was given as punishment and is thus outside the scope of the immunity, that has been allowed to remain. No prima face evidence that it was given as 'punishment' or of malicious motives is required prior to the substantive hearing, although the plaintiff at the substantive hearing will have to establish as a matter of fact that the treatment did involve wrongful or malicious conduct. Again, in a strike out application the onus is on the applicant (the defendant) to show the impeached conduct falls outside the immunity. This significantly limits the usefulness of the leave provision as a filter on claims progressing to a substantive hearing.

Third, in the cases to date, institutional defendants have had no success in alleging that a claim is an abuse of process on the basis it is so old that it cannot be fairly defended. In J v CHFA the Crown defendant applied to strike out the proceeding on the basis it was an abuse of process because the excessive delay (the events had occurred 50 years earlier), combined with the plaintiff's failure to provide proper particulars identifying tortfeasors and when events occurred, caused it significant prejudice. The Court said that the delay and absence of records or contemporaneous documents was unfortunate but was equally prejudicial to the parties. It is difficult to imagine a claim that could be more historic. Contrast this with the approach of the Australian courts towards private defendants in the Chelmsford deep sleep therapy cases. In the 1980s and 1990s the New South Wales Supreme Court twice stayed disciplinary proceedings against practitioners. It held that, due to the 7-10 and 13-21 year periods that had elapsed between the events complained of and the laying of complaints, continuing the proceedings would be so unfairly and unjustifiably oppressive so as to constitute an abuse of process. The language used, particularly in the 1986 judgment, about the negative effect of the delay on the practitioners is not replicated when the defendant is an institution such as the Crown or a religious body.

The Court's reluctance to determine limitation and leave provisions at an interlocutory stage causes significant cost and disadvantage to the defendant. Defendants and the courts incur huge cost in proceeding to a full hearing where the limitation defence or immunity may be upheld (most of the plaintiffs in the New Zealand historic claims receive civil legal aid). Each of the mental health hearings to date has taken at least two weeks. The court system will not be able to accommodate substantive hearings for

the more than 240 claims lodged with any haste. While the plaintiff may benefit from receiving "their day in court", he or she must still overcome the defences to succeed. The parties and their witnesses face the stress of a full hearing, and the defendant has the attendant pressures to settle the proceeding prior to the hearing.

Courts should be more willing to address limitation and immunity arguments at an interlocutory stage, especially where the defendant has put forward evidence indicating that the plaintiff will face significant difficulty in overcoming these defences at the hearing. For example, prior to the date of "reasonable discoverability" alleged, or inconsistent with the disability alleged, the plaintiff may have published a book or given public interviews (often in the course of patient advocacy) about their experiences at psychiatric institutions. The Court should not shy away from having a "mini trial" on the issue of, for example, reasonable discoverability, where the hearing is likely to only involve a few witnesses, or on disability, where the hearing may primarily require expert psychiatric evidence. Further, the Court should be open to holding the proceeding to be an abuse of process. Limitation periods exist for a reason and should not be ignored simply because the defendant is an institution such as the Crown or a church organisation.

5. CONCLUSION

While there is a strong case that historic mental health claims should be aired and addressed it does not follow that the procedural protections of limitation periods and statutory mental health immunities should be abrogated. The New Zealand experience to date has shown that the limitation defences may be upheld at trial, thus where the defendant can raise a strong case that the procedural protections apply, this should be tested at an interlocutory stage through the leave application rather than the higher standard of the defendant's strike out application, and in advance of putting the parties to the expense and delay of a substantive trial.

REFERENCES

1. The general limitation period for bringing a personal injury proceeding in New Zealand is two years (or six years with leave); thus any claim brought more than six years after the event is prima facie, out of time.

2. A summary of rationales for limitation statutes is set out in Law Commission, Limitation Defences in Civil Proceedings LCR6 (1988, Wellington) para [101]-[110] (online: www.lawcom.govt.nz).

3. See McInroe v Leeks & Attorney-General CP12/94, High Court at Wanganui, 2 August 1996, Master Thomson (NZ) (refusal to strike out an initial claim relating to the unit). The Lake Alice settlement process is interesting in itself. A summary can be found in Zentveld v Minister of Health, CIV-2003-085-528, District Court at Wellington, 11 September 2006,

Judge Broadmore (NZ) and in an opinion piece by Lynley Hood, "Reliable evidence and due process" NZ Lawyer (28 October 2005) at p 5-6.

4. Knight v Crown Health Funding Agency CIV-2005-485-2678, High Court at Wellington, 16 November 2007, Gendall J at para [80]-[83] (NZ). The Crown Health Funding Agency is a government entity that holds the liabilities of government health bodies from pre-1993.

5. J v Crown Health Funding Agency CIV-2000-485-876, High Court at Wellington, 8 February 2008, Gendall J at para [594] (NZ).

6. Deep sleep therapy involved narcosis and ECT. A Royal Commission of Inquiry into Chelmsford reported in 1990 that 24 people had died from the therapy between 1963 and 1979 and others had been injured. It made serious findings against the practitioners involved. Disciplinary proceedings were twice stayed by the Courts. In the 1990s approximately 100 individuals filed civil proceedings relating to treatments at Chelmford between 1970 and 1977, see Tweedale v Herron [1997] NSWSC 168 and reference to disposal of the proceedings in Gill v Eatts & Anor [1999] NSWSC 1056 at para [22], [24] and [49].

7. The plaintiffs alleged that they were sterilised for reasons other than those permitted by the statute. See Muir v R in right of Alberta [1996] 132 DLR 695 (Alta QB); E(D) v R (2003) BCSC 1013, (CanLii) and DE v British Columbia (2005) 252 DLR (4th) 687. See text at footnotes 21-24.

8. As acknowledged by the Court in J v CHFA, 7 June 2007, Gendall J, (refusing to strike out the claim as an abuse of process on the basis of delay and the lack of particulars of the alleged assaults).

9. For example in J v CHFA, none of the plaintiffs' witnesses had witnessed the assaults alleged. The eight former patients she called in support gave evidence of their own experience at the institution. Likewise the Crown called evidence from eight former nurses and two former psychiatrists from the institution, only two of whom had been identified by the plaintiff and one of who remembered the plaintiff.

10. Accepted as a complex issue which made a trial by jury inappropriate in the Lake Alice litigation, see McInroe v Leeks & Attorney-General CA219/99, 31 May 2000 (CA) (NZ).

11. See discussion in J v CHFA (8 February 2008) at para [59]-[73].

12. See P v CHFA and Attorney-General; B v CHFA and Attorney-General CIV-2003-485-1625 & CIV-2004-485-746, High Court at Wellington, S France J at para [71] (NZ), referencing the plaintiffs' argument that the immunity provisions should be read consistently with current human rights instruments.

13. J v CHFA, 8 February 2008 at para [474].

14. There is also a statutory bar against proceedings for compensatory damages for personal injury from acts post-1974 and for some pre-1974 acts as a result of the accident compensation scheme, see Injury Prevention, Rehabilitation and Compensation Act 2001, s 317.

15. Limitation Act 1950, s 4(7).

16 Either under s 6 Mental Health Amendment Act 1935 (repealed) or s 124 Mental Health Act 1969 (repealed).

17. Broadly, the appeal is as to whether the plaintiffs require the leave of the High Court to proceed because the mental health acts in force at that time contained immunity and leave provisions, including whether the immunity covers omissions to act; any conduct done pursuant to an express

statutory duty; or voluntary or informal patients. See P v Crown Health Funding Agency; B v Crown Health Funding Agency [2007] NZCA 298 [leave to appeal granted] (CA) and High Court, S France J (19 December 2006) [the judgment appealed from].

18. Whether this exception applies to physical assaults is disputed: White v Attorney-General CIV-1999-485-85; CIV-2001-485-864, High Court at Wellington, Miller J, para [404]-[410] (NZ) (historic child welfare claim).

19. Limitation Act 1950, s 24.

20. J v CHFA , 8 May 2008, and Knight v CHFA, 16 November 2007.

21. Muir v R in right of Alberta [1996] 132 DLR 695 (Alta QB).

22. For a summary of Alberta settlements see Geoffrey Scotton, "Closing a Dark History in Alberta History" 19 The Lawyers' Weekly, 33 (14 January 2000).

23. E(D) v R (2003) BCSC 1013, (CanLii).

24. DE v British Columbia (2005) 252 DLR (4th) 687. The British Columbia statute of limitation provides that the ultimate limitation period of 30 years does not apply to sexual assaults. In 2005 the nine successful plaintiffs concluded an out-of-court settlement.

25. Tweedale v Herron [1997] NSWSC 168.

26 W v Attorney-General [1999] 2 NZLR 709 (CA) (a historic child welfare claim), applied in mental health claims eg J v CHFA, CP No 70/00, High Court at Wellington, 21 March 2000, Master Thomson (NZ); upheld on appeal by the High Court, 24 June 2001, Durie J (NZ).

27. McInroe v Leeks & Attorney-General, 2 August 1997, Master Thomson. At one stage, the High Court refused to strike out claims where the plaintiffs had failed to provide any evidence as to how the obvious limitation defences would be met (as they related to events some 30 years ago) in response to the strike out application. This was overturned on appeal but the judge exercised his discretion to not to strike out the claims and allowed the plaintiffs a further opportunity to file that information: see P v CHFA 27 January 2006, AJ Gendall at para [42]-[44] and on appeal, 19 December 2007, S France J at para [124]-[127].

28. For example, J v CHFA, 7 June 2007, Gendall J, para [33]-[34].

29. For example, See Tweedale v Herron [1997] NSWSC 168 at para [5].

30. Muir v R in right of Alberta [1996] 132 DLR 695 (Alta QB) at para [199].

31. Sections of the pleadings in J v CHFA were struck out as within the immunities ie ECT, insulin therapy and seclusion. The defendant applied to strike out portions of the amended claim, partly on the basis that that the plaintiff had repleaded the treatments previously struck out had been administered as punishment so as to circumvent the immunities. Justice Gendall said that where the particulars alleged wrongful or malicious conduct or motives they could remain: J v CHFA, 7 June 2007 at para [3], [21]-[24].

32. See P v CHFA; B v CHFA, 19 December 2007, S France J at para [95]-[97].

33. J v CHFA, 7 June 2007, HC, para [6], [25]-[28].

34. Herron v McGregor & Ors; Gill v McGregor v Ors (1986) 6 NSWLR 246 (NSWSC); Walton v Gardiner (1993) 177 CLR 378 (HCA).

35. Pursuing disciplinary proceedings after the 7-10 year delay was described as “a cruel blow” and “tantamount to persecution”, Herron v McGregor & Ors at p 257.

36. See for example the reasoning applied in favour of private defendants in Herron v McGregor & Ors at p 256-257.