

Mental health law profiles

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Australia and the USA, two high-income countries within the increasingly divergent Anglo-Saxon tradition, provide the focus of this issue's thoughtful and stylistically diverse mental health law profiles. An emerging question in this series is whether law primarily aimed at protecting the civil liberties of people with a mental disorder may have reached its high point. With the economic crisis, the continuing influence of neo-liberal economics, the global retreat of the welfare state and the rise in the numbers of older people, neglect rather than coercion may be the more pressing issue. Kirkby and Henderson suggest that, in Australia, more emphasis should

be put on ensuring access to good-quality, evidence-based treatment, and this position seems to be echoed to some extent in the USA, according to Vitacco and Degroot. The latter authors write in favour of community treatment orders, while the former refer to evidence seriously questioning their effectiveness or superiority in terms of service use, social functioning and quality of life. An interesting issue raised in the Kirkby and Henderson review is the increasing contribution of private/independent practitioners in the provision of compulsory mental healthcare and this, in Australia at least, appears to be related to the greater use of community treatment orders.

Australia's mental health legislation

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Australia has a generally progressive approach to mental health law, reflective of international trends in human rights. Responsibility for most legislation is vested in the six States and two Territories, a total of eight jurisdictions, such that at any given time several new mental health acts are in preparation. In addition there is a model mental health act that promotes common standards. Transfer of orders between jurisdictions relies on Memoranda of Understanding between them, and is patchy. State and Territory legislation is generally cognisant of international treaty obligations, which are themselves the preserve of the Federal Parliament and legislature. UK legislation has had a key influence in Australia, the 1959 Mental Health Act in particular, with its strong emphasis on voluntary hospitalisation, prefacing deinstitutionalisation.

Since 1959 the key developments in Australian mental health legislation have concerned the review processes by tribunals, with some jurisdictions taking a more legalistic approach, such as legal representation at all tribunal hearings, while others make this optional, at the discretion and expense of the patient. With the shift to community care, community treatment orders have been introduced, reflecting the most common and preferred locus of long-term care. Guardianship acts are commonly invoked, for example for

the management of financial affairs and typically run in parallel with mental health acts (MHAs). Dementia-related aged care is also supported by guardianship acts. Criminal justice and mental impairment acts typically provide for insanity defences and admissions to forensic secure mental health units.

A development of particular interest in Australia is the shift of an increasing proportion of care and treatment under MHAs to private practice. Under the universal coverage of the federally funded Medicare rebate scheme, private general practitioners, private psychiatrists and, on a limited basis, private psychologists, combined, outweigh the public mental health system. Historically these groups played a minor role in the care of 'involuntary' patients but they are moving to centre stage as the emphasis on community treatment increases.

Personality disorder is rarely mentioned in Australian mental health legislation, except where solely antisocial behaviour or antisocial personality is exempted from the definition of mental illness. In principle, individuals with personality disorder(s) are judged against the same criteria for mental illness and risk of harm as others are.

Some legislation sets out standards of care, although more commonly services seek to warrant these by accreditation processes. Advance directives, decision-making capacity (including capacity to consent to treatment) and access to advocacy are three topical issues exercising the minds of policy-makers and drafting committees. These are areas

that are relevant to the whole of health and indeed beyond, not just mental health, although Australia does not have overarching legislation, such as the UK's Mental Capacity Act 2005, to refer to.

Mental health acts and compulsory treatment

There is a model mental health act that promotes common standards (National Working Group on Mental Health Policy, 1994). Typically, MHAs define mental illness in terms of abnormalities of cognition, mood or behaviour, with exemptions such as political beliefs and gender orientation. They regulate all civil involuntary admissions, based on risk to self or others and, variably, to health.

Applications and recommendations for involuntary treatment are made by doctors, but the issue has to be decided by mental health tribunals or guardianship boards, although in some jurisdictions family may provide substitute consent to treatment. Discharge from compulsory treatment orders is by treating doctors or tribunal. The principle of least restrictive care applies. Standard tribunal review periods and processes for requesting *ad hoc* reviews and appeals are explicit, and similar provisions apply to renewals of orders. 'Special treatments' are regulated, including psychosurgery and electroconvulsive therapy (ECT), the latter in terms of standards and consent, the former (seldom used) with compulsory tribunal oversight.

Services for asylum seekers

Over the past decade, controversy has surrounded the mental health problems of asylum seekers in detention centres, often in remote parts of Australia. MHAs are subordinate to the Immigration Act. Recent contracts between host states and detention providers have included specific requirements to provide mental health services and clear guidelines regarding clinical authority where individuals come under MHA orders.

Comparative research

With multiple jurisdictions, comparative studies of the outcomes of different authorisation and review processes might well be undertaken, for example regarding the different experiences of those subject to MHA orders, or mitigation of harm to self or others. However, such comparative research within Australia is conspicuous by its absence. One systematic review seeking to determine whether compulsory treatment orders bring any benefit to patients concluded that they brought no significant difference in service use, social functioning or quality of life compared with standard care (Kisely *et al*, 2011). This was based on two trials in the USA. A valuable overview of the situation in Australia and New Zealand has been provided by McSherry & Wilson (2011) in light of the Convention on the Rights of Persons with Disabilities. Gray *et al* (2010) compared Australian and Canadian legislation and found significant philosophical differences

regarding the purpose of involuntary admission. They noted that Australian MHAs have a relatively strong treatment focus.

Community scrutiny, rights of carers and access to treatment

Community scrutiny of mental health law has increased substantially. Consumerism is well developed and valued in Australia. Legislation and explanatory materials are available online. Community views are sought and typically represented at the table in reviews or development of legislation. Non-governmental organisations (NGOs) also have an important say.

Venkataraman & McSherry (2010) have examined the introduction of legislative provisions promoting the rights of carers; they noted the new Scottish system of 'named persons' and other recent provisions enabling access to information and more involvement in decision-making. Clinicians are aware of the need to reconcile the provision of evidence of impairment to a tribunal while at the same time not damaging their relationship with the patient, who is usually present at the hearing. Tribunals repeatedly insist that they be presented with explicit evidence of mental illness. As elsewhere, there seems to be no way to resolve this.

There is some interest in subsampling mental healthcare within the general law concerning consent to care or determinations of competence. MHAs have not led to improved treatment resources. Some authors believe that 'the priority for future research lies in exploring the factors which enhance treatment access and outcomes for the mentally ill rather than debating the shape or content of mental health law' (Carney, 2007).

An increasing emphasis on right to treatment and an associated widening of criteria to include prevention of deterioration of health is driving the application of MHAs to cover non-custodial community-based care, aimed at maintaining the patient's place in the community. This is in marked contrast to the historical use of MHAs to sanction compulsory admissions to asylums, removing the patient from the community.

This demonstrates that MHAs are malleable instruments, particularly when they are tuned to the voices of a range of stakeholders and are also subject to a robust parliamentary process in debating any changes to legislation. Modern communications are also playing a role, widening consultative processes, improving access to legislation and facilitating the business processes associated with statutory reviews by tribunals. Although the language of legislation retains arcane aspects, the workings of mental health laws are becoming less mysterious through greater transparency, and less authoritarian through participation and communication.

Contribution to health outcomes

Arguably, mental health law has progressed faster than our understanding of the health outcomes of its implementation. In Australia, reflecting global

trends, the rise of evidence-based clinical practice is potentially at odds with rights-based law. Medicine places primacy on outcomes, including broad concepts such as quality of life and consumer and carer satisfaction. A growing empirically based critique of mental health law may be anticipated, moving beyond 1970s concerns about 'rotting with your rights on' to questions about the relative therapeutic benefits of different legislative approaches. This would represent a hybridisation of medical and legal thinking, potentially with a common ethical foundation.

Another interesting trend is the substantial investment made in quality improvement methodologies in recent decades, most notably service and practice accreditation schemes, which are common in Australia. These provide a compelling alternative to legislative mandating of minimum standards of care in MHAs. In this model, mental health law and accreditation schemes are part of a portfolio of safeguards, rather than mere separate

entities, and the protections in a given jurisdiction would be assessed accordingly.

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Dangerousness and mental health treatment: civil commitment in the USA

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Civil commitment standards in the USA have undergone dramatic changes over the past 50 years. The relevant statutes have largely focused on treatment, but how this treatment has been administered and the placement of individuals undergoing commitment have been dynamic. There have also been changes in commitment as it relates to sexual offenders and individuals deemed not competent to proceed to trial. As legislatures strive to find a balance between mandated treatment and civil liberties, changing standards of commitment provide opportunities for scholarship and research.

Civil commitment, a mechanism for mandating treatment due to dangerousness, is one of the most contentious areas of mental health law. In the USA the contentiousness is related to the often precarious balance of protecting the civil liberties of an individual with a mental illness versus protecting society from potentially violent individuals. The government has a right under *parens patriae* to protect individuals who are unable to care for themselves or are a danger to themselves; in addition, the government has authority under

police power to protect society. When properly done, these two apparently orthogonal ideas can work harmoniously, and both the rights of the individual and the protection of society will be safeguarded. This paper reviews several issues related to the civil commitment process in the USA, including laws and due process, recent developments in civil commitment and treatment issues in civil commitment.

Civil commitment law, dangerousness and due process

Civil commitment laws have recently undergone greater scrutiny as they are viewed as a potential prophylactic to violence in the wake of mass killings at Virginia Tech University in Blacksburg, Virginia, a political event in Tucson, Arizona, and a shooting at an elementary school in Newtown, Connecticut. This was especially evident in the case of Seung-Hui Cho, who underwent a civil commitment hearing prior to the murders of 32 people at Virginia Tech. During that hearing it was decided that Cho did not meet the criteria for civil commitment because he was deemed not 'imminently dangerous' (Pfeffer, 2008). Likewise, there is evidence that Jared Lee Loughner, who killed 6 and injured 14 more in Tucson, Arizona,