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Background

In the last decade, most Mental Health Acts (MHAs) in Australia and New Zealand have been reformed and/or supplemented with detailed mandatory guidelines. The landscape of mental health law is changing quickly, and the Literature Review provides an overview of that landscape, focusing on how these changes affect the role of psychiatrists.

The Literature Review was developed under the oversight of members of the Faculty of Forensic Psychiatry, both in Australia and New Zealand, and is part of the Royal Australian and New Zealand College of Psychiatrist's (RANZCP) Mental Health Legislation Project. The Project was initiated by the RANZCP CEO following member discussions at the Branch Chairs' Forum and Members' Advisory Council, and the overall aim has been to develop a RANZCP position statement regarding the nine Australian and New Zealand MHAs. This document – Position Statement 92 'Mental health legislation and psychiatrists: putting the principles into practice' – was approved by the RANZCP Board in April 2017.

As well as informing the development of Position Statement 92, the Literature Review fills a gap in the existing publications as it compares all the MHAs in their treatment of central topics that affect psychiatrists. It creates a framework that connects the forces driving law reform with the MHAs themselves, noting where the MHAs converge and diverge, and discussing what this means in practice. This framework allows a range of controversies to be addressed, and indicates some of the future directions that law reform might take.

The Literature Review starts with principles largely sourced from international law before proceeding into specific topics. Current MHAs are generally aligned with the *UN Principles for the Protection of Persons with Mental Illness 1991*, as opposed to the more recent *Convention on the Rights of Persons with Disabilities (CRPD)*. The CRPD conceives of 'disability' as the product of interaction with social/environmental barriers, as opposed to a deficiency or deviation from the norm.

Although the CRPD Committee calls for the abolition of MHAs and forensic patient legislation, this is unlikely to occur in the foreseeable future, but the CRPD is helping to drive law reform that emphasises recovery, decision-making capacity and supported decision making. The criteria for involuntary treatment and commitment have been further narrowed and additional process elements (such as a stronger role for tribunals) have been added in order to emphasise less restrictive alternatives. The practical results of this law reform are unclear, however, as demonstrated by debates concerning Community Treatment Orders and related topics, and substantial differences between the MHAs remain, especially regarding patients with decision-making capacity who refuse treatment.

Legal tests that determine forensic patient status are discussed. Reform proposals regarding the insanity defence centre on whether it should accommodate additional conditions. With regard to unfitness to plead and stand trial, debate centres on whether the test should extend beyond cognitive factors to encompass other factors that affect decision-making. The diverse forensic patient dispositions are also surveyed.

Similarly, the power to order seclusion and restraint is increasingly regulated and subject to review, but major differences between the MHAs persist, and the CRPD Committee has called for the outright abolition of these practices. The CRPD also contains a right to health, which has implications not only for resource provision but also on the question of what duties mental health services owe to potential users. Lastly, regulated treatments (ECT and psychosurgery) are considered - including the specific provisions that apply to informed consent.

Introduction

Like the Mental Health Acts themselves, this paper starts with an overview of the principles before moving into specific topics where those principles are expressed. Each chapter begins by exploring what the Acts have in common, then moving on to the major points of divergence. Each chapter ends by discussing the practical implications of law reform for psychiatrists and some of the controversies raised in the literature. For the sake of brevity, the focus throughout is upon adult psychiatric patients; important subgroups such as children and adolescents are the subject of other RANZCP publications.

Recent Australian and New Zealand Mental Health Acts

| LEGISLATION | STATUS |
|---|-----------------------------------|
| <i>Mental Health Act 2007</i> (NSW) <i>Mental Health Act 1990</i> (NSW) | Current Repealed: 16 Nov 2007 |
| <i>Mental Health Act 2014</i> (Vic) <i>Mental Health Act 1986</i> (Vic) | Current Repealed: 1 July 2014 |
| <i>Mental Health Act 2016</i> (Qld) <i>Mental Health Act 2000</i> (Qld) | Current Repealed: 5 March 2017 |
| <i>Mental Health Act 2014</i> (WA) <i>Mental Health Act 1996</i> (WA) | Current Repealed: 30 Nov 2015 |
| <i>Mental Health Act 2013</i> (Tas) <i>Mental Health Act 1996</i> (Tas) | Current Repealed: 1 Jan 2014 |
| <i>Mental Health Act 2009</i> (SA) <i>Mental Health Act 1993</i> (SA) | Current Repealed: 11 June 2009 |
| <i>Mental Health Act 2015</i> (ACT) <i>Mental Health (Treatment and Care) Act 1994</i> (ACT) | Current Repealed: 1 April 2016 |
| <i>Mental Health and Related Services Act 1998</i> (NT) | Current |
| <i>Mental Health (Compulsory Assessment and Treatment) Act 1992</i> (NZ) | Current |

Chapter One: Mental Health Act principles

1. International law has developed rapidly in this field, shaping recent Australian and New Zealand Mental Health Acts in many ways, although the Acts continue to show striking differences from one another and none is fully compliant with international law.¹ The key international documents have been the *United Nations Principles for the Treatment of Persons with Mental Illness 1991* (the UN Principles)² and the *United Nations Convention on the Rights of Persons with Disabilities* (the CRPD) which entered into force in 2008 (and was ratified by Australia and New Zealand that year). The influence of the *personal recovery* paradigm on the Acts will also be discussed.

1.1 The UN Principles

2. The UN Principles are not binding upon states but they help to interpret the binding obligations arising from human rights treaties when applied to persons with mental illness.³ After affirming fundamental rights and freedoms – such as the right to be treated with humanity and respect – the UN Principles set out legal standards and procedures in considerable detail. These cover matters such as diagnosis, involuntary admission criteria, informed consent and the proper use of medication, as well as seclusion and restraint. According to some commentators, all Australian Mental Health Acts were consistent with the UN Principles by 2005,⁴ although the same cannot be said for the CRPD (discussed below). The UN Principles remain the most detailed global declaration of human rights in the context of mental illness.⁵
3. A key passage is found in UN Principle 9.1: ‘Every patient shall have the right to be treated in the *least restrictive environment* and with the *least restrictive or intrusive treatment* appropriate to the patient’s health needs and the need to protect the physical safety of others’. This provision not only reinforces the aim of providing care in the community,⁶ it also directs mental health professionals to only use coercive powers and substituted decision-making as a last resort. In their Objects or Principles, all Australian mental health legislation aspire to provide services in the least restrictive manner, and unclear provisions must be interpreted in the light of this principle. The New Zealand Act makes no reference to this principle but it is one of the purposes of the Act, according to the Guidelines.⁷
4. The goal is typically restated in later passages in the Acts concerning how apprehension and compulsory assessment, examination, detention and treatment are to occur. Thus, even where coercive powers are authorised, they must still be used in the least restrictive manner available. The South Australian (SA) Act draws attention to this requirement by stating that ‘services should be provided on a voluntary basis as far as possible, and otherwise in the least restrictive way and in the least restrictive environment that is consistent with their efficacy and public safety.’⁸

¹ Professor Ian Freckleton, ‘Chapter 18: Mental Health Law’ *Select Issues in Health Law* (2013) p. 703.

² *United Nations Principles for the Treatment of Persons with Mental Illness and for the Improvement of Mental Health Care* (Adopted by General Assembly Resolution 46/119 of 17 December 1991)

³ Gostin, Lawrence and Gable, Lance, ‘The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health’ *Maryland Law Review* 63 (2004), p. 24.

⁴ Mental Health Council of Australia, ‘Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia’ (2005), p.37. However, the Report goes on to state that ‘the stories related by consumers and practitioners during these consultations suggest that either the legislation is not yet consistent with the UN Mental Health Principles or that the legislation has not been effective in protecting consumers and carers against abuses.’

⁵ Kelly, Brendan D, ‘Human rights in psychiatric practice: an overview for clinicians’ *British Journal of Psychiatry* Vol 21 (2015) p. 56.

⁶ Gostin et. al., above n 3, p. 37.

⁷ Ministry of Health. 2012. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health: Introduction.

⁸ *Mental Health Act 2009* (SA) s7 (1) (b).

5. Principle 9.1 continues to grow in significance, as can be seen by its heightened profile in recent Australian Mental Health Acts. The older Victorian Act,⁹ for instance, contained only four references to the principle of least restrictive treatment and environment (in the context of the Objects, involuntary admission, community support services and official visitor functions). The new Act extends it to minimise the restriction of patient communications¹⁰ and the provision of treatment where patients do not consent.¹¹ Seclusion and restraint may now be used only where 'all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable'¹². The Victorian Chief Psychiatrist's Guidelines do not set out options, but the relevant New South Wales (NSW) Health Policy Directive lists 15¹³ and the New Zealand Standards contain additional guidance about educating staff in aggression management and de-escalation strategies.¹⁴
6. By being incorporated into the Acts at key points, the least restriction principle imposes many duties and limits upon mental health services in the exercise of their powers. However, the principle also protects them from liability when they *fail* to use their powers. The Australian High Court, in *McKenna*, considered a case where a NSW patient was discharged into the care of his friend and killed him hours later. The Court had to determine the duty of the hospital to discharge patients where care of a less restrictive kind is available. It unanimously held that this duty overrode the duty of care towards persons who may have been harmed by the patient upon release. This suggests that practitioners cannot be held liable for discharging or failing to detain a patient.
7. If it were otherwise, a reasonable doctor would sometimes detain patients until they showed no signs of mental illness at all,

'But that is not what the *Mental Health Act* required. It required the *minimum* interference with the liberty of a mentally ill person. It required that the person be released from detention unless the medical superintendent of the hospital formed the opinion that no other care of a less restrictive kind was appropriate and reasonably available... Those provisions are inconsistent with finding the common law duty of care alleged by the relatives.'¹⁵

8. In comparable circumstances, however, psychiatrists in New Zealand may be committing a crime. Three recent amendments to the *Crimes Act 1961* – at sections 151, 195 and 195A – raise this possibility. Section 195, for example, may apply when staff at a hospital with a duty to detain a 'child or vulnerable adult' fail to do so, if the failure is 'a major departure from the standard of care to be expected of a reasonable person', and the patient then experiences 'suffering, injury [or] adverse effects to health' as a result. These issues have not yet been tested in New Zealand courts.
9. As mentioned, the New Zealand Act makes no obvious reference to the UN Principles, but it was designed to comply with them and for the most part it does.¹⁶ Several other instruments bear upon the interpretation of the Act, adding to the safeguards for protecting human rights. The Second Reading Speech, for example, stresses that Community

⁹ *Mental Health Act 1986* (Vic).

¹⁰ *Mental Health Act 2014* (Vic) s16 (3).

¹¹ *Ibid*: s71. This is further discussed below, in Chapter 3.2.

¹² *Ibid*: s105.

¹³ NSW Health *Policy Directive 2012_035*, p.8.

¹⁴ Ministry of Health, *New Zealand Standard 8134.2.2:2008*, p.10.

¹⁵ *Hunter and New England Local Health District v McKenna; Hunter and New England Local Health District v Simon* (2014) at 31 and 33. The *Mental Health Act 1990* (NSW) was the Act in question, in particular s20: 'A person must not be admitted to, or detained in or continue to be detained in, a hospital under this Part unless the medical superintendent is of the opinion that no other care of a less restrictive kind is appropriate and reasonably available to the person.' The Act has since been repealed, but the relevant provisions are replicated throughout the 2007 Act, eg: s12 (1) (b) and s68 (a) and (f).

¹⁶ Human Rights Commission (New Zealand), 'Human Rights in New Zealand' (2010) p. 367.

Treatment Orders will promote treatment in the *least restrictive environment*.¹⁷ The Guidelines to the Act noted earlier (and the supplementary Guidelines) are very detailed, and seek to incorporate elements of the UN Principles, the New Zealand Bill of Rights and the Code of Health and Disability Services Consumer Rights into everyday practice.¹⁸ Notably, psychiatrists providing second opinions on compulsory treatment must consider whether it is the least restrictive alternative and whether it is justified in regard to the Bill of Rights and the Code of Rights.¹⁹ The relationship between these legal instruments is explored further in later chapters.

1.2 The CRPD

10. The CRPD does not claim to create new rights; instead it represents a development of existing human rights law as found in the UN Declaration of Human Rights and related documents.²⁰ Non-government organisations and consumer and community representatives were strongly involved in lobbying during the creation of the CRPD, and the final product 'embraces the aim of making persons with disabilities visible as different, but equal, members of society. In order to facilitate this change, it clarifies and amplifies in unprecedented detail what human rights mean in the context of disability'.²¹ All commentators agree that it has major significance; the CRPD is said to require reshaping of societies in a way required by no other human rights treaty.²²
11. Treaties normally list previous international agreements covering the same subject matter. The CRPD, however, does not include the UN Principles on this list. This indicates that the CRPD is grounded in a radically different philosophy, aiming to change the fundamental role of mental health laws.²³ According to Rosemary Kayess, the CRPD is based on a *social* model, which holds that disability results from interaction between an impairment and social/environmental barriers; the *medical* model of disability underlying the UN Principles, which views disability as a deficiency or deviation from the norm, is largely rejected.²⁴ Instead of facilitating decisions by the clinician in the best interests of the patient, the overriding aim of the CRPD is to foster the autonomy and independence of the patient, including their freedom to make their own choices and be actively involved in decisions that concern them, and to enable family members and others to provide support.²⁵
12. Current Acts in Australia and New Zealand are shaped by both the CRPD and the UN Principles, with the latter playing a far larger role. The language of the CRPD has not been directly incorporated into Australian and New Zealand Acts,²⁶ but the philosophy finds some expression in the growing commitment to recovery-focused care (the next section explores this point in more detail).
13. Unlike the UN Principles, the CRPD is binding upon states, but under the Australian and New Zealand legal systems, its articles do not become part of domestic law until they are

¹⁷ O'Regan, Katherine, 'Mental Health (Compulsory Assessment and Treatment) Bill: Second Reading', *New Zealand Hansard* (March 12 1992).

¹⁸ *New Zealand Bill of Rights Act 1990* (NZ) and the *Health and Disability Commissioner (Code of Health and Disability Services Consumer Rights) Regulations 1996* (NZ).

¹⁹ *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act*, above n 5, 10.2.2.

²⁰ Weller, Penny, 'Developing Law and Ethics: The Convention on the Rights of persons with Disabilities' *Alternative Law Journal* 35 (1) (2010), p. 8.

²¹ Kampf, Annegret, 'Involuntary Treatment Decisions', in McSherry, Bernadette and Weller, Penny (eds) *Rethinking Rights-Based Mental Health Laws* (2010), p. 133.

²² Lawson, A, 'The United Nations Convention on the Rights of persons with Disabilities: New Era or False Dawn?' (2007) *Syracuse Journal of International Law and Commerce* 563 at 597.

²³ Kayess, Rosemary [external expert on the Australian Government delegation to the CRPD negotiations], 'Deconstructing the CRPD', *Speech to the Melbourne Social Equity Institute 2nd Biennial Conference* (4 February 2016).

²⁴ Kayess, Rosemary; French, Phillip, 'Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) *Human Rights Law Review* Vol 8.1, p. 5.

²⁵ CRPD, Preamble.

²⁶ Although it has influenced the Objects of the *Mental Health Act 2015* (ACT): Explanatory Memorandum, *Mental Health Bill 2015* (ACT) para 2.15.

specifically incorporated into Acts of Parliament.²⁷ The CRPD is intended to guide the development of domestic legal systems, and states parties regularly report on their progress to the UN Committee on the Rights of Persons with Disabilities - the CRPD Committee. While the UN Principles allowed substituted decision-making, involuntary commitment and treatment of mentally ill persons in their best interests, it is unclear if the CRPD does so, and this has radical implications for mental health regimes.²⁸

14. The central controversy involving the CRPD stems from Article 14 (1) (b):

States parties shall ensure that persons with disabilities, on an equal basis with others:

- a. Enjoy the right to liberty and security of person;
- b. Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that *the existence of a disability shall in no way justify a deprivation of liberty*.

This provision could mean that laws allowing involuntary treatment and commitment should be abolished. Alternatively, it could mean that the presence of disability *alone* does not justify the application of such laws to an individual, and that other factors must be present, such as threats to safety of the person or others.²⁹

15. A similar controversy exists with regard to Article 12 (2) which affirms the right of disabled persons to 'enjoy legal capacity on an equal basis with others in all walks of life.' The Article goes on to set out safeguards to ensure that decision-making capacity is exercised freely. As a whole, it can be read as demanding an end to all forms of substituted decision-making³⁰ and tests of decision-making capacity in legal contexts.³¹ Alternatively, it can be read to allow both measures, if safeguards are in place.
16. When Australia and New Zealand ratified the CRPD in 2008, the Australian government declared that it favours the latter interpretations of both articles.³² This would allow the continued operation of existing mental health law, albeit with modifications to ensure stronger protections for the human rights of patients – in particular, the rights to dignity and autonomy. No such declaration has been made by the New Zealand government.
17. In both cases, however, the CRPD Committee has favoured the former interpretations, calling for Australia to repeal all legislation allowing:

'medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders.'

The Committee also recommended that Australia abolish tests of *legal capacity* and 'take immediate steps to replace *substituted* decision-making with *supported* decision-making'³³ (these terms are discussed further in Chapter Three). Similar concerns were raised in

²⁷ *Attorney-General for Canada v Attorney-General for Ontario* [1937] AC 326, 347–348; *Kioa v West* [1985] 159 CLR 550, 570.

²⁸ Minkowitz, Tina 'Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities' in McSherry, Bernadette and Weller, Penny (eds) *Rethinking Rights-Based Mental Health Laws* (2010), pp. 151.

²⁹ McSherry, Bernadette, 'Mental Health Laws: Where to From Here?' *Monash University Law Review* (2014) p. 182-3.

³⁰ *Ibid*, p. 190.

³¹ Dawson, John, 'A realistic approach to assessing mental health laws' compliance with the CRPD', *International Journal of Law and Psychiatry* 40 (2015) 70-79

³² 'United Nations Convention on the Rights of persons with Disabilities: Australian Declaration' *United Nations Treaty Series* (vol. 2515).

³³ McSherry, Bernadette, 'Mental Health Laws: Where to From Here?' *Monash University Law Review* 40 (1) (2014) p. 184 and 190.

regard to New Zealand³⁴ and many other countries.³⁵ The Committee also issued recent Guidelines calling on states to abolish laws permitting the insanity defence and declarations of unfitness to stand trial.³⁶

18. The interpretation favoured by the Committee is authoritative – in the sense that governments must place great weight upon it – but not binding, as it can be rejected when strong counter-arguments are presented.³⁷ Critics hold that its interpretation is radical and unrealistic in its consistent elevation of patient autonomy over competing values, and its insistence that legal capacity is never lost.³⁸ Professor Freeman et al. have also argued that other human rights will be endangered if the Committee's recommendations are adopted. For example, rights to *life* and *health* will be compromised if it is impossible to administer involuntary treatment for life-threatening medical conditions and suicidal ideation. The absence of Committee members with a clinical background was held to be responsible for an approach which veers sharply away from previous intergovernmental agreements and what is currently deemed best medical practice.³⁹
19. Others have welcomed the Committee's approach, calling for mental health laws to be abolished on the grounds that they are inherently discriminatory and incompatible with contemporary human rights norms.⁴⁰ Some wish to see an end to all involuntary treatment and detention of persons with mental illness. Others wish to ground such powers purely on tests of capacity. Professor George Szmukler argues that 'only a generic law – one applicable to all individuals with a serious decision-making problem, whatever its cause – would be acceptable.'⁴¹
20. Szmukler and Dawson (among others)⁴² favour a 'fusion' model that eliminates the Mental Health Acts and transfers the power to order involuntary detention and psychiatric treatment from public officials (principally psychiatrists) to guardians. The change is promoted as a means to reduce the stigma attached to mental illness and promote earlier intervention (before the high thresholds for involuntary treatment in the Acts are met). The proposed reform is also said to promote the dignity and autonomy of the patient, as the guardian will normally be a trusted friend or family member. Proponents also point to the anomaly that persons suffering other forms of mental impairment – such as dementia or severe intellectual disability – have treatment decisions made by a guardian, while persons with severe mental illness experience a form of 'clinical guardianship' on the part of treating psychiatrists.⁴³
21. Several arguments have been levelled against the fusion model. Mental Health Acts contain coercive powers that allow for rapid intervention in emergency situations (further discussed in Chapter Two); guardianship laws currently lack these provisions, and delegating such powers to the guardian would change the character of their relationship to the patient, potentially introducing a great deal of conflict. Mental Health Acts have also developed extensive regulation of these powers, and multiple systems to monitor, review

³⁴ Committee on the Rights of Persons with Disabilities, 'Concluding Observations on the initial report of New Zealand' (3 October 2014).

³⁵ Freeman, M. C.; Kolappa, Kavitha; de Almeida, J.M.C.; Kleinman, Arthur; Makhshvili, N; Pakhati, Sifiso; Saraceno, Benedetto; Thornicroft, Graham, 'Reversing hard won victories in the name of human rights: a critique of the General Comment of Article 12 of the UN Convention on the Rights of Persons with Disabilities' *The Lancet* Vol 2, No. 9 (2015), pp. 5-6.

³⁶ Committee on the Rights of Persons with Disabilities, 'Guidelines on the Convention on the rights of Persons with Disabilities' (adopted during the Committee's 14th session, held in September 2015), para 16.

³⁷ Szmukler, George, 'UN CRPD: equal recognition before the law' *The Lancet* Vol 2, No. 11 (2015).

³⁸ Dawson, above n 31, pp. 70-79.

³⁹ Freeman et. al, above n 35, pp. 5-6.

⁴⁰ Minkowitz, Tina 'Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities' in McSherry, Bernadette and Weller, Penny (eds) *Rethinking Rights-Based Mental Health Laws* (2010) pp. 151, 167 and 170-1; Campbell, Tom, 'Mental Health Law: Institutionalised Discrimination' *Australian and New Zealand Journal of Psychiatry* 554 (1994).

⁴¹ Szmukler, above n 37.

⁴² Rosenman, Stephen, 'Mental Health Law: An Idea whose time has passed' 1994; Allen, Murray 'Why Specific Legislation for the Mentally Ill?' *Alternative Law Journal* Vol 30:0 (June 2005), 103.

⁴³ Rees, Neil 'The Fusion Proposal: A Next Step?' in McSherry, Bernadette and Weller, Penny (eds) *Rethinking Rights-Based Mental Health Laws* (2010), pp. 87-9.

and appeal their use. Again, guardianship laws would need to be greatly altered to accommodate these safeguards. Furthermore, mental illness is unlike other forms of decision-making impairment in two senses: it may be temporary (and treatable), and those experiencing severe mental illness often lack awareness of their condition. Short-term involuntary treatment ordered by a psychiatrist may alleviate their condition and give them greater autonomy in the long run, thus warranting a separate legal regime for ordering treatment.⁴⁴

22. Although there is no foreseeable prospect of mental health laws being abolished in Australia or New Zealand,⁴⁵ some fusion has already occurred.⁴⁶
23. Instead of focusing on the fusion model, Professor Bernadette McSherry advocates a greater emphasis on CRPD Article 25. This provision develops the right to the '*highest standard of physical and mental health*' – and it may help to resolve the impasse in debates between those emphasising autonomy and those emphasising the need for treatment where consent is lacking. Better resourced and targeted mental health-care would enable earlier, less drastic treatment on a voluntary basis, rendering coercive psychiatric practices far less necessary, although these practices would still play a role.⁴⁷ This issue is explored further in Chapter Six.

1.3 Recovery-oriented practice

24. A distinction can be drawn between *clinical* recovery (focused on an objective improvement in symptoms and function) and *personal* recovery, which centres on the subjective experience and personal goals of people with lived experience of mental illness. Recovery-oriented practice primarily refers to the latter dimension, and challenges services to accommodate these needs and goals. This involves treating people with lived experience as 'experts on their lives and experiences while mental health professionals are considered experts on available treatment services'.⁴⁸ As noted by the RANZCP, the concept is now 'a mainstream principle of mental health care, applicable beyond its origins as a social movement of people severely affected by mental illness'.⁴⁹
25. In the last decade, Australian Acts have started to adopt language that recognises the value of personal recovery – generally in the Principles or Objects. The new WA Act contains a Charter of Mental Health Care Principles, requiring services to 'uphold a person-centred focus... including by recognising life experiences, needs, preferences, aspirations, values and skills' and to promote 'recovery focused attitudes'.⁵⁰ The Queensland Act requires 'the importance of recovery-oriented services and the reduction of stigma' to be recognised and taken into account.⁵¹
26. Recovery was recently added to the Objects of the NSW Act,⁵² and the Principles now state that 'every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and recovery plans and to consider their views and expressed wishes' ('recovery plans' have replaced 'plans for ongoing care').⁵³ The same effort must be made to obtain consent to those plans, monitor capacity to consent and 'support people who lack that capacity to understand'.⁵⁴

⁴⁴ Ibid, pp. 90-91. Arguments for and against the fusion proposal were canvassed in greater detail during the recent review of Victorian guardianship laws: Victorian Law Reform Commission, 'Guardianship' *Final Report No. 24* (2012) Chapter 25.

⁴⁵ Rees, Neil, *ibid* p. 92.

⁴⁶ Victorian Law Reform Commission, *above n 44*, p. 532fn.

⁴⁷ McSherry, *above n 29*, pp. 196-7.

⁴⁸ Victorian Department of Health 2011, *Framework for recovery-oriented practice*, State Government of Victoria, Melbourne, p.2.

⁴⁹ Royal Australian and New Zealand College of Psychiatrists, 'Recovery and the psychiatrist' *Position Statement 86* (2016).

⁵⁰ *Mental Health Act 2014* (WA) Schedule 1 Principle 3.

⁵¹ *Mental Health Bill 2016* (Qld) s5 (k).

⁵² *Mental Health Act 2007* (NSW) s3 (a). The amendment came into force on 31 August 2015.

⁵³ *Ibid*, s68 (h). The amendment came into force on 31 August 2015.

⁵⁴ *Ibid*, s68 (h1). The amendment came into force on 31 August 2015.

27. The new Victorian Act goes furthest towards legislating the concept, frequently deploying the phrase 'recovery outcomes that the patient would like to achieve' (ensuring an emphasis on *personal* recovery). The phrase is included not only in the Principles but also in many later passages that specifically regulate coercive powers. These recovery outcomes are primary factors that psychiatrists must regard when deciding if involuntary treatment is warranted.⁵⁵
28. The Victorian Act also contains a unique provision: 'persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery *that involve a degree of risk*'.⁵⁶ This acknowledges that the recovery approach 'involves promoting people's choice, agency and self-management', and as a result, 'a degree of risk tolerance in services becomes necessary.' The inherent tension between this goal and the duty of care is acknowledged by the Victorian Department of Health.⁵⁷
29. The New Zealand Act does not appear to incorporate the concept of personal recovery. Although the Guidelines do link relapse prevention plans to helping patients 'better manage their own condition and to produce positive mental health and wellbeing outcomes', it is not clear that this language goes beyond the objectively verifiable matters encompassed by the clinical model.⁵⁸
30. In 2013, the Australian Department of Health published *A National Framework for recovery-oriented mental health services: guide for practitioners and providers*. Although brief, it links to useful resources on the topic, and attempts to clarify what the emerging principle means in practice. It acknowledges that involuntary assessment and treatment may sometimes be the least restrictive option to protect a person's health and safety, but insists that 'interventions can still be provided from a recovery orientation, recognising that self-determination is a vital part of successful treatment and recovery. An important aspect of treatment in the involuntary setting is to support the person to regain their capacity to make informed decisions.'⁵⁹
31. At later stages, when capacity is restored, broader recovery strategies can be pursued.⁶⁰ The therapeutic relationship is stressed as the key to 'reducing and removing coercion while reducing harmful risks and increasing opportunities for positive risk-taking and positive learning'. Other factors such as supported decision-making, advance directives, cultural sensitivity and peer support have a role to play in achieving these goals.⁶¹

Chapter Two: Involuntary commitment and treatment

2.1 The Commonwealth context

32. All Mental Health Acts express a tension between the contesting values of *autonomy*, and the perceived need for coercion to prevent *danger* or *harm* (to the patient or others).⁶² This latter value is normally complemented by provisions that enable coercion to ensure patients receive vital *care* – the *need for treatment* criterion. The clear trend in recent decades has been toward greater emphasis on autonomy and a corresponding erosion of the coercive powers available to psychiatrists; this is especially true for Australia and New Zealand, as will be seen.
33. The broadest comparison of recent Mental Health Acts was conducted in 2009 by the Universities of Cambridge and Derby; 32 Acts across Commonwealth countries were

⁵⁵ For example, see *Mental Health Act 2014* (Vic) ss46 (2)(a), 48 (2)(a) and 55 (2)(a).

⁵⁶ *Ibid*, s11 (d).

⁵⁷ Victorian Department of Health, above n 48, p.3.

⁵⁸ *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act*, above n 5, 10.1.

⁵⁹ Australian Department of Health, *A National Framework for recovery-oriented mental health services: guide for practitioners and providers* (Endorsed by the Australian Health Ministers' Advisory Council on 12 July 2013) Chapter 3.

⁶⁰ *Ibid*, Chapter 3.

⁶¹ *Ibid*, Chapter 6.

⁶² Fistein E.C., Holland A.J., Clare I.C.H., and Gunn M.J, 'A comparison of Mental Health Law from diverse Commonwealth jurisdictions', *International Journal of Law and Psychiatry* 32 (2009), p. 147.

compared and contrasted and an autonomy rating produced for each Act.⁶³ Drawing on guidelines developed by the World Health Organization and the Council of Europe, the rating took into account the following matters, which are a useful starting point to frame any detailed discussion of coercive powers:

Diagnosis: Does the Act explicitly require that involuntary patients suffer from *mental illness*? If so, does the Act define the term – thereby creating a threshold that must be met before involuntary status can be imposed?

Exclusion Criteria: Does the Act prevent certain characteristics from becoming grounds for involuntary treatment in their own right, since they may be irrelevant to the diagnosis? Six characteristics were listed, including drug use, religious belief and sexual preferences (Australian Acts often contain many more).

Therapeutic Aim: Does the Act allow persons to be detained purely to serve the public interest, or must the detention have a therapeutic intent to be legitimate? If the latter, is there a requirement that the treatment is likely to be effective in some way?

Risk: Are the grounds of *harm* or *care* left unqualified, meaning that persons in a very wide range of circumstances may warrant involuntary treatment? Or does a 'narrow' approach apply, where involuntary treatment must be necessary to prevent *immediate* harm to the person or others, or to prevent *serious* deterioration?

Capacity: Is there a requirement to assess a person's capacity to make decisions about their treatment? If so, can a person with capacity still lose the right to refuse treatment if their decision is deemed unreasonable by their clinician?

Review Process: Can the patient have their involuntary status reviewed by an independent body, and if so, will it happen automatically?

34. Taking these factors into account, an *autonomy score* was developed for each Act. The highest possible score would require a narrow definition of mental illness, all six exclusion criteria, a requirement that involuntary treatment is likely to alleviate the condition, a likelihood of imminent serious harm (to the person or others) or serious deterioration if it is not provided, and monthly automatic independent legal review. The average score was 15.4 (out of a possible 30). All Australian Acts with the exception of SA had scores over the average, while that of England and Wales was 12. The highest rating in the entire Commonwealth was the Northern Territory (NT), on 25, while New Zealand was 19.

2.2 Recent changes to the legislative criteria

35. Since the study was completed, Mental Health Acts in all Australian states (but not territories) have been or will soon be replaced.⁶⁴ These all provide even more safeguards for autonomy, as a brief examination of changing criteria in Victoria and Western Australia makes clear.

⁶³ Ibid, pp. 147-155.

⁶⁴ The *Mental Health Bill 2016* (Qld) was passed on 18th February 2016. The Department of Health expects it to take effect in November 2016: Queensland Health 'Implementation of the Mental Health Act 2016' <<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/act-2016/implementation/default.asp>> accessed 7 June 2016. The Act itself can also be accessed on this webpage.

36. The *Mental Health Act 1986* (Vic) required that ‘the person *appears* to be mentally ill’;⁶⁵ the equivalent provision in the *Mental Health Act 2014* (Vic) simply states ‘the person *has* mental illness’,⁶⁶ thereby requiring practitioners to have more confidence in their diagnosis.
37. The risks need to be greater too; the earlier Act required that involuntary treatment be necessary for ‘for his or her health or safety... or for the protection of members of the public’.⁶⁷ The new Act raises the threshold, requiring the probability of ‘*serious* deterioration in the person’s physical or mental health; or *serious* harm to the person or another person.’⁶⁸ This change draws on UN Principle 16, which refers to a ‘serious likelihood of immediate or imminent harm to that person or to other persons... or a serious deterioration in his or her condition’.
38. Moreover, a new qualifier has been added: ‘the immediate treatment *will* be provided’.⁶⁹ The former Act stated that the treatment *can* be obtained by subjecting the person to an involuntary treatment order. This change reinforces the therapeutic aim, but the Act does not offer guidance as to the resources or quality of care that must be provided to constitute *treatment*.⁷⁰ As will be seen in Chapter Six, this issue has implications in court and tribunal settings.
39. Changes in Western Australia have been far more profound. The old legislation – *Mental Health Act 1996* (WA) – allowed involuntary treatment:
- i. to protect the health or safety of that person or any other person; or
 - ii. to protect the person from self-inflicted harm of a kind described in subsection (2); or
 - iii. to prevent the person doing serious damage to any property.⁷¹

Subsection (2) includes harms that have no equivalent in other Australian Mental Health Acts: ‘serious financial harm’ or ‘lasting or irreparable harm’ to relationships, or ‘serious damage to the reputation of the person’.⁷²

The *Mental Health Act 2014* (WA) – which commenced 30 November 2015 – requires:

- i. a *significant* risk to the health or safety of the person or to the safety of another person; or
 - ii. a *significant* risk of *serious* harm to the person or to another person.⁷³
40. Community Treatment Orders (CTOs) are also available where ‘a significant risk of the person suffering serious physical or mental deterioration’ exists.⁷⁴ There is no counterpart to the wide-reaching provisions of subsection (2) in the old Act. Not only are the new criteria far more stringent, the list of exclusion criteria that do not (by themselves) demonstrate mental illness was doubled, from six to twelve.⁷⁵ They now include involvement in ‘personal or professional conflict’ and the fact of having received psychiatric treatment (at any time). Additionally, any diagnosis of mental illness must now conform to ‘internationally accepted standards prescribed by the regulations’.⁷⁶

⁶⁵ *Mental Health Act 1986* (Vic), s8 (1) (a).

⁶⁶ *Mental Health Act 2014* (Vic), s5 (a).

⁶⁷ *Mental Health Act 1986* (Vic), s8 (1) (c).

⁶⁸ *Mental Health Act 2014* (Vic), s5 (b).

⁶⁹ *Ibid*, s5 (c).

⁷⁰ *Ibid*, s6.

⁷¹ *Mental Health Act 1996* (WA), s26 (1)

⁷² *Ibid*, s26 (2)

⁷³ *Mental Health Act 2014* (WA) s25 (1) (b)

⁷⁴ *Ibid*, s25 (2) (b) (iii)

⁷⁵ *Mental Health Act 1996* (WA) s4 (2); *Mental Health Act 2014* (WA) s6 (2)

⁷⁶ *Mental Health Act 2014* (WA) s6 (4). According to the Explanatory Memorandum, these standards include the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition and the World Health Organization’s *International Classification of Diseases 10*.

41. A Report to the National Mental Health Working Group in 2000 found that Mental Health Acts across Australia were displaying more concern to protect human rights and more uniformity overall.⁷⁷ This trend has clearly continued, partly in order to implement the UN Principles and the CRPD.⁷⁸ At the end of 2015, all decisions to order involuntary commitment and treatment in Australia required, at a minimum: the person to be suffering from mental illness (or a condition with similar manifestations), a nexus between that illness and serious risks to health and/or personal or public safety, the provision of treatment for that illness, and for there to be no less restrictive means of providing that treatment available. However, as Professor Ian Freckleton observes, these Acts remain 'extraordinarily lacking in uniformity'.⁷⁹

2.3 Mental illness and related terms

42. The most obvious difference between the Acts lies in the fact that each contains its own definition of *mental illness*. Not only do the definitions differ greatly, they often change when new Acts are introduced. In discussing the inadequacy of what later became the NSW definition, Dr John Ellard identified the central dilemma for those trying to turn psychiatric concepts into legal terms: 'those who draft mental health laws, wise though they may be, cannot be expected to provide definitions which probably do not exist and which no one else has been able to discover... we are trying to create categories where there are only dimensions, or things where there are only processes.'⁸⁰
43. The most cursory definition is found in SA: simply 'any illness or disorder of the mind'.⁸¹ The other definitions all contain quantitative elements (such as 'significant disturbance' or 'serious impairment'), but differ as to whether they relate to *symptoms of impairment* or *ordinary mental processes which are impaired* or both. Another difference lies in whether *behaviour* is part of the definition.
44. The NSW Act focuses on *symptoms* and *behaviour*, stating that mental illness is characterised by: 'delusions, hallucinations, serious disorder of thought form, a severe disturbance of mood, and sustained or repeated irrational behaviour indicating the presence of one or more of the aforementioned symptoms.'⁸²
45. The Victorian Act relates mental illness to *ordinary mental processes which are impaired* – a 'significant disturbance of thought, mood, perception or memory'. Queensland (in both the old and current Acts) is the same, but the disturbance must be 'clinically significant'.⁸³ Western Australia is similar, although it draws attention to the consequences; mental illness under the new Act is 'a condition that is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and significantly impairs (temporarily or permanently) the person's judgment or behaviour.'⁸⁴
46. The other Acts combine the approaches in varying ways. Tasmania, for instance, looks to 'a serious impairment of thought (which may include delusions); or a serious impairment of mood, volition, perception or cognition'.⁸⁵ The ACT and NT Acts incorporate symptoms, ordinary mental processes and behaviour.⁸⁶ Some Acts go on to state that the serious or permanent effects of alcohol use or drug-taking may be an indication of a mental illness.⁸⁷
47. The NT Act also includes two conditions which are not found in the other Acts and which do not necessarily involve mental illness: *mental disturbance* and *complex cognitive*

⁷⁷ McSherry, Bernadette, 'Sex, Drugs and Evil Souls: The growing reliance on Preventive Detention Regimes' (2006) *Monash Law Review* 12, p. 247.

⁷⁸ Freckleton, above n 1, p. 703.

⁷⁹ *Ibid*, p.703.

⁸⁰ Ellard, John, 'The Madness of Mental Health Acts' *Australian and New Zealand Journal of Psychiatry* (24) 1990.

⁸¹ *Mental Health Act 2009* (SA) s3.

⁸² *Mental Health Act 2007* (NSW) s4.

⁸³ *Mental Health Act 2014* (Vic) s4. *Mental Health Act 2000* (Qld) s12; *Mental Health Act 2016* (Qld) s10.

⁸⁴ *Mental Health Act 2014* (WA) s6.

⁸⁵ *Mental Health Act 2013* (Tas) s4.

⁸⁶ *Mental Health Act 2015* (ACT) s10; *Mental Health and Related Services Act 1998* (NT) s6.

⁸⁷ *Mental Health Act 2013* (Tas) s4; *Mental Health Act 2014* (WA) s6; *Mental Health Act 2016* (Qld) s10.

impairment (CCI). The former denotes recent behaviour that suggests a severely impaired ability to function in a socially acceptable way, combined with a serious level of aggression or irresponsibility.⁸⁸ CCI denotes an apparently permanent cognitive impairment that substantially reduces the patient's capacity for self-care or decision-making or social functioning; again, aggressive or seriously irresponsible behaviour is part of the definition.⁸⁹ Either condition allows for short-term involuntary admission at a psychiatric facility to be ordered.⁹⁰

48. In addition to mental illness, the ACT and NSW Acts also refer to *mental disorder*.⁹¹ The statutes treat it in very different ways. In NSW, it describes *behaviour* 'so irrational' that 'temporary care, treatment or control is necessary' to prevent serious physical harm to the person or others, and allows for up to 3 days detention. The patient may or may not have a mental illness.⁹²
49. In the ACT, the old Act referred to *mental disturbance*, 'a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion'.⁹³ The new Act replaces this term with *mental disorder* and keeps the definition, with one key difference: while the earlier version did not refer to mental illness at all, the new term explicitly does *not* include mental illness.⁹⁴
50. Where mental disorder is found, a *community care order* of indefinite duration may be made that mandates one or more of the following: treatment, care and support; medication for the mental disorder; participation in a counselling, training, therapeutic or rehabilitation program; limits on communication between the patient and other people.⁹⁵ A *restriction order* may also be made on health or safety grounds (for the benefit of the patient or others) and to ensure the treatment, care and support is provided. The restriction order may direct where the patient is to live, who they must not approach and what activities they must not undertake; detention at a community care facility is one possible order.⁹⁶
51. The New Zealand Act does not refer to patients with mental illness at all. It defines *mental disorder* in terms that are much closer to the definitions of *mental illness* found in Australian Acts, but unlike the Australian Acts it incorporates the involuntary treatment criteria (a and b, below) into the definition.⁹⁷ Thus, mental disorder:

means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it :

- a. poses a serious danger to the health or safety of that person or of others; or
- b. seriously diminishes the capacity of that person to take care of himself or herself.

52. 'b' has no equivalent in Australia or the UK. It greatly lowers the threshold at which involuntary treatment becomes lawful – because a patient's difficulties in maintaining accommodation, relationships, work or good nutrition assume greater significance⁹⁸ – but this may be offset by support from friends, family and whānau. In practice, 'a certain

⁸⁸ *Mental Health and Related Services Act 1998* (NT) s15.

⁸⁹ *Ibid*, s6.

⁹⁰ The Mental Health Review Tribunal makes the relevant order. For mental disturbance, the longest possible order is for 14 days detention before it must be reviewed: s123 (5) (b). For CCI, the outer limit is 14 days, at which point the patient must be released or else detained on the grounds of mental illness or mental disturbance: s123 (5) (ba) and (6B)N. By contrast, detention on the grounds of mental illness may be ordered for three months before it is automatically reviewed: s123 (5) (a).

⁹¹ References to mental disorder do occur in the Western Australian Act, but only in the context of apprehending and transporting persons from interstate: *Mental Health Act 2014* (WA) ss87-91.

⁹² *Mental Health Act 2007* (NSW): ss15 and 31. Weekdays and public holidays are not counted.

⁹³ *Mental Health (Treatment and Care) Act 1994* (ACT) Schedule 1.

⁹⁴ *Mental Health Act 2015* (ACT) s9.

⁹⁵ *Ibid*, s67.

⁹⁶ *Ibid*, ss68-69.

⁹⁷ *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s2.

⁹⁸ McKillop, Matthew, 'Compulsory Treatment of Non-Dangerous Mental Health Patients in New Zealand' (2010) *New Zealand Law Students Journal* 329.

minimum capacity has been generally considered sufficient in all but the most exceptional cases',⁹⁹ and compulsory treatment orders are typically grounded in the *serious danger* criterion.¹⁰⁰

53. Because involuntary treatment criteria are part of the NZ definition, *mental disorder* is a dynamic term. It has been argued that 'to say of someone that he is mentally disordered or not... says very little about his present clinical state. What it does speak to, is whether or not in all the circumstances compulsory treatment is justified'.¹⁰¹ Clinical matters are part of the definition, but the social context of the patient may alleviate concerns that are raised in (a) and (b). The uncertainty of the term also suggests that other human rights instruments can aid in its interpretation, in borderline cases – notably, section 11 of the *Bill of Rights Act* (the right to refuse medical treatment).¹⁰²

2.4 Making and reviewing an involuntary status determination

54. The divergence among the Acts is not limited to different commitment and compulsory treatment criteria; it finds expression in the frameworks that operate after initial assessment in a mental health facility. Processes that enable the imposition and review of compulsory treatment vary even more between jurisdictions than do the criteria themselves, although convergence is starting to occur on this level as well. Observers have argued that the NSW Act has a 'legal model' that is 'geared towards due process',¹⁰³ while Victoria features a 'clinical model' that 'confers substantial determinative powers on psychiatrists'.¹⁰⁴ By briefly setting out the key features of these models, we can get a better idea of the variation found among Australian mental health regimes. Unlike the Australian Acts, the New Zealand Act only empowers judges to make compulsory treatment orders after the initial assessment period (the orders are later reviewed by a tribunal).^{104a}
55. In NSW, a person may be involuntarily detained under a wide variety of circumstances.¹⁰⁵ Once detained, they must be examined by an authorised medical officer within 12 hours, and released if no finding of mental illness or disorder is made.¹⁰⁶ The following steps allow for three kinds of diagnosis (ill/disordered/neither), and second and third opinions, so they aren't easily summarised. The key points are that two diagnoses of mental disorder enable brief detention to occur. When one psychiatrist identifies mental illness, and another concurs or identifies mental disorder, the tribunal must then conduct a Mental Health Inquiry 'as soon as practicable'.¹⁰⁷
56. If the tribunal finds that the person is mentally ill, it can order that they be released into the supervision of a carer, or placed on a CTO, or detained for up to 3 months for further observation or treatment.¹⁰⁸ If it finds no mental illness exists, it must discharge the person.¹⁰⁹ Until July 2010, the Inquiry was performed by a magistrate;¹¹⁰ the shift to a tribunal was intended to ensure specialist oversight of these coercive powers.¹¹¹ However,

⁹⁹ *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act*, above n 5, 10.1.6.

¹⁰⁰ Dr Norris, Julie, *private communication* (23/3/2016).

¹⁰¹ Dunlop, Nigel, 'Compulsory Psychiatric Treatment and the Meaning of 'Mental Disorder'' (2006) *New Zealand Law Journal*.

¹⁰² *Ibid*.

¹⁰³ Barnett, Michael, 'Developing National Civil Commitment Laws', *University of Western Sydney Law Review* 3 (2012), p. 35.

¹⁰⁴ Carney, Terry; Tait, David; Beupert, Fleur, 'Pushing the Boundaries: Realising Rights Through Mental Health Tribunal Processes?' *Sydney Law Review* 329 (2008), p. 10.

^{104a} *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ): ss17 and 79-80.

¹⁰⁵ Carney, Terry; Tait, David; Perry, Julia; Vernon, Alikki; Beupert, Fleur, *Australian Mental Health Tribunals* (2011) p. 62.

¹⁰⁶ *Mental Health Act 2007* (NSW): s27 (b).

¹⁰⁷ *Ibid*: s27 (d).

¹⁰⁸ *Ibid*: s35 (5).

¹⁰⁹ *Ibid*: s35 (3 and 4). Release can be postponed for up to 14 days if the Tribunal believes it to be in the person's best interests.

¹¹⁰ *Courts and Crimes Legislation Further Amendment Act 2008* (NSW) Sch 16.

¹¹¹ Burton, Cherie, 'Second Reading Speech, 27 November 2008' *Courts and Crimes Legislation Further Amendment Act 2008* (NSW). The issue was addressed indirectly in the parliamentary debates.

- the legislation allows for a single member to conduct hearings, and when this occurs the member must be a lawyer.¹¹²
57. In contrast, as noted by Professor Carney et al. in 2011, Victorian psychiatrists *make* orders and the Victorian Mental Health Tribunal *reviews* them.¹¹³ This continues to be the case for short-term orders under the new Act. A psychiatrist may make an Assessment Order, requiring compulsory assessment; afterwards, a different psychiatrist may make a Temporary Treatment Order (TTO) which may impose inpatient or community treatment.¹¹⁴ Within 28 days, the tribunal may make a Treatment Order (which lasts up to 6 months for inpatients and 12 months for those on a CTO), or revoke the TTO.¹¹⁵
 58. The tribunal must consist of three members – one lawyer/legal expert, one psychiatrist, and one community member (the last having special interest, experience or relevant knowledge in relation to mental illness).¹¹⁶ Although the legal member presides,¹¹⁷ the Act displays a stronger commitment to the idea of multidisciplinary review than its NSW counterpart. In principle, this ensures that not only the legal aspects are canvassed (checking the criteria for coercion are met), but also the *clinical* and *social* aspects of the patient's situation.¹¹⁸
 59. Recent changes have resulted in a good deal of convergence, perhaps enough to put in question the idea that the NSW and Victorian Acts still represent different models for framing coercive psychiatric powers.
 60. Writing in 2011, Professor Carney et al stressed the importance of having an order for involuntary treatment automatically reviewed by an independent body, so the length of time before this occurs helps determine how much control clinicians have over the process.¹¹⁹ In NSW, post-assessment review 'as soon as practical' meant about a week when it was still being conducted by a magistrate; when the tribunal took over this role, it announced that this means 3 to 4 weeks¹²⁰ (this shift has been subject to criticism).¹²¹ In Victoria, the period was previously within 8 weeks;¹²² under the new Act, it is now 4 weeks – roughly the same as NSW.¹²³
 61. Secondly, it was considered significant that the old Victorian Act empowered psychiatrists to make CTOs lasting for up to 12 months.¹²⁴ The new Act, as noted, vests that power with the tribunal, as is the case in NSW.
 62. In examining the differences that do remain in 2016 what is perhaps most notable are the safeguards for patient liberty at the time of tribunal review. The NSW tribunal must inquire about whether medication is affecting the person's ability to communicate, it must have due regard to cultural factors and expert evidence in regard to them, and it must ensure that the patient has been adequately informed about their rights and the hearing itself.¹²⁵ The corresponding section in the Victorian Act contains no such provisions.¹²⁶ This suggests that the NSW Act places more weight on the right to due process – that is, the key feature of a legal model.
 63. Many studies have explored how mental health tribunals operate in practice, and two findings stand out. Firstly, conflicting conclusions have been drawn as to whether legal or psychiatric members dominate the proceedings.¹²⁷

¹¹² Carney et. al., above n 105, p. 97.

¹¹³ Ibid, p. 60.

¹¹⁴ *Mental Health Act 2014* (Vic): ss28, 45-48.

¹¹⁵ Ibid: ss51, 55 and 57.

¹¹⁶ Ibid: ss163 and 179.

¹¹⁷ Ibid: s180.

¹¹⁸ Carney et. al., above n 1056, pp. 97-99.

¹¹⁹ Ibid, pp. 13 and 64-5.

¹²⁰ Ibid, p. 67.

¹²¹ Ryan, Christopher James; Callaghan, Sascha; Large, Matthew, 'Long time, no see: Australians with mental illness wait too long before independent review of detention' *Alternative Law Journal* (2010) 35 (3).

¹²² *Mental Health Act 1986* (Vic): s30 (1).

¹²³ *Mental Health Act 2014* (Vic): s51 (1).

¹²⁴ Carney et. al., above n 105, p. 65, in reference to *Mental Health Act 1986* (Vic): ss 12AC(5), 14.

¹²⁵ *Mental Health Act 2007* (NSW): s35 (2).

¹²⁶ *Mental Health Act 2014* (Vic): s55.

¹²⁷ Carney et. al., above n 105, p. 103-4.

64. Secondly, Australian tribunal hearings are quite short compared to those in other Commonwealth countries. In a 2000 study, it was found that a third of Australian hearings are over in less than 10 minutes, and only 4% last longer than half an hour. By comparison, most English hearings last for more than 1 hour, and hearings running longer than 2 hours are common in England, Scotland and Ontario.¹²⁸ New Zealand hearings are 'formal and robust', typically lasting 1.5 to 2.5 hours, with structured reports, pre-hearing teleconferences, and attendance by counsel, family and treating health professionals.¹²⁹
65. Professor Carney et al advocate equipping Australian tribunals with the resources to conduct longer, more thorough hearings. Partly this is to fulfil the formal legal and social goals of review, but also to help patients and carers articulate their views properly and understand the complex, confusing mental health system. In helping all participants to understand each other's rights, roles and decisions, and the resources that are available, it is hoped that more constructive and less adversarial relationships might be fostered.¹³⁰

2.5 Discussion

66. The practical effect of the different laws is not easy to measure. Partly this stems from limitations in the publicly available data. Authorities in different states vary in the amount of material they publish on rates of involuntary hospitalisation and CTOs, and the time periods which are covered by this material. The orders themselves also vary a great deal (SA, for instance, uses a unique system that features three levels of involuntary treatment orders). As a result, it is difficult to establish which mental health systems are more prone to actually use coercive powers, and the degree to which legislative change affects the use of those powers.¹³¹
67. US experience suggests that the legal changes may have had unintended results. A meta-review of 19 US studies found that laws tightening involuntary commitment and treatment criteria had no long-term effects.¹³² Where the *need for care* was removed as a ground for civil commitment, many persons with untreated psychosis were committed at a later point anyway, as a *danger* to themselves or others after their condition deteriorated.¹³³
68. This line of research supports Professor Carney et al.'s observation that 'policy and service outcomes defy easy simplification... and the extent of change over time as legislative models alter is easily overstated.' Other factors may do far more to shape those outcomes, such as the funding and organisation of mental health services, and the progressive development of theory, training and practice within psychiatry itself.¹³⁴
69. Debate over the use of CTOs illustrates this point. Despite having similar legal regimes to authorise their use,¹³⁵ they are much more prevalent in Australasia than in Canada. The world's highest rate of CTO usage is in Victoria, at 98.8 per 100,000 persons; the Canadian average is 6 per 100,000.¹³⁶ Although promoted as a less restrictive alternative to involuntary commitment, this assertion has been challenged, in part because the introduction of CTOs in the *Mental Health Act 2007* (England and Wales) has focused attention on their implications. A debate in the *British Journal of Psychiatry* summarised the

¹²⁸ Ibid, p. 91.

¹²⁹ Dr Norris, Julie, *private communication* (23/3/2016).

¹³⁰ Carney et. al., above n 105, pp. 280-1.

¹³¹ Brayley, John; Alston, Andrew; Rogers, Kynan, 'Legal criteria for involuntary mental health admission: clinician performance in recording grounds for decision' *Medical Journal of Australia* Vol 203. 8 (2015).

¹³² King, Robert; Robinson, Jacqueline, 'Obligatory dangerousness criteria in the involuntary commitment and treatment provisions of Australian Mental Health Legislation', *International Journal of Law and Psychiatry* (2011) 34, p.65.

¹³³ Ibid, p.65.

¹³⁴ Carney et. al., above n 105, p. 3.

¹³⁵ Rugkasa, Jorun, 'Effectiveness of Community Treatment Orders: The International evidence' *The Canadian Journal of Psychiatry* Vol. 61(1) (2016) p. 16.

¹³⁶ O'Donoghue B, Brophy L, Owens N, Rasic M, McCullough B, Huang B, Vine R, McKenna B, 'Rate of community treatment orders and readmission orders following reconfiguration of community mental health services' *Australasian Psychiatry* Vol 24.3 (2016) p. 2.

- main arguments for and against the use of CTOs (although the party arguing against their introduction conceded there are rare occasions where they are necessary).¹³⁷
70. Criticism over their use was grounded on the lack of a convincing evidence base (a point reinforced in the most recent meta-review),¹³⁸ the danger that they can lead to higher overall levels of compulsion (because they generally last much longer than inpatient orders), and the possibility that they distract from the need to ensure adequate services are made available on a voluntary basis. Critics imply that they encourage suboptimal care because 'less thought needs to go into how to provide good-quality support on the therapeutic basis of trust and willingness, rather than coercion.'¹³⁹ These points have also been argued forcefully in Australia.¹⁴⁰
 71. Those supporting the introduction of CTOs stressed the need to uncouple involuntary treatment from inpatient wards, and the need to ensure that patients lacking insight into their illness adhere to medication regimens. Many patients in this category, it is argued, will not undergo voluntary treatment even if excellent services are available. The argument is also made that evidence-based evaluation is problematic regarding compulsory treatment.¹⁴¹
 72. A crucial variable in explaining the use of coercive powers lies in the logic of clinical assessments themselves and the way they interact with the law. Professor Freckleton has noted several 'extra-legislative descriptors' that commonly operate in psychiatric testimony to tribunals, such as *insightlessness*, *non-compliance*, *promiscuity*, *absconding*, *violence*, *substance dependence*, *disorganisation*, and *poor hygiene*.
 73. The descriptors are relevant as factors bearing upon the existence of legislative criteria, not as substitutes for them. These factors can acquire significance that is not warranted by the Acts, which strictly confine the grounds for imposing involuntary status.¹⁴²
 74. A New York Law Professor – Michael Perlin – goes much further, levelling serious criticisms at the profession in North America, arguing that it has undermined law reform by developing new arguments and pretexts to justify involuntary commitment. He cites the widespread use of these extra-legislative descriptors as examples of what he calls 'sanist' attitudes and 'pretextual' practice.¹⁴³
 75. While accepting some of this critique, Professor Freckleton has explored ways that descriptors can promote 'fair and evidence-based decision-making' if employed in a critical fashion (he also argues that *insightlessness* and *non-compliance* should be incorporated into the Acts).¹⁴⁴ Context is crucial to using descriptors in a critical manner. For example: how much time has elapsed since relevant behaviour such as violence was last recorded? Was it recorded properly? Was it produced by circumstances no longer present? Does it have a cultural significance that is not obvious? How does the patient regard it now?¹⁴⁵
 76. When coercive powers are used on the basis of these descriptors, and it is unclear how they relate to the legal tests, it is hard to know if those powers are being used appropriately. This breaches several UN Principles, in particular 16 (2), which requires the grounds of admission to be communicated to the patient and a review body. A recent South Australian

¹³⁷ Lawton-Smith, Simon (For); Dawson, John; Burns, Tom (Against) 'Community treatment orders are not a good thing', *The British Journal of Psychiatry* Vol. 193.2 (Jul 2008).

¹³⁸ 'In sum, all the meta-analyses concur with the available RCT evidence and the systematic reviews in their findings: CTOs have not been shown to improve patient outcomes' Rugkasa, above n 135, p. 22.

¹³⁹ Lawton-Smith, above n 137.

¹⁴⁰ Light, Edwina M; Kerridge, Ian H; Ryan, Christopher J; Robertson, Michael D, 'Out of sight, out of mind: making involuntary community treatment visible in the mental health system', *The Medical Journal of Australia* (2012) 196 (9): 591-593; Patel, Gunvant, 'Community-Treatment Orders in Victoria: a clinic-ethical perspective' *Australasian Psychiatry* Vol 16.5 (October 2008).

¹⁴¹ Burns, Tom, above n 137.

¹⁴² Freckleton, Ian, 'Factors in Involuntary Status Decision-Making' in McSherry, Bernadette and Weller, Penelope (eds) *Rethinking Rights-Based Mental Health Laws* (2010) pp. 204-6 and 229.

¹⁴³ Perlin, Michael, *The Hidden Prejudice: Mental Disability on Trial* (2000), pp. 85-6.

¹⁴⁴ *Ibid*, pp. 206 and 229. Others have echoed the call to incorporate *insight* into the Acts, eg: Anand, Sumit and Pennington-Smith, Paul A, 'Compulsory treatment: rights, Reforms and the role of Realism' *Australian and New Zealand Journal of Psychiatry* 47 (10) 2013, p. 896; Lawton-Smith, above n 137. This topic is returned to in the discussion on capacity in Chapter 3.4.

¹⁴⁵ Freckleton, above n 142, pp. 213 and 227.

study found that only 40% of forms authorising involuntary detention addressed all the legal requirements (when *the need for immediate treatment* was removed from the analysis, compliance rose to 68%). The authors argued that the reasoning on forms should be regularly monitored for quality assurance (ensuring accuracy and sound reasoning) and that clinicians receive support to improve their performance. The authors also noted that a variety of provisions exist in Australian Acts regarding whether and how patients must be informed of their rights, or the grounds for detention, or both.¹⁴⁶

Chapter Three: Capacity to withhold consent to psychiatric treatment

77. Increasingly, the process of ordering involuntary treatment involves a duty to assess the capacity of patients to give informed consent.¹⁴⁷ This duty is often paired with an explicit duty to *communicate* details of the proposed treatment in a manner likely to be understood, and a duty to *support* patients to make a decision where they experience difficulty doing so.¹⁴⁸ Clear patterns emerge, when examining the obligations on practitioners across Australia and New Zealand, but the jurisdictions still diverge in important ways.
78. This divergence complicates an area already fraught with ambiguity (as shown by disputes over the meaning of the CRPD) and misunderstandings between the legal and medical professions. The Australian capacity assessment paradigm has been described as ‘an ad hoc implementation of various legal and clinical approaches which are reliant upon individual skill and the ability of the professionals conducting the assessment.’¹⁴⁹ After mapping out the legal terrain, implications for practitioners – such as the growing use of *advance statements* – will be explored. Treatments with their own capacity assessment provisions (electroconvulsive therapy and psychosurgery) are not addressed in this chapter.

3.1 Definitions and tests

79. There are two forms of *legal capacity*. The first kind recognises that someone is a person in the eyes of the law, endowed with rights and obligations; it is sometimes called *personhood* or *standing*. Loss of this capacity is termed *civil death*, and in some countries it continues to be the fate of mentally ill people.¹⁵⁰ Article 12 (1) of the CRPD seeks to prevent this, affirming that ‘persons with disabilities have the right to recognition everywhere as persons before the law’.
80. The second kind means the capacity to make decisions; it is sometimes termed *competence*, *legal agency* or *active legal capacity*.¹⁵¹ Unless otherwise stated, it is the type of capacity referred to from now on. The remaining paragraphs in Article 12 affirm that ‘disabled people possess capacity ‘on an equal basis with others in all aspects of life,’ and set out the need for supports and safeguards to enable its exercise where a disability impairs it. States must ‘take appropriate measures’ to provide support for the exercise of legal rights, and to provide safeguards against the abuse of supported decision-making schemes (such as the exercise of undue influence on those decisions by support persons).¹⁵²
81. In contrast to the CRPD Committee, as noted earlier, the Australian Government declared that *substituted* decision-making is also allowed by Article 12, as a ‘measure of last resort’

¹⁴⁶ Brayley, John; Alston, Andrew; Rogers, Kynan, ‘Legal criteria for involuntary mental health admission: clinician performance in recording grounds for decision’ *Medical Journal of Australia* 203 (8) (2015).

¹⁴⁷ Ryan, Christopher; Callaghan, Sascha; Peisah, Carmelle, ‘The capacity to refuse psychiatric treatment: A guide to the law for clinicians and tribunal members’, *Australian & New Zealand Journal of Psychiatry* (2015) Vol. 49(4), p. 325.

¹⁴⁸ *Ibid*, p. 328.

¹⁴⁹ Purser, Kelly; Magner, Ellis S; Madison, Jeanne, ‘A therapeutic approach to assessing legal capacity in Australia’, *International Journal of Law and Psychiatry* 38 (2015), p. 18.

¹⁵⁰ McSherry, Bernadette; Wilson, Kay, ‘The concept of capacity in Australian mental health law reform: Going in the wrong direction?’, *International Journal of Law and Psychiatry* (2015) 40, p. 62.

¹⁵¹ McSherry, et. al., above n 150, p.62.

¹⁵² Vickery J, *Nicholson & Ors v Knaggs & Ors* (2009) VSC 64, at 69.

for persons with ‘cognitive or decision-making disabilities’ so acute that they suffer ‘an inability to assess or communicate their needs’. This is to ensure, among other things, that disabled persons receive proper medical treatment.¹⁵³

82. Without the *mental* capacity to make a treatment decision, then, the *legal* capacity to make it is lost.¹⁵⁴ So at what point is a person incapable of assessing or communicating their needs, and liable to have consent given or refused on their behalf? The answer depends on the test of capacity that applies in a given jurisdiction.
83. Mental Health Acts in NSW, SA, and the NT contain no test, so these jurisdictions rely on the common law – specifically, the case of *Hunter and New England Area Service v A* (not to be confused with *Hunter v McKenna*, discussed in Chapter One).¹⁵⁵ The NSW case concerned an Advance Care Directive (ACD) made by an individual before entering a coma. The ACD forbid life-saving treatment, and the court held that the person was capable of making that choice when the directive was made; accordingly, he was denied treatment and died. McDougall J explored the issue of capacity at length, discussing UK judgments that affirm the existence of a *presumption of capacity* to accept or refuse medical treatment. He held this to exist in Australian law as well.¹⁵⁶ To administer treatment without consent, a clinician must rebut the presumption by establishing, on the balance of probabilities, that the patient:
1. is unable to comprehend and retain the information which is material to the decision, in particular as to the consequences of that decision; or
 2. is unable to use and weigh the information as part of the process of making the decision.¹⁵⁷
84. Note the centrality of the decision-making process. The capacity to make the decision is what must be assessed, not whether or not the resulting choice is ‘unwise or foolish’.¹⁵⁸ The test has been termed a *cognitive* or *functional* test and it is issue-specific, ‘recognising that mental capacity may fluctuate and that it needs to be assessed at a particular time in relation to a particular decision.’¹⁵⁹ Crucially, the importance of the decision must be considered; a person may lack the capacity to make decisions regarding treatment, yet possess the capacity to decide to buy a cup of coffee.¹⁶⁰
85. In an emergency situation, where it is not practicable to obtain consent, and treatment is reasonably necessary, no consent is required. Clinicians must then act in the best interests of the patient unless the proposed treatment is contrary to their known wishes (if those wishes were expressed when the patient did possess capacity).¹⁶¹ Drs Eagle and Ryan suggest the following approach, when in doubt: *if* a known factor gives rise to doubts about capacity (such as a head injury, recent overdose or refusal of assessment/treatment decision that is very unusual or inappropriate) *and* a foreseeable risk of serious harm exists *and* there is no less restrictive way to assess capacity or prevent risk *then* a clinician should detain the person for as long as necessary to minimise the risk or assess capacity, using the least force possible.¹⁶²

¹⁵³ McSherry et. al, above n 150.

¹⁵⁴ *Ibid*, p.64.

¹⁵⁵ *Hunter and New England Area Service v A* (2009) NSWSC 761.

¹⁵⁶ *Ibid*, at 23.

¹⁵⁷ *Ibid*. at 25.

¹⁵⁸ *Ibid*, at 14.

¹⁵⁹ McSherry, et. al., above n 150, p.64.

¹⁶⁰ *Hunter*, above n 156, at 24.

¹⁶¹ *Ibid*, at 31-4 and 40.

¹⁶² Eagle, Kerri; Ryan, Christopher, ‘Potentially incapable patients objecting to treatment: doctor’s powers and duties’ *Medical Journal of Australia* 6 (7 April 2014) p. 354.

86. The reasoning in *Hunter* was later affirmed in SA,¹⁶³ the ACT¹⁶⁴ and WA.¹⁶⁵ Like *Hunter*, the WA case addressed medical treatment in the broad sense, and did not directly engage the Mental Health Act, which had its own relevant provisions.¹⁶⁶
87. The UK rulings¹⁶⁷ that inspired *Hunter* also found expression in the *Mental Capacity Act 2005* (UK) ('the MCA'). It has a clear influence on most Acts which do contain capacity tests (WA, Queensland, Victoria and Tasmania and the ACT). For this reason, the MCA will be treated as the template for the Australian and New Zealand provisions, and the main divergences noted.
88. After establishing the presumption of capacity,¹⁶⁸ the MCA requires all practicable steps be taken to help the person make a decision,¹⁶⁹ and states that an unwise decision does not demonstrate lack of capacity.¹⁷⁰ Capacity relates to the particular decision and the time it is made,¹⁷¹ and is lacking if the person is unable:
- a. to understand the information relevant to the decision,
 - b. to retain that information,
 - c. to use or weigh that information as part of the process of making the decision, and
 - d. to communicate his decision (whether by talking, using sign language or any other means).¹⁷²
89. These provisions are replicated almost exactly in the new Victorian and Tasmanian Acts,¹⁷³ as well as the WA Act that came into force at the end of November 2015.¹⁷⁴
90. The ACT's new Act contains a similar, slightly more detailed test,¹⁷⁵ and places far more emphasis on capacity than any other existing or proposed legislation. Promoting the capacity to determine and participate in treatment decisions is now an Object of the Act;¹⁷⁶ this is elaborated in several provisions that affirm the right to refuse treatment and the right to be informed about and obtain several forms of assistance to aid decision making.¹⁷⁷ If capacity is fluctuating, a practitioner must – if it is reasonably practicable – wait and give the patient a chance to consider matters when their capacity has returned¹⁷⁸ (the new Victorian Act contains a similar provision).¹⁷⁹
91. The new WA Act goes into some detail about what it is that must be understood: a clear explanation of the proposed treatment that contains sufficient information to enable the person to make a balanced judgment about it, identifying and explaining any alternative treatment and warning the person of any inherent risks. The information that must be communicated by the clinician is generally limited to that which a reasonable patient would consider significant.¹⁸⁰
92. The test in the old Queensland Act also states what must be understood – simply 'the nature and effect' of treatment decisions – but does not address the other elements of

¹⁶³ *H LTD v J & Anor* [2010] SASC 176 (2010), at 35.

¹⁶⁴ *In the Matter of ER (Mental Health and Guardianship and Management of Property)* [2015] ACAT 73, at 21-3. The *Human Rights Act 2004* (ACT) was held to lend added support to the presumption of capacity, at 44.

¹⁶⁵ *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229, at 23.

¹⁶⁶ *Mental Health Act 1996* (WA), ss96-7. The new Act is considered below.

¹⁶⁷ In particular: *Re MB* (1997) 2 FCR 514, at 553.

¹⁶⁸ *Mental Capacity Act 2005* (UK), s1 (2).

¹⁶⁹ *Ibid*: s1 (3).

¹⁷⁰ *Ibid*: s1 (4).

¹⁷¹ *Ibid*: s2 (1).

¹⁷² *Ibid*: s3 (1).

¹⁷³ *Mental Health Act 2014* (Vic) s68; *Mental Health Act 2014* (Tas) s7.

¹⁷⁴ *Mental Health Act 2014* (WA) s15.

¹⁷⁵ *Mental Health Act 2015* (ACT) s7.

¹⁷⁶ *Ibid*: s5 (b).

¹⁷⁷ *Ibid*: ss6 and 8.

¹⁷⁸ *Ibid*: 8 (1) (g).

¹⁷⁹ *Mental Health Act 2014* (Vic) s75 (3).

¹⁸⁰ *Mental Health Act 2014* (WA) s19.

cognition – *retaining* and *weighing* the information.¹⁸¹ The new Queensland Act retains this approach while adding more detail about what must be understood; one of the items is ‘that the person has an illness, or symptoms of an illness, that affects the person’s mental health and wellbeing.’¹⁸² This appears to incorporate the element of *insight*.

93. No specific test is contained in the New Zealand Act. When a compulsory treatment order is sought, a District Judge must examine the patient and consult with the responsible clinician and one other health professional.¹⁸³ If the judge makes the order, the patient must accept any treatment the clinician directs during the first month.¹⁸⁴ After this point, the patient must give informed consent to any further treatment unless a second psychiatrist (appointed by the Review Tribunal) approves it.¹⁸⁵ The patient’s capacity to give or withhold consent is to be assessed according to the MCA criteria set out above; the test is contained in the Guidelines.¹⁸⁶ The Act itself does not contain a presumption of capacity, but one is contained in the *Code of Health and Disability Services Consumers’ Rights*,¹⁸⁷ and the Guidelines incorporate it.¹⁸⁸

3.2 Refusal

94. Although similar cognitive tests are being adopted into the Acts, different consequences flow from a finding of capacity. Most US jurisdictions, it should be noted, allow for detention of mentally ill persons but uphold the right of capable persons to refuse treatment. Canada also tends to recognise this right while Acts in the UK¹⁸⁹ and most of Australia tend not to, as they are more focused on ensuring treatment.¹⁹⁰ New Zealand resembles Australia on this point.
95. The NT, ACT, Queensland, Tasmania and WA Acts only permit involuntary treatment when the person lacks the capacity to make treatment decisions. In the NT, however, ‘unreasonable refusal’ by a capable person can be overruled by the clinician.¹⁹¹ In shifting to a new Act, Queensland has removed the reference to unreasonable refusal.¹⁹²
96. In NSW, the rule in *Hunter* would seem to imply that a competently-made decision to refuse treatment must be respected, whether or not it is reasonable. However, the Act undermines this by requiring that ‘every effort that is *reasonably practicable* should be made to obtain the consent of people with a mental illness or mental disorder when developing treatment plans’.¹⁹³ Arguably, this implies that there may be unusual circumstances where a competent refusal can be overruled.¹⁹⁴
97. A similar argument applies to the SA Act, as it currently lacks a capacity test. *Hunter* applies, yet the Act allows compulsory treatment if it is the least restrictive option.¹⁹⁵
98. Compared to the old Victorian Act, the new Act has gone a long way towards ensuring a right of refusal for competent patients. Refusal may still be overridden, but the clinician must perform extensive consultation before doing so. The views and preferences of the

¹⁸¹ *Mental Health Act 2000* (Qld) ss8, 10

¹⁸² *Mental Health Act 2016* (Qld) s14 (1)

¹⁸³ *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s18 (3) and (4).

¹⁸⁴ *Ibid*: s59 (1).

¹⁸⁵ *Ibid*: s59 (2) (b).

¹⁸⁶ Ministry of Health. 2012. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health: 10.2.1.; *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s130 (a).

¹⁸⁷ *Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996* (NZ) R7 (2).

¹⁸⁸ *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, above n 7, 8.4.

¹⁸⁹ Dawson, above n 31, p. 76.

¹⁹⁰ Roper, Cath E.; Edan, Vrinda, ‘Autonomy in Jeopardy: Contrasting Participatory Health Models with Patient Decision Making Under Mental Health Law’ *Journal of Participatory medicine* Vol. 3 (2011), p. 2.

¹⁹¹ *Mental Health and Related Services Act 1998* (NT) s14; *Mental Health Act 1996* (WA) s4; *Mental Health Act 2013* (Tas) s40. The new Western Australian Act retains this provision, in s25.

¹⁹² *Mental Health Act 2016* (Qld) s12.

¹⁹³ *Mental Health Act 2007* (NSW) s68 (hl).

¹⁹⁴ Ryan et. al., above n 147, p. 325.

¹⁹⁵ *Mental Health Act 2009* (SA) s21.

patient about the treatment and its alternatives, the reasons for those views and preferences, and the views of nominated persons, guardians and carers (if the carer–patient relationship will be affected) are among the matters that the psychiatrist must consider.¹⁹⁶

99. An additional complication exists in construing the psychiatrist’s powers and duties under the new Act, because the preceding section contains wording that is unclear, if not contradictory. A clinician must seek consent before administering treatment, and must presume that decision-making capacity exists; however, the clinician does not have to seek consent if he or she ‘forms the opinion that the other person does not have the capacity.’¹⁹⁷ On the face of it, the clinician *must* presume the patient has capacity but *may* presume they do not. This has not been clarified by parliamentary materials or reported court or tribunal decisions.
100. The New Zealand Act contains a right to treatment but no right to refuse it.¹⁹⁸ Consent is to be sought when the patient possesses capacity, but the Act allows the second opinion to overrule competent refusal. According to Jeremy Skipworth, this renders capacity ‘largely irrelevant’ for the purposes of the Act.¹⁹⁹ The guidelines do acknowledge that *consent*, in the context of a CTO ‘refers to both informed consent and the lesser *assent*, which may be influenced by an element of coercion.’²⁰⁰

3.3 Applying the tests

101. Dr Ryan et al. conducted a detailed analysis of capacity test criteria which has many implications for psychiatrists. Some of these will be touched on before broader observations about the practitioner’s role are discussed.
102. The tests in *Hunter* and the Tasmanian Act require that the loss of capacity is due to an *impairment or disturbance of mental functioning*; the other jurisdictions have no such requirement. This suggests that, in the former states, there may be conditions which compromise decision making yet do not count for the purposes of the test. Adjustment disorders may fall into this category, although courts in the UK have found that a wide variety of conditions such as pain and severe fatigue do in fact count in this context.²⁰¹ Moreover, the inclusion of adjustment disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition) would make them more likely to meet the needs of the test.
103. A patient can only *understand* when a clinician explains matters properly. The clinician applying a test, then, has a *duty to communicate* in a manner likely to be understood. This may require a support person such as a friend or translator. Rendering clinical thinking transparent is the key, although doing so while avoiding jargon will often be challenging.²⁰² Environmental factors like distracting noise should be taken into consideration. Comprehension can be checked by asking the patient to paraphrase.²⁰³
104. *Retention* of information need only be ‘brief’ according to the Tasmanian Act (the only Act which establishes a timeframe). This likely suggests that holding onto information long enough to make the decision will suffice.²⁰⁴
105. The meaning of *use or weigh the information* has been construed in very broad terms by the courts, and it is usually the crux of the matter. The process need not be rational or reasonable. Instead, it means ‘one of the many ways that people ordinarily process

¹⁹⁶ Ryan et. al., above n 147, p. 325; *Mental Health Act 2014* (Vic) s71.

¹⁹⁷ *Mental Health Act 2014* (Vic) s70.

¹⁹⁸ *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s66.

¹⁹⁹ Skipworth, Jeremy, ‘Should Involuntary Patients with Capacity have the Right to Refuse Treatment,’ *New Zealand’s Mental Health Act in Practice* (2013), p. 213.

²⁰⁰ Ministry of Health. 2012. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health: 10.2.1; *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s18 (4).

²⁰¹ Ryan et. al., above n 147, p. 328.

²⁰² Roper et. al., above n 191, p. 2.

²⁰³ Ryan et. al., above n 147, p. 328.

²⁰⁴ *Ibid*: p. 329.

information when not affected by an impairment of, or disturbance in, the functioning of the brain.²⁰⁵

106. For instance, a patient suffering from chronic paranoid schizophrenia and a necrotic ulcer successfully obtained an injunction against amputation. He favoured less drastic treatment which would give him a much lower chance of survival. The court found that he did understand and weigh the information, in his fashion, accepting the possibility of dying but having excessive confidence in the treating team. This is one way a person with no impairment could weigh up the situation.²⁰⁶
107. On the other hand, a woman with a severe needle phobia who needed an emergency caesarean was found to lack capacity to refuse the treatment; her fear at the sight of the cannula and oxygen mask overwhelmed her decision-making processes. In such a circumstance, 'one object may so force itself upon the attention of the invalid as to shut out all others that may require attention', with the effect that the information cannot be weighed.²⁰⁷
108. The patient must be able to *communicate* 'relatively consistent or stable choices.'²⁰⁸ Where the other elements of capacity are present, this is unlikely to be a major obstacle outside the context of severe impairments like catatonia. It may, however, impose a duty on clinicians to obtain assistance from specialists such as speech pathologists.²⁰⁹

3.4 Discussion

109. A point about terminology must be made, to ensure clarity here: the *presumption of capacity* is a legal concept that simply places the burden of rebutting it onto the practitioner. It does not relieve the practitioner of the need to check that capacity exists when good clinical practice requires them to do so. Professor David Skegg drew an analogy with the police here: in court, the defendant is presumed innocent until proven guilty, but the police themselves need not presume the person is innocent— it is their proper role to investigate suspects. Similarly, it is often natural to presume that a patient lacks capacity – one obvious example would be a person who refuses necessary treatment after a failed suicide attempt.²¹⁰
110. Observers have lamented the poor interface between the medical and legal professions on the issue of capacity. A familiarity with tests of mental capacity for purely clinical purposes does not guarantee an understanding of legal capacity and its implications (and vice versa). The problem is not only exacerbated by diverse and rapidly changing legal tests – the range of clinical tests themselves 'creates the potential for inconsistency in assessment as it is dependent upon individual preferences for the different capacity assessment tools and the communication between the professions.'²¹¹
111. Although Fistein et al. state that most psychiatric patients are capable of making treatment decisions, and 'this can be reliably assessed using a checklist derived from legal definitions',²¹² the proliferation of such tests suggests that reliable assessment is far from straightforward. Different tests are appropriate for different populations, conditions and service contexts (acute, emergency etc.), and are predicated upon different understandings of the underlying concepts – especially regarding the way patients *use* information. The

²⁰⁵ Ibid: p. 330.

²⁰⁶ *Re C* (1994) 1 All ER 819.

²⁰⁷ Bellhouse, J., Holland, A. J., Clare, I. C., & Gunn, M. 'Capacity-based mental health legislation and its impact on clinical practice: 2) treatment in hospital' *Journal of Mental Health Law* (August 2003), citing Butler-Sloss J, *Re MB (An Adult: Medical treatment)* (1997) 38 Butterworths Medical Law Reports 175.

²⁰⁸ *In the Matter of ER*, above n 165, at 74.

²⁰⁹ Ryan et. al., above n 149, p. 331.

²¹⁰ Skegg, PDG, 'Presuming Competence to Consent: Could anything be sillier?' *University of Queensland Law Journal* Vol. 30, No. 2 (2011).

²¹¹ Purser et. al., above n 149, p. 22.

²¹² Fistein et al., above n 32, p. 153, citing Bellhouse, J., Holland, A. J., Clare, I. C., & Gunn, M. 'Capacity-based mental health legislation and its impact on clinical practice: 2) treatment in hospital' *Journal of Mental Health Law* (August 2003).

- lack of consensus regarding key terms prevents a single 'gold standard' test from being developed.²¹³
112. According to a recent comparison of 19 tests oriented towards US legal capacity criteria,²¹⁴ however, the MacArthur Competence Assessment Tool for Treatment, may come close to filling this role. This is due to its comprehensiveness, its extensive testing across different populations, the range of training materials available, and the brief application period (15–20 minutes). Nevertheless, the authors emphasised that 'a strictly formulaic approach to the assessment of capacity is unlikely to capture specific individual nuances; therefore, capacity assessment instruments should support, but not replace, experienced clinical judgement.'²¹⁵
 113. A Canadian paper sets out some useful advice for practitioners on the legal role of their assessments. Courts are particularly interested in the following questions: How experienced is the assessor? How long did the assessment take? Was there more than one? Where was it held? Was anyone else present? How comfortable was the patient (health, rest, nutrition etc.)? Were careful notes taken of the entire interview? Which capacity test was utilised? What facts support the opinion (preferably detailed clinical observations and test results)?²¹⁶
 114. Another useful perspective emerges from a UK study in 2009 which concluded that 'emergency health-care workers do not have adequate knowledge about how to assess capacity and treat people who either refuse or lack capacity.' Only 10% of nurses and 67% of doctors were judged correct.²¹⁷ The study did not target psychiatrists, but it should alert psychiatrists when considering opinions formed by other health-care workers.
 115. Australasian psychiatrists 'now need to have capacity considerations at the front of their minds when making treatment decisions',²¹⁸ but involuntary treatment will still require a risk of future harm or deterioration, and the interaction of these criteria with the capacity criterion may have unfortunate unintended effects. This is because the meaning of 'harm' remains ambiguous; does it include the suffering caused by severe depression or abusive hallucinations? Or does it only refer to additional harms that are the result of these symptoms, like suicide? The former is the case in NSW, according to a Supreme Court decision,²¹⁹ but the law is unclear elsewhere. If the experience of mental illness alone cannot count as harm, there will be people who are suffering greatly and lacking capacity but – because they are not likely to deteriorate in a drastic manner – it may be impossible to order needed treatment for them.²²⁰
 116. Criticisms of the capacity paradigm have been raised. Dr Sumit Anand observed that the cognitive test fails to capture the crucial element of *voluntariness*, but 'an argument can be made that severe mental illness ipso facto robs the individual of their innate ability to make voluntary decisions'. Apathy, avolition, psychotic ambivalence, delusions and hallucinations are given as examples where this may occur. *Insight* is proposed as a better paradigm for incorporating volition, cognition and even capacity.²²¹
 117. Dr Carlos d'Abrera developed these points and made a further observation: 'because they are task and time specific, capacity assessments by definition exclude a range of historical factors such as patterns of relapse that might otherwise inform the need for coercive

²¹³ Lamont, S., Jeon, Y. H., & Chiarella, M. 'Assessing patient capacity to consent to treatment: An integrative review of instruments and tools' *Journal of clinical nursing* 22(17-18) (2013) 2387-2403.

²¹⁴ These are slightly different to the MCA approach: they are widely agreed to be *understanding, appreciation, reasoning and communicating/expressing a choice*: *Ibid*, p. 2388.

²¹⁵ *Ibid*, p. 2399.

²¹⁶ Allan, Madam Justice, 'Capacity Assessments in British Columbia – Some Thoughts on Educating The Decision Makers', *Elder Law Review* Vol. 2 (2006).

²¹⁷ Arnold, Philip, 'The practitioner knows best? Assessment of patient capacity and responses to refusal of treatment in emergency health-care' *New Zealand Law Students Journal* 4 (2013), p. 24.

²¹⁸ Callaghan, Sascha and Ryan, Christopher J, 'Rising to the human rights challenge in compulsory treatment – new approaches to mental health law in Australia' *Australian and New Zealand Journal of Psychiatry* 46 (7) (2012), p. 619.

²¹⁹ *Re J (no.2)* (2011) NSWSC 1224 at 101.

²²⁰ Callaghan and Ryan, above n 220.

²²¹ Anand, Sumit and Pennington, Paul A, 'Compulsory treatment: Rights reforms and the role of realism' *Australian and New Zealand Journal of Psychiatry* 47 (10) 2013.

treatment.’ A person may regain capacity but not necessarily insight, for example, and this may lead them to cease taking medication that will prevent a relapse. He opposed the use of capacity as a threshold criterion and warned that ‘capacity-centred laws will inevitably oblige the treating psychiatrist to fracture countless management decisions into ever smaller algorithms in order to satisfy statutory requirements’.²²²

3.5 Supported decision-making and advance statements

118. As noted by Dr Sudeep Saraf, the Victorian Act was the first to break from the old model of substituted decision-making guided by the best interests of the patient, and to embrace the supported decision-making paradigm. It sets out a range of supports such as nominated persons, provision for advance statements and access to second opinions and the Mental Health Commissioner.²²³
119. The new paradigm reflects a central concern of the recovery approach, which is to encourage the maximum possible collaboration between clinicians and their patients, while respecting the latter’s choices. Increasingly, this places a duty on psychiatrists to carefully identify deficits in capacity and try to overcome these with supports, rather than trying to substitute a decision.²²⁴ Again, the new ACT legislation is explicit in this regard, stating that ‘a person must not be treated as not having decision-making capacity unless all practicable steps to assist the person to make decisions have been taken’.²²⁵
120. A large part of this paradigm concerns social support, such as building a network of people to help patients overcome their isolation, understand their situation and articulate their views. Support people are obviously expected to play a much larger role than assisting decision-making, but it is useful here to note their heightened profile in recent Acts.
121. The new WA Act is a striking example. It includes a table of 25 Notifiable Events and a whole Part setting out who to contact and how to record that contact.²²⁶ These events include the detention of an individual to allow them to be taken to an authorised hospital or other place; release from that detention is also a Notifiable Event. Where a decision is made that it is not in the individual’s interests for the notification to occur, a record of the decision must be made and filed, and a copy sent to the Chief Mental Health Advocate.²²⁷
122. The Act also requires a *treatment, support and discharge plan* to be prepared for all involuntary inpatients, detained mentally impaired accused persons and those on CTOs²²⁸ (formerly, it was only required for those on CTOs).²²⁹ The psychiatrist has a duty not only to include much more detail than previously, but also to involve the following people in the preparation and review of the plan: the patient (whether or not they have capacity) and any parent, guardian, nominated person, carer or close family member (if applicable).²³⁰ Carers, it should be noted, were not referred to at all in the old Act; there are 73 references in the new Act.
123. It will take time for all parties to adjust to new roles and expectations in this setting (not least because of the resource implications for mental health services). The intensity of support necessary for some patients will blur the line between supported and substituted decision-making, warranting extra vigilance on the part of psychiatrists as to whether the support person is exploiting their role to manipulate or take advantage of the patient.²³¹

²²² d’Abrera, Carlos, ‘Capacity in mental health law: Are we heading in the right direction?’ *Australian and New Zealand Journal of Psychiatry* 49 (9) (2015).

²²³ Saraf, Sudeep, ‘Advance statements in the new Victorian Mental Health Act’, *Australasian Psychiatry* vol 23 (3) (2015), p. 230.

²²⁴ Kampf, above n 21, pp. 142-3.

²²⁵ *Mental Health Act 2015* (ACT) s8 (d).

²²⁶ *Mental Health Act 2014* (WA) Part 9; Schedule 2.

²²⁷ *Mental Health Act 2014* (WA) s142.

²²⁸ *Mental Health Act 2014* (WA) s185.

²²⁹ *Mental Health Act 1996* (WA) s68.

²³⁰ *Mental Health Act 2014* (WA) s188.

²³¹ McSherry, above n 29, p. 192.

124. *Advance statements* (the terminology varies widely) are documents that ‘set out a person’s preferences in relation to treatment in the event that the person becomes a patient.’²³² They are an integral part of the move towards a more collaborative clinical relationship, but their full legal implications will also take time to manifest.
125. For example: the Victorian Act provides that psychiatrists can make treatment decisions at odds with the advance statement if the preferences are not ‘clinically appropriate’ or ‘ordinarily provided by the designated health service.’²³³ The patient must be informed of this decision and (if they want) provided with written reasons within 10 business days. However, ‘it is not clear what remedies are available to the patient following the receipt of these written reasons... one avenue is to request a review of their status as a compulsory patient [by the Mental Health Tribunal].’²³⁴ Since the patient would be seeking a different treatment, and not necessarily an end to compulsory status (which is difficult to achieve at any rate), this is unlikely to be a satisfying option for either the patient or the practitioner.
126. The Queensland Act makes no reference to service provision at this point, but does allow wider scope for psychiatrists to substitute their clinical judgement for the advance statement. Preferences that are not ‘clinically relevant or appropriate’, or which do not allow ‘medications that are clinically necessary’ can be overruled. Note that these are only the listed examples; there will be other situations in which there is no ‘less restrictive way for a person to receive the treatment and care that is reasonably necessary’.²³⁵
127. The new ACT Act, on the other hand, curtails clinical authority more than its Victorian counterpart. Only when the expressed wishes are ‘unsafe or inappropriate’ can the practitioner provide treatment contrary to the advance statement. One of the two following conditions must then be satisfied:
- i. the person is willing to receive the treatment *and* a guardian/attorney/health attorney approves; or
 - ii. the ACT Civil and Administrative Appeals Tribunal orders the treatment.²³⁶

Chapter Four: Forensic psychiatry

128. This review centres on the Mental Health Acts and relevant literature. It is not possible to analyse the legislation framing forensic psychiatry in a similar manner within the confines of this paper, as the law is mostly contained in separate Acts and case law dealing with crime, criminal procedure, sentencing and special classes of offenders. What follows instead is a discussion of *fitness to stand trial*, *the insanity defence*, and *forensic patient dispositions*.

4.1 Fitness to stand trial

129. Across Australia and New Zealand, a variety of legislative tests exist to establish whether defendants are unfit to stand trial. These tests are grounded in longstanding common law authority which has been criticised as establishing an ‘unduly narrow test of a defendant’s intellectual abilities.’²³⁷ A number of law reform proposals have been considered – most notably, approaches that would align fitness tests with the current approach to assessing decision-making capacity discussed in the last chapter.
130. Broadly speaking, Australia and New Zealand continue to follow the approach set out in *Pritchard*²³⁸ and developed in *Presser*.²³⁹ The *Pritchard* test establishes basic requirements (ability to *plead* and *comprehend the proceedings so as to make a proper defence*), and

²³² Saraf, above n 225.

²³³ *Mental Health Act 2014* (Vic) s83 (1).

²³⁴ Saraf, above n 225, p. 232.

²³⁵ *Mental Health Act 2016* (Qld): s 13 (1) Note.

²³⁶ *Mental Health Act 2015* (ACT) s28 (5).

²³⁷ Brookbanks, WJ; Mackay, RD, ‘Decisional competence and ‘best interests’: establishing the threshold for fitness to stand trial’ *Otago Law Review* 3 (2010).

²³⁸ *R v Pritchard* (1836) 173 ER 135.

²³⁹ *R v Presser* (1958) VR 45. Stewart, Jeanette; Woodward, Mary; Hepner, Ilana, ‘Fitness to stand trial, human rights and possibilities from England and Wales’ *Journal of Law and Medicine* 22 (2015) p. 887; Brookbanks, above n 239.

remains the legal test in England and Wales.²⁴⁰ A similar test applies in Scotland.²⁴¹ The seven 'Presser criteria' are as follows; if the accused is unable to perform one or more of the following tasks, he or she is unfit to stand trial:

1. Understand the charge;
2. Plead to the charge and exercise the right to challenge jurors;
3. Understand generally, the nature of proceedings (that it is an inquiry) as to whether the accused person did what they are charged with;
4. Follow the course of proceedings;
5. Understand the substantial effect of any evidence that might be used against them;
6. Make their defence or answer the charge; or
7. Give any necessary instructions to their legal counsel.

131. The essential elements of this test are found in Acts across all but three Australian jurisdictions (although Victoria, the NT, the ACT and Tasmania also note that memory loss is not enough to establish unfitness).²⁴² New Zealand legislated a similar test,²⁴³ which also does not assess a defendant's competence to make decisions in their best interest.²⁴⁴ NSW and the Commonwealth have not legislated a test, and so rely on the common law,²⁴⁵ while Queensland has enacted a minimal test that still allows for the operation of the common law ('fit to plead at the person's trial and to instruct counsel and endure the person's trial, with serious adverse consequences to the person's mental condition unlikely').²⁴⁶

132. As the Australian Law Reform Commission observed:

'The common law test of unfitness to stand trial has been criticised in a number of recent inquiries in Australia and overseas. In particular, the common law may place an undue emphasis on a person's intellectual ability to understand specific aspects of the legal proceedings and trial process, and too little emphasis on a person's decision-making ability.'²⁴⁷

This statement echoes calls from law reform bodies in Scotland,²⁴⁸ England and Wales,²⁴⁹ and Victoria.²⁵⁰ The Law Commission (England and Wales) observed that 'Incapacity... may arise from an inability to use or negotiate information that has been understood'.²⁵¹

133. The Commission went on to affirm the view of Dr Tim Rogers that 'There is a widespread belief among forensic psychiatrists that many mentally ill defendants in the current system may not be receiving a fair trial.'²⁵² The test is best suited to measuring intellectual deficiency, but psychotic conditions like schizophrenia are not usually associated with such deficiency,²⁵³ even though they present obvious challenges to the conduct of a defence.

²⁴⁰ The Law Commission, 'Unfitness to Plead' *Consultation Paper No 197* (2010), para 2.44.

²⁴¹ Scottish Law Commission, 'Discussion Paper on Insanity and Diminished Responsibility' *Discussion paper No 122* (2003), para 4.2.

²⁴² *Crimes Act 1900* (ACT) s 311; *Criminal Code* (NT) s 43J; *Criminal Law Consolidation Act 1935* (SA) s 269H; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 8; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 6(1); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 9.

²⁴³ *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 4.

²⁴⁴ *The Solicitor-General v Dougherty* (2012) NZCA 405.

²⁴⁵ Australian Law Reform Commission, 'Access to Justice: Eligibility to stand trial' Discussion Paper 81 (22 May 2014); NSW Law Reform Commission, 'People with cognitive and mental health impairments in the criminal justice system: Criminal responsibility and consequences' *Report 138* (May 2013), p. 16.

²⁴⁶ *Mental Health Act 2000* (Qld) Schedule.

²⁴⁷ Australian Law Reform Commission, above n 247.

²⁴⁸ Scottish Law Commission, above n 242, Para 4.32.

²⁴⁹ The Law Commission, above n 241, para 2.47.

²⁵⁰ Victorian Law Commission, 'Review of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*' *Report 28* (2014).

²⁵¹ The Law Commission, above n 241, para 3.15.

²⁵² *Ibid*, para 2.60.

²⁵³ Brookbanks et. al., above n 238.

134. The current tests also fail to take into account the ability to give evidence, or the fact that ‘fitness’ in this context may fluctuate by the time of the trial, or the widespread inconsistency in assessments by psychiatrists applying the criteria.²⁵⁴ This last point is addressed by Dr Russ Scott, in a detailed paper on the need for a new test in Queensland, where he observed that ‘lack of a clearer standard for determining fitness may... result in imprecise and idiosyncratic practices developing’.²⁵⁵
135. Various reform proposals have been suggested in order to incorporate a modern test of decision-making capacity into the fitness determination. The Law Commission sets out ways that the MCA criteria could be applied in this setting:²⁵⁶

Understand the information relevant to the decisions they will need to make in the course of a trial – This may apply to someone with an acquired brain injury (and would seem to incorporate the matters covered by the existing tests).

Retain that information – This may apply to someone with severe attention-deficit hyperactivity disorder who cannot focus on or retain new information.

Use or weigh that information as part of the decision-making process – This may apply to a person suffering from paranoid schizophrenia who understands the factual elements of the charge but sees no point in pleading as he or she believes everyone in court including the defence counsel is part of a conspiracy against them.

Communicate their decision – for instance, a person with severe autism who can process the information but does not acknowledge others.

136. The Australian and Victorian Law Reform Commissions support this proposal.²⁵⁷ The NSW Law Reform Commission instead favours incorporating the existing test into statute in NSW, with the addition of an element referring to the ability to use information as part of a rational decision-making process, and an ‘overarching principle’ that the defendant receives a fair trial.²⁵⁸
137. The role of support in this context is likely to affect fitness assessments, and its provision would meet the duty set out in Article 12 of the CRPD to ensure equal legal capacity by providing necessary assistance.²⁵⁹ Dr Stewart et al. surveyed Australian law regarding persons who may assist vulnerable witnesses and defendants in the courtroom. Such law is sparse and insufficient (for instance, it may allow support persons to be present in the courtroom but not to speak) or underutilised (such as courts using their power to modify their own procedures). England and Wales, by contrast, has adopted a system of Registered Intermediaries to actively facilitate communication with young witnesses who are vulnerable on account of ‘mental disorder or impairment of intelligence and social functioning or physical disability/disorder’.²⁶⁰
138. The paper notes that UK courts have considered such support for defendants:

‘Plainly consideration should be given to the use of these powers or other ways in which the characteristics of a defendant evident from a psychological or psychiatric report can be accommodated with the trial process so that his limitations can be understood by the

²⁵⁴ Ibid, para 2.64.

²⁵⁵ Scott, Russ, ‘Fitness for Trial in Queensland’ *Psychiatry, Psychology and Law* Vol 14 No. 2 (2007), p. 342.

²⁵⁶ The Law Commission, above n 241, paras 3.15-3.20.

²⁵⁷ Australian Law Reform Commission, above n 246, paras 7.40 and 7.46.

²⁵⁸ Ibid, paras 7.32-3.

²⁵⁹ Stewart et. al, above n 240, p. 892.

²⁶⁰ Ibid, p. 892, quoting from the *Youth Justice and Criminal Evidence Act 1999* (UK) s 16.

jury, before a court takes the very significant step of embarking on a trial of fitness to plead.²⁶¹

139. As noted by Brookbanks et al., there is a 'yawning gap' between the old fitness tests and current medical knowledge, which may amount to discrimination, and this leaves the tests open to challenge using the European Convention on Human Rights, which the UK is a party to.²⁶² Should a challenge succeed, it is likely that the capacity model based on the MCA will be adopted. Law reformers in Australia and New Zealand may then succeed in having similar legislation introduced.
140. Professor Jill Peay has explored the challenges that this model would present, such as adapting the capacity test to the context (e.g. Would the same test be suitable for guilty and not guilty pleas? For all possible charges? For all phases of the trial? For all possible sentences that may result?). Greater tension between courts and the mental health sector is likely too, because rapid growth in the population of defendants found unfit will strain resources in that sector.²⁶³

4.2 The insanity defence

141. Like the tests regarding fitness to stand trial, modern versions of the insanity defence are – for the most part – detailed restatements of principles established in the early 19th century. In the case of insanity defence, however, law reform bodies are not pressing to greatly alter these principles. Instead, debates centre on what conditions should be included within the scope of the defence.²⁶⁴
142. In response to the attempted assassination of the British Prime Minister in 1843,²⁶⁵ the House of Lords developed the *M'Naghten Rules*. A defendant was to be found not guilty if – at the time of committing the act – he was 'labouring under such a defect of reason, from *disease of the mind*, as not to *know the nature and quality of the act...* or, if he did know it, that he did not *know he was doing what was wrong*'.²⁶⁶
143. As a result, there are two separate ways in which a mental condition may prevent criminal responsibility arising under the traditional test. It operates in New Zealand and all Australian jurisdictions (including the Federal) accompanied by extracts from judgements that clarify key terms.²⁶⁷ In most Australian jurisdictions, the defence also applies where the condition robbed the accused of the necessary *volition* to be criminally responsible (see below).
144. New Zealand, Queensland and Tasmania retain the term *disease of the mind* and include *natural imbecility* (referring to intellectual disability). These terms have been criticised as outdated and offensive in a recent New Zealand review of the defence, but it was felt that they work well enough in practice, and the risks and difficulty involved in changing them would not be worthwhile.²⁶⁸
145. Other Australian jurisdictions instead use terms such as *mental illness*, *unsoundness of mind* or *mental impairment*. The statutes define these terms in very different ways, and to

²⁶¹ Ibid, p. 894, quoting Thomas LJ, *R v Walls* (2011) EWCA Crim 443 at 37.

²⁶² Brookbanks et. al., above n 238.

²⁶³ Peay, Jill, 'Civil Admission Following a Finding of Unfitness to Plead', in Sherry, Bernadette and Weller, Penelope (eds) *Rethinking Rights-Based Mental Health Laws* (2010) pp. 251-4.

²⁶⁴ Williams, C. R, 'Development and Change in Insanity and Related Defences' *Melbourne University Law Review* 28 (2000).

²⁶⁵ *M'Naghten's Case* (1843) 8 ER 718.

²⁶⁶ Allnutt, S., Samuels, A., & O'Driscoll, C., 'The Insanity Defence: From wild Beasts to M'Naghten' *Australasian Psychiatry*, 15(4) (2007).

²⁶⁷ Law Commission (New Zealand), 'Mental Impairment Decision-Making and the Insanity Defence' Report 120 (2010); p. 4. NSW Law Reform Commission, 'People with cognitive and mental health impairments in the criminal justice system: criminal responsibility and consequences' *Consultation Paper 6* (2010) p. 53 and Appendix D. The NSW provisions are quite minimal, incorporating the case law by referring to the accused being 'mentally ill, so as not to be responsible, according to law, for his or her action at the time': *Mental Health (Forensic Provisions) Act 1990* (NSW) s38.

²⁶⁸ Law Commission (New Zealand), above n 269, p. 6.

very different degrees; what follows is a brief survey to illustrate this point and not an attempt at summarising them all.

146. Victoria and Queensland do not define the terms at all. For the purposes of the insanity defence, NSW refers to the *Mental Health Act* definition of mental illness;²⁶⁹ NT, on the other hand, uses completely different definitions of mental illness in these two contexts.²⁷⁰
147. For insanity defences in NT, WA, ACT, SA and the Commonwealth Criminal Code, mental illness is treated as a form of *mental impairment* – a term that also includes senility, intellectual disability and brain damage. In NT, *involuntary intoxication* is expressly included as well, while intoxication is expressly *excluded* in SA.²⁷¹ Controversially, *severe personality disorders* are listed as mental impairments in the ACT and Commonwealth Criminal Codes (see below).
148. The first arm of the test is little used. It has often been interpreted narrowly, to indicate the accused did not know the ‘physical character’ of the act being committed (for example: that the weapon was a weapon, or that using it would kill the victim). The Australian High Court stated it in broader terms by referring to ‘the capacity to know and understand the significance of the act’, and the Queensland and WA statutes reflect this wider definition²⁷² (this usage of ‘capacity’ is not to be confused with ‘decision-making capacity’ as discussed elsewhere in this paper).
149. The second arm – dealing with knowledge of *wrongness* – is used far more often.²⁷³ It applies even when the accused knew their actions were illegal, if they could not understand why they were wrong. Did a disability prevent the accused from knowing ‘it was a wrong act to commit in the sense that ordinary men understand right from wrong [and] considering with some degree of composure and reason what he was doing and its wrongfulness’? Despite being grounded in a questionable view of ordinary decision-making processes,²⁷⁴ this clarification – from the Australian High Court ruling in *Porter* – is often cited, and it has been incorporated into several statutes.²⁷⁵ New Zealand law uses similar language, by referring to the defendant’s incapacity to know the act was ‘morally wrong, having regard to the commonly accepted standards of right and wrong’.²⁷⁶
150. This inquiry draws attention to the incapacity to *understand*,²⁷⁷ not to *feel*. An inability to feel empathy was found insufficient to warrant an insanity defence in *Willgoss*, where several psychiatrists had diagnosed ‘gross psychopathy’ before and after the crime was committed.²⁷⁸ However, it is possible that a personality disorder may deprive an accused of the ability to *know* their actions were wrong. This is the case even in jurisdictions which do not include a reference to personality disorders, because ‘the emphasis is not upon the label which a psychiatrist may place upon a prisoner’s personality’, but the way the disorder affects a person’s mental functioning.²⁷⁹ Ultimately, courts will approach the question ‘in a broad common sense way and not necessarily in accordance with medical evidence.’²⁸⁰
151. Several law reform bodies have canvassed proposals to include a reference to personality disorders in insanity defence statutes. Arguments in favour note that the crucial question still remains – was there a nexus between that disorder and the act in question? – and expert evidence will be available to explore it. Moreover, the application of the defence can

²⁶⁹ *Mental Health (Forensic Provisions) Act 1990* (NSW) s3;

²⁷⁰ Compare the definition in the *Criminal Code* (NT) s43A (‘an underlying pathological infirmity of mind, whether of long or short duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary stimuli’) with the much longer, more elaborate definition in the *Mental Health and Related Services Act 1998* (NT) s6.

²⁷¹ *Criminal Law Consolidation Act 1935* (SA) s 269A.

²⁷² Allnut et. al., above n 268, p. 296.

²⁷³ Sentencing Advisory Council (South Australia), ‘A Discussion Paper Considering the Operation of Part 8A of the *Criminal Law Consolidation Act 1935* (SA)’ *Discussion Paper* (2013), p. 8.

²⁷⁴ NSW Law Reform Commission, above n 269, p.68.

²⁷⁵ *R v Porter* (1936) 55 CLR 182; *Criminal Code* (Cth) s7.3; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic); *Criminal Code* (ACT) s27; *Criminal Code* (NT) s43A.

²⁷⁶ Law Commission (New Zealand), above n 269, p. 43; *Crimes Act 1961* (NZ) s23.

²⁷⁷ Law Commission (New Zealand), *ibid*, p. 44.

²⁷⁸ *Willgoss v The Queen* (1960) 105 CLR 295, at 8.

²⁷⁹ Sentencing Advisory Council (South Australia), above n 274, p. 39.

²⁸⁰ *Ibid*, p. 39.

be restricted to defendants with severe personality disorder; this is the approach that has been taken in the ACT and the Commonwealth Criminal Code, and it has not opened the floodgates.

152. The proposal has nonetheless been rejected in WA, NSW, SA and Victoria; the floodgates after all, may have been held back simply because defendants fear indeterminate detention within a forensic unit.²⁸¹ Forensic psychiatrists appear to have generally opposed the proposal; in Victoria, one noted that most offenders could 'squeeze into' the definition of personality disorder, and Forensicare noted that it does not have the resources to safely manage a large number of offenders.²⁸² Both sides of the debate seem to have agreed that personality disorders are not well understood, but they drew different conclusions as to how the law should accommodate the development of psychiatric knowledge in this area.²⁸³
153. As mentioned, most Australian jurisdictions have introduced a third arm to the defence, one that concerns *volition*. It applies to defendants who were subject to an irresistible impulse leaving them 'unable to control their conduct'.²⁸⁴ If it existed in NSW, it would have applied in *Heatley*, where the accused killed his cellmate – despite having no malice towards the victim, and despite knowing it was wrong to do so – because he was experiencing homicidal urges at the time.²⁸⁵
154. It can be difficult to distinguish this arm of the insanity defence (also known as *insane automatism*) from the defence of *sane automatism*, which results in outright acquittal.²⁸⁶ This is an 'exceedingly complex' area of law, but essentially sane automatism applies where the involuntary action does not arise from a 'disease of the mind' and is unlikely to recur. A number of conditions (such as hyperglycaemia and somnambulism) are very difficult to categorise for the purpose of these defences.²⁸⁷
155. Where this arm of the insanity defence is unavailable, law reform bodies have recently examined proposals to incorporate it. The NSW Law Reform Commission supports the change while its counterparts in Victoria and New Zealand do not.²⁸⁸ Supporters note that 'impairment of volition and difficulty with self-monitoring and self-control are common effects of an acquired brain injury'.²⁸⁹ This may also be the case for other forms of cognitive or mental health impairment. As is the case with personality disorders, expertise will be available to test the defence, and there has not been a steep rise in the number of acquittals in jurisdictions that allow it.
156. Similar counterarguments apply, however, and the challenge of determining a loss of volition is extremely high; in the words of the American Psychiatric Association, 'the line between an irresistible impulse and an impulse not resisted is probably no sharper than that between twilight and dusk.'²⁹⁰
157. Other conditions raise comparable dilemmas, especially when found in combination with each other. As noted by Associate Professor Andrew Carroll,

²⁸¹ NSW Law Reform Commission, 'People with cognitive and mental health impairments in the criminal justice system: criminal responsibility and consequences' *Report 138* (2013) p.p. 58-60.

²⁸² Victorian Law Reform Commission, 'Review of *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*', *Final Report 28* (2014), p. 112.

²⁸³ NSW Law Reform Commission, above n 268, pp. 58-60.

²⁸⁴ This is the language employed by the *Criminal Law Consolidation Act 1935* (SA) s269C (c). The following express the idea in slightly different ways: *Criminal Code* (Cth) s7.3 (1) (c); *Criminal Code* (NT) s43A s(1)(c); *Criminal Code* (ACT) s27; *Criminal Code* (Tas) s16 (1) (b); *Criminal Code* (WA) s27 (1); *Criminal Code* (Qld) s27 (1).

²⁸⁵ *R v Heatley* (2006) NSWSC 1199. The defendant was convicted of manslaughter (rather than murder) on the basis of substantial impairment: The NSW Law Reform Commission, 'People with cognitive and mental health impairments in the criminal justice system: criminal responsibility and consequences' *Consultation Paper 6* (2010), p. 61.

²⁸⁶ Victorian Law Reform Commission, 'Review of *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*', *Final Report 28* (2014) p. 108.

²⁸⁷ Law Commission (New Zealand), above n 268, p. 5.

²⁸⁸ NSW Law Reform Commission, above n 268, p. 5.

²⁸⁹ NSW Law Reform Commission, above n 268, p. 69; Law Commission (New Zealand), above n 268, p. 7; Victorian Law Reform Commission, above n 284, xlii.

²⁹⁰ Law Commission (New Zealand), above n 268, p. 50.

'There are some boundary issues around drug associated psychoses, particularly for example when people with established psychotic illnesses intentionally abuse substances and therefore become acutely psychotic. It is very difficult to establish clear boundaries in these matters...' ²⁹¹

158. Given the fact that psychiatric diagnostic criteria have been developed for the purpose of treating and researching disorders, and not for the purpose of determining criminal responsibility, a heavy burden is placed on psychiatrists to make the current defence workable, ²⁹² no matter what its precise wording. And whatever the content of the expert advice and directions from the judge, jurors will inevitably apply their own moral framework to the question of guilt. As noted by Applebaum, in the US context:

'Perceptions of which cases should be exempted from punishment are relatively resistant to alteration by rules of law, suggesting that they are embedded in individual moral codes. Many would-be reformers of the insanity defence – especially those who would abolish it altogether – have missed this point. The insanity defence is less an imposition on commonly held notions of morality than an expression of them.' ²⁹³

4.3 Forensic patient dispositions

159. According to a recent overview, Australian forensic mental health regimes exhibit greater variation in policy and performance than possibly any other area of government service delivery. The civil mental health systems, by contrast, have been subject to major reform in recent years, and it can be argued that 'national consistency appears to be the federal government's favoured approach to health reform – with the exception of forensic mental health'. ²⁹⁴ Forensic mental health systems vary markedly along every dimension, such as the legal tests that determine who will enter them, the orders that can be made (*dispositions*), the institutions that decide which order to make, and the resources available to give effect to these orders. The legal tests have been discussed; the other dimensions will be touched on to explore issues for practitioners and reform proposals.
160. Before proceeding, it should be noted that the term *forensic patient* in the following section refers to persons who have entered the forensic mental health system after being found unfit to stand trial or not guilty by reason of mental illness. Alternative terms apply in Australia and New Zealand (such as *special patient* in New Zealand), and other people can be deemed forensic patients by law, such as defendants remanded or bailed pending a determination of their fitness to stand trial, ²⁹⁵ and prisoners who have been transferred to a secure mental health unit following a diagnosis of mental illness. ²⁹⁶
161. After the UK Parliament passed the *Criminal Lunatics Act* in 1800, courts lost the option to simply acquit and release insane defendants. The special verdict of insanity was formalised (although the definition came later), and it required detention at 'his majesty's pleasure'. In theory, the Act allowed for detention until they were no longer dangerous; in practice, confinement was for life. This regime was introduced to the Australian and New Zealand colonies. In recent decades, new perspectives from the worlds of psychiatry and human rights have led the creation of new, more nuanced dispositions (these alternatives to indefinite detention may have prompted greater use of the insanity defence). ²⁹⁷

²⁹¹ Victorian Law Reform Commission, above n 268, p. 112.

²⁹² NSW Law Reform Commission, above n 268, p. 25.

²⁹³ Appelbaum, Paul S, *Almost A Revolution: Mental Health Law and the Limits of Change* (Oxford University Press, New York, 2004) p. 191-4, cited in Law Commission (New Zealand), above n 268, p. 53.

²⁹⁴ Hanley, Natalia; Ross, Stuart, 'Forensic Mental Health in Australia: Charting the Gaps', *Current Issues in Criminal Justice* Vol. 24 (3) (2013).

²⁹⁵ *Mental Health (Forensic Provisions) Act 1990* (NSW) s14; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s39 (1) (a).

²⁹⁶ *Criminal Justice (Mental Impairment) Act 1999* (Tas) s36A; *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) ss45-6.

²⁹⁷ Sentencing Advisory Council (South Australia), above n 274, pp. 100-101.

162. All Australian and New Zealand jurisdictions allow for detention at a forensic mental health facility, conditional release, or unconditional release (for minor offences).²⁹⁸ The first two options are sometimes grouped under the heading of a *forensic order* (FO) or a similar title. Some jurisdictions also allow the courts to order involuntary treatment as a non-forensic patient (providing the patient is certified as mentally ill by at least one psychiatrist), bringing them wholly under the relevant mental health legislation.²⁹⁹
163. Different safeguards have been introduced to ensure that forensic patients are not inevitably subject to an FO for life. Courts in SA and the ACT must set a *limiting term* that is equal to the prison sentence that would have applied if a finding of guilt had been made.³⁰⁰ In deciding this hypothetical sentence in SA, no reduction can be made to take account of the defendant's mental impairment.³⁰¹
164. New Zealand and NSW only provide limiting terms for patients found unfit to stand trial. In NSW it is equal to the prison term that would have otherwise been applied, and can be extended if the court is satisfied that release will seriously endanger anyone (including the forensic patient themselves).³⁰² In New Zealand the limiting term is 10 years for an offence punishable by life imprisonment, or half the maximum prison sentence otherwise.³⁰³ Victoria and NT take a similar approach to New Zealand, although the order may be extended.³⁰⁴ Elsewhere, regular reviews must be carried out to decide if a new disposition (including unconditional release) should be made.³⁰⁵
165. The issue of *who* makes these orders is harder to summarise, because courts, ministers, mental health tribunals and treating clinicians play different roles in different jurisdictions; moreover, responsibility is often determined by the interaction of criminal law and Mental Health Acts. A review by Professor Dan Howard concluded that 'there is something absurd about this variety of models in a country of barely 21 million souls'.³⁰⁶
166. The Queensland Mental Health Court allows the largest scope for involvement by psychiatrists, and has been described as 'arguably... the most enlightened and sophisticated method of determining criminal responsibility and mandatory treatment for mentally ill offenders'.³⁰⁷ The judge –assisted by two psychiatrists – is 'uniquely situated to conduct an independent investigation'.³⁰⁸ Elsewhere, it is generally the defendant who calls a psychiatrist as witness, ensuring that the psychiatrist will be cross-examined by the prosecution (and likely perceived as partial to the defence by decision-makers); in Queensland, the court not only engages their own expert witness, the rules of evidence are relaxed as well. This allows a thorough inquiry into matters bearing on the existence of a mental illness, such as the behaviour of the accused in the weeks preceding the offence, or testimony from carers.
167. The model is also geared to ensure early psychiatric intervention.³⁰⁹ A court may make an order to have the patient receive an initial assessment at an authorised mental health service; if the psychiatrist decides the patient needs to be detained, a treatment plan must

²⁹⁸ *Ibid*, pp. 116-122.

²⁹⁹ For example, New Zealand: *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s25.

³⁰⁰ The *Crimes Act 1914* (Cth) has a similar provision, but the court may replace the sentence with unconditional release or up to three years of conditional release: s20BJ.

³⁰¹ *Criminal Law Consolidation Act 1935* (SA) s269O (2); *Criminal Code* (ACT) ss302, 304.

³⁰² *Mental Health (Forensic Provisions) Act 1990* (NSW) s23 (1) and Schedule 1.

³⁰³ *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s30.

³⁰⁴ *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) ss27, 28 and 35; *Criminal Code* (NT) s 43ZG.

³⁰⁵ *Mental Health (Forensic Provisions) Act 1990* (NSW) s46; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s37; *Mental Health Act 2000* (Qld) s203; *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s24; *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s77.

³⁰⁶ Howard, Dan, 'The Detention of Forensic Patients in New South Wales and other Australian Jurisdictions – Some new developments and some thoughts on uniformity' Paper presented at the International Criminal Law Conference, Sydney (11 October 2008) p. 12.

³⁰⁷ Scott, Russ, 'Court-Ordered Treatment for Serious Offenders with Mental Illness' 16 *JLM* 405 (2008) p.412.

³⁰⁸ Edmond, W. M., 'Second reading speech' (14 March 2000) *Mental Health Bill 2000* (Qld), p. 350.

³⁰⁹ *Ibid*, p. 350.

- be prepared (and discussed with the patient) as soon as practicable.³¹⁰ Given that months can elapse before the court reaches a verdict, this clearly helps to facilitate care.
168. Unlike most jurisdictions, which confer the power to vary or revoke an FO on ministers³¹¹ or courts,³¹² in Queensland it is the Mental Health Review Tribunal which makes this decision. It must regard:
- a. the patient's mental state and psychiatric history
 - b. each offence leading to the patient becoming a forensic patient
 - c. the patient's social circumstances
 - d. the patient's response to treatment and willingness to continue treatment.³¹³
169. A 2006 Senate Committee noted that most states and territories had already transferred this power from ministers, thereby depoliticising the issue of forensic patient release³¹⁴ (this has not occurred in New Zealand).³¹⁵ Since this allows decisions to be based solely on legal and clinical considerations, the trend is likely to result in more release, increasing the need to provide medium-security facilities and treatment options in the community.³¹⁶ As in other aspects of the forensic system, however, such resources tend to fall far short of what is needed to provide effective long-term care and prevent deterioration.³¹⁷
170. The Senate Committee observed that the 'best-resourced facilities for caring for forensic offenders are in Victoria... however, even in Victoria resources are inadequate.' The Thomas Embling Hospital, for example, opened in 2000 and was expected to cater to a peak prison population of 2500; 4 years later, that population was already 3624, and imprisonment rates had increased from 66 per 100,000 to 94 per 100,000 of the population. Moreover, 'nationwide there appears to be no forensic facilities for adolescents, meaning treatment regimes for this group involve transfers back and forth between health facilities and detention, disrupting recovery.'³¹⁸
171. In recent years, Australian governments have begun to recognise these issues, although they are a long way from being solved. Some of the pressure to address them is coming from UN human rights instruments such as the CRPD and the *Standard Minimum Rules for the Treatment of Prisoners*. The latter mandates that mentally ill prisoners (not just forensic patients) be treated under medical supervision and management in specialised institutions. Law reform, resource issues and treatment needs are canvassed in some detail in the *National Statement of Principles for Forensic Mental Health*,³¹⁹ which was endorsed by the Australian Health Ministers Advisory Council in 2006.
172. The Statement acknowledges that 'in terms of service planning and development, forensic mental health has been neglected and reform has lagged behind mainstream mental health services.' They stress that offenders have the right to the same access and quality of mental health care as the general population; these services ought to be geographically and organisationally separate from mainstream prisons; they ought to be integrated with appropriate housing and community mental health services; the UN Principles apply, including in regards to consent to treatment; patient confidentiality must be respected; ministers should play no role in deciding what orders apply; and consistent state and territory legislation is desirable.

³¹⁰ *Mental Health Act 2000* (Qld) s72.

³¹¹ For example, New Zealand: *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s77.

³¹² For example, NT: Criminal Code (NT) ss43ZH and ZK.

³¹³ *Mental Health Act 2000* (Qld) s203.

³¹⁴ Australian Senate, 'Mental Health and the criminal justice system' *Senate Committee Report* (22 April 2006) 13.118.

³¹⁵ *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s33 (3).

³¹⁶ Australian Senate, above n 316, 13:120.

³¹⁷ Brayley, John, 'Crisis in forensic patient mental health inpatient care' *MedicSA* (May 2011).

³¹⁸ Australian Senate, above n 316, 13.73-75.

³¹⁹ Mental Health Services in Australia, 'National Statement of Principles for Forensic Mental Health' (2006) Preamble.

Chapter Five: Seclusion and restraint

173. In 2005, the Australian Health Ministers Advisory Council endorsed the goal of reducing and, where possible, eliminating the use of seclusion and restraint in mental health services. Affirming UN Principles 11.11³²⁰ and 11.8,³²¹ the intent is to ensure that these practices are only used as a last resort, and to minimise adverse events that accompany them. It was acknowledged that this goal requires a systemic approach which fosters incident reporting and a non-punitive culture, and implied that the high variation in definitions and clinical standards is an obstacle to this aim.³²²
174. 10 years later, the National Mental Health Commission noted major reductions in the use of seclusion and restraint, but this has been quite uneven across the different jurisdictions (seclusion rates in 2014–15 varied from a high of 31 events per 1000 bed days in NT to 2.7 in the ACT; the national average is 12).³²³ Problems relating to inconsistent definitions, data collection, standards and organisational culture also persist.³²⁴ The Victorian Act refers to both seclusion and restraint as *restrictive interventions*; the terms will be used interchangeably below unless it is necessary to be more specific.

5.1 Definitions

175. The Acts differ in regard to the restrictive interventions that they define, which interventions they regulate, and whether they regulate them in the Act and/or the Regulations (which conform to the Act and are usually mandatory).
176. The jurisdictions generally define *seclusion* as ‘the confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented’. Minor differences in wording exist, but the main differences lie in qualifying terms; in Tasmania, the confinement must also be *deliberate*, to count as seclusion, and the Act expressly states that it also counts as seclusion when applied to forensic patients.³²⁵ The old WA Act contained minimal detail,³²⁶ but the new Act adds that the person ‘is being provided with treatment or care at an authorised hospital’ and ‘is not secluded merely because the person is alone in a room or area that the person is unable to leave because of frailty, illness or mental or physical disability.’³²⁷
177. The new WA, Victoria, and Tasmania Acts and the New Zealand and ACT Guidelines variously refer to *restraint*, *bodily restraint* and *physical restraint* - generally in terms of applying force to restrict the movement of the patient. *Mechanical restraint* is generally defined in all the Acts or Regulations (except for New Zealand and the ACT) as a device applied to the patient’s body that restricts movement. Several Acts go on to expressly exclude devices used appropriately to treat physical disease or injury.³²⁸

³²⁰Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others.’ The Principle also requires its use to be recorded, monitored, notified, and in humane conditions.

³²¹ ‘...treatment may also be given to any patient without the patient’s informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons.’ This would appear to allow chemical restraint, under a narrow range of circumstances.

³²² National Mental Health Working Group (2005) ‘National safety priorities in mental health: a national plan for reducing harm, Health Priorities and Suicide Prevention Branch’, Department of Health and Ageing, Commonwealth of Australia, Canberra, p. 17.

³²³ Australian Institute of Health and Welfare, ‘Use of restrictive practices during admitted patient care’ (2015) *Mental Health Services in Australia* < <http://mhsa.aihw.gov.au/services/admitted-patient/>>.

³²⁴ National Mental Health Commission, ‘A case for change: Position Paper on seclusion, restraint and restrictive practices in mental health services’, May 2015.

³²⁵ *Mental Health Act 2013* (Tas) s3.

³²⁶ *Mental Health Act 1996* (WA) s116.

³²⁷ *Mental Health Act 2014* (WA) s212.

³²⁸ For example: *Mental Health Act 2014* (WA) s227 (4) and (5).

178. The ACT Guideline also refers to *restraint by threat* – ‘the direct or implied threat to use restraint against a person.’³²⁹

5.2 Chemical restraint

179. *Chemical restraint* is the practice whose definitions are the most inconsistent and difficult to summarise, so it needs to be considered separately. Only three jurisdictions explicitly define it; these definitions differ greatly from one another, as does the subsequent regulation. Depending on the jurisdiction, the use of medication to reduce arousal and agitation may be seen as an acceptable alternative to seclusion and restraint, rather than a form of restraint in itself.
180. In Tasmania, it is defined as ‘medication given primarily to control a person’s behaviour, not to treat a mental illness or physical condition’,³³⁰ and can be authorised by the Chief Civil Psychiatrist.³³¹
181. In NSW, it is ‘a pharmacological method used solely to restrict the movement or freedom of a consumer’ and equated with ‘the overuse of sedation’. Chemical restraint is prohibited, but medication applied in emergencies or as part of a treatment plan does not count as chemical restraint.³³²
182. In New Zealand, it is loosely defined as ‘various medicines... used to ensure compliance and to render the person incapable of resistance’, and outlawed altogether.³³³
183. In SA, the Chief Psychiatrist’s Guideline states that there is ‘no agreed definition available’.³³⁴ The Guiding Principles of the Act state that ‘medication should be used only for therapeutic purposes or safety reasons and not as a punishment or for the convenience of others’.³³⁵ Effectively, this would appear to be identical to the NSW position.
184. Similarly, the Queensland Act allows medication to be administered only when ‘clinically necessary for the patient’s treatment and care for a medical condition’; this scenario includes ‘preventing imminent serious harm to the patient or others’.³³⁶ This also appears to allow it on the same grounds as NSW. Note that NSW, New Zealand, SA and Tasmania separate therapeutic and safety goals while Queensland seems to treat safety as a therapeutic goal.
185. The ACT Guideline appears designed to eliminate confusion between therapeutic and emergency uses of medication. Instead of chemical restraint, the Guideline defines *forcible giving of medication*, which is ‘given to a person against their will when under restraint’ and ‘considered immediately necessary by the treating team for a person’s health and safety and/or the safety of others’.³³⁷
186. The Victorian Chief Psychiatrist’s Guideline is sparse on this subject. It notes that the decision to use medication during a restrictive intervention is a medical decision, and that it is appropriate to ‘target symptoms of mental illness and reduce acute arousal and agitation’, but ‘the use of medication to restrict movement (analogous to physical and mechanical restraint) is potentially hazardous and has no defined place in the Act or practice’.³³⁸ There is ambiguity in this statement, as it neither permits nor prohibits the practice. This is despite the fact that chemical restraint is defined and regulated in the same

³²⁹ ACT Health, ‘Policy: Restraint of a Person – Adults Only’ *CHHS16/025* (19 February 2016), p. 17.

³³⁰ *Mental Health Act 2013* (Tas) s3.

³³¹ *Ibid*: s57 (1) (b) (i).

³³² NSW Health *Policy Directive 2012_035*, p. 5.

³³³ This is confirmed in the subsequent paragraph: ‘All medicines should be prescribed and used for valid therapeutic indications’, Ministry of Health, *New Zealand Standard 8134.2.2:2008*, p. 5.

³³⁴ Office of the Chief Psychiatrist, ‘Restraint and Seclusion in Mental Health Services Policy Guideline’ *SA Health* (07/May/2015), p. 28.

³³⁵ *Mental Health Act 2009* (SA) s7 (g).

³³⁶ *Mental Health Act 2016* (Qld) s272.

³³⁷ ACT Health, above n 330, p. 16.

³³⁸ Chief Psychiatrist’s Guideline, ‘Restrictive Interventions in designated mental health services’ *Department of Health and Human Services* (02/July/2014), p. 6.

manner as other restrictive interventions in the Victorian *Disability Act*³³⁹ (and is the most commonly used form of restraint in the disability sector).³⁴⁰

5.3 Regulation

187. Within any given Act, seclusion and restraint tend to be regulated in a similar manner. Putting the special case of chemical restraint to one side, all the Acts allow the use of restrictive interventions necessary to prevent physical harm to the patient or others (although they all use a different form of words).
188. The Acts go on to regulate this power in a variety of ways. Some add qualifiers to 'harm' such as *imminent* or *serious*.³⁴¹ Most restate the least restrictive principle in this specific context; for example, the NT Act states restrictive intervention should only be used when 'no other less restrictive method of control is applicable or appropriate and it is necessary'.³⁴² The Victorian Act and the New Zealand and NSW Health Department Guidelines also require all other options to have been trialled or considered first.³⁴³ The New Zealand Act states a *right to company*, then frames the power to seclude as an exception to that right.³⁴⁴
189. Major divergences become obvious when looking at other grounds for the use of restrictive interventions. NSW has the most stringent criteria, allowing them only to manage the risk of *serious imminent harm*. The NT also allows interventions to stop patients *persistently destroying property*;³⁴⁵ WA does too, although the damage must be *serious*.³⁴⁶ In addition, the NT allows seclusion and restraint to prevent *absconding*,³⁴⁷ while the ACT only allows restraint on this ground.³⁴⁸
190. The ACT, NT and New Zealand Acts also allow restrictive interventions to provide *treatment*,³⁴⁹ as do the Acts in SA and Tasmania, which have the widest grounds for allowing seclusion and restraint. SA and Tasmania each have what appears to be a 'catch-all' provision that would presumably encompass absconding, property damage and other matters. The Tasmanian Act permits seclusion *to provide for the management, good order or security of an approved hospital*.³⁵⁰
191. SA allows staff to use 'confinement' and 'reasonable force':
 - a. for the purpose of carrying the inpatient treatment order applying to the patient into effect and ensuring compliance with this Act; and
 - b. for the maintenance of order and security at the centre or the prevention of harm or nuisance to others.³⁵¹

While they do not necessarily contradict each other, this power to ensure *compliance, order, and the prevention of nuisance* seems at odds with Guiding Principle 7 (h) of the SA

³³⁹ *Disability Act 2006* (Vic) s3: 'the use, for the primary purpose of the behavioural control of a person with a disability, of a chemical substance to control or subdue the person but does not include the use of a drug prescribed by a registered medical practitioner for the treatment, or to enable the treatment, of a mental illness or a physical illness or physical condition'. Part 7 regulates restrictive interventions.

³⁴⁰ Australian Law Reform Commission, 'Equality, Capacity and Disability in Commonwealth Laws' *Report 124* (2014) p. 244.

³⁴¹ For example: *Mental Health Act 2014* (Vic) ss110 and 113.

³⁴² *Mental Health and Related Services Act 1998* (NT) ss61 (3) and 62 (3).

³⁴³ *Mental Health Act 2014* (Vic) s105; NSW Health *Policy Directive 2012_035*, p. 12; Ministry of Health, *New Zealand Standard 8134.2.2:2008*, p. 9 and *8134.2.3:2008*, p. 6.

³⁴⁴ *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s71.

³⁴⁵ *Mental Health and Related Services Act 1998* (NT) ss61 (3) (c) and 62 (3) (c).

³⁴⁶ *Mental Health Act 2014* (WA) ss216 (1) (ii) and 232 (1) (ii).

³⁴⁷ *Mental Health and Related Services Act 1998* (NT) ss61 (3) (d) and 62 (3) (d).

³⁴⁸ ACT Health, above n 330, p. 5.

³⁴⁹ *Mental Health and Related Services Act 1998* (NT) ss61 (3) (a) and 62 (3) (a); *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s71 (2) (a); ACT Health, above n 330, p. 5.

³⁵⁰ *Mental Health Act 2013* (Tas) s56 (5) (d).

³⁵¹ *Mental Health Act 2009* (SA) s34A (2).

Act: ‘mechanical body restraints and seclusion should be used only as a last resort for safety reasons and not as a punishment *or for the convenience of others*.’

192. Different Acts empower different persons to order seclusion and restraint. The ACT confines this power to the Chief Psychiatrist, Care Coordinator (in community care facilities) and – in emergency departments – a Medical Officer or Mental Health Officer.³⁵² SA confers the power on the widest range of persons – simply ‘treatment centre staff’.³⁵³ Most Acts resemble New Zealand, which confers the power upon the responsible clinician or, in an emergency, a nurse or other health professional.³⁵⁴
193. In moving to the new Act, WA has, unusually, expanded the range of persons who possess this power; formerly, it was ‘a medical practitioner or, in an emergency, a senior mental health practitioner’,³⁵⁵ while it is now ‘a medical practitioner or mental health practitioner at an authorised hospital or the person in charge of a ward’.³⁵⁶
194. Most Acts also make provision for senior personnel to confirm, vary or revoke orders made by others. In Queensland, for example, the senior registered nurse on duty may authorise seclusion, but must immediately tell a doctor, who must examine the patient as soon as practicable and cancel or confirm the order.³⁵⁷ The director of the facility is also empowered to order the release at any time.³⁵⁸ The Acts also contain a variety of detailed provisions regarding intervals at which the patient must be clinically observed, which matters must be recorded, what facilities must be provided, and who must be notified.
195. Most Acts limit the duration of seclusion and restraint to the *minimum period necessary*.³⁵⁹ Some Acts expressly limit the duration of these orders (from WA – which allows 30 minutes for restraint and 2 hours for seclusion, to Tasmania – which allows 7 hours for both).³⁶⁰ The NT only imposes an absolute limit on seclusion for those admitted as voluntary patients (6 hours).³⁶¹ However, the Acts generally allow extensions after an examination by a psychiatrist or doctor if the criteria still apply.³⁶²
196. Three Acts contain penalties for imposing seclusion or restraint without proper authority. The old WA Act imposed a \$1000 fine (now lifted to \$6000).³⁶³ The NT imposes 40 penalty units.³⁶⁴ The old Queensland Act imposed 50 penalty units,³⁶⁵ but the current Act lifts this to 200 – and it specifically refers to unlawful chemical restraint.³⁶⁶

5.4 Discussion

197. As noted in the Victorian Chief Psychiatrist Guideline, ‘the use of restrictive interventions has been linked to re-traumatisation of past experiences, serious injuries and even death.’³⁶⁷ Use of seclusion and restraint fell across Australia by about 11% annually in the 5 years before 2014.³⁶⁸ New Zealand rates of seclusion were gradually rising before a *Seclusion reduction policy* was introduced in 2009; the number of people secluded has

³⁵² ACT Health, above n 330, p. 5.

³⁵³ *Mental Health Act 2009* (SA) s34A (2).

³⁵⁴ *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s71 (2).

³⁵⁵ *Mental Health Act 1996* (WA) ss122 and 118.

³⁵⁶ *Mental Health Act 2014* (WA) ss214 (1) and 230 (1).

³⁵⁷ *Mental Health Act 2000* (Qld) s162R.

³⁵⁸ *Ibid*: s162V.

³⁵⁹ For example: *Mental Health Act 2013* (Tas) ss56 (1) and 57 (1).

³⁶⁰ *Mental Health Act 2014* (WA) ss218 and 234; *Mental Health Act 2013* (Tas) ss56 (2) and 57 (2).

³⁶¹ *Mental Health and Related Services Act 1998* (NT) s62 (10).

³⁶² For example: *Mental Health Act 2014* (WA) s234.

³⁶³ *Mental Health Act 1996* (WA) ss118 and 128; *Mental Health Act 2014* (WA) ss213 and 229.

³⁶⁴ *Mental Health and Related Services Act 1998* (NT) ss62 (2) and 61 (1).

³⁶⁵ *Mental Health Act 2000* (Qld) ss162C and 162K.

³⁶⁶ *Mental Health Act 2016* (Qld) ss255, 269 and 272.

³⁶⁷ Victorian Department of Health, ‘Restrictive Interventions in designated mental health services’ *Chief Psychiatrist’s Guideline* (2 July 2014) p.1.

³⁶⁸ National Mental Health Commission, ‘A case for change: Position Paper on seclusion, restraint and restrictive practices in mental health services’ (May 2015) pp. 14-5.

fallen gradually since then, and the number of hours spent in seclusion has fallen by a third.³⁶⁹

198. Pressure to reduce or eliminate restrictive interventions continues to build from several directions, such as the increasing attention being paid to consumer and carer experiences,³⁷⁰ the growing role of the 'recovery approach' in mental health care itself,³⁷¹ commitments made and restated by Health Ministers,³⁷² and the development of quality assurance and safeguards in the National Disability Insurance Scheme.³⁷³ Moreover, the CRPD Committee and the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatments or punishments have called for an absolute ban on 'restrictive practices such as chemical, mechanical and physical restraint and seclusion'.³⁷⁴
199. Many models exist to guide the reduction of seclusion and restraint, and the National Mental Health Commission has usefully summarised research on this issue. It emphasises multi-intervention strategies around the following themes:
- Leadership at all levels of the health sector (national to local) committing to and prioritising the reduction of restrictive interventions. This includes helping staff to see that the reduction will benefit them by providing a safer, less stressful environment.
 - Improving organisational culture to promote better communication with consumers (Canberra Hospital is cited as a model here).
 - Better engagement with families, carers and support people.
 - Changes to the physical environment (for example: *sensory modulation rooms* - designed and equipped to reduce distress - have been successful in New Zealand and Victoria).³⁷⁵
 - Better training for staff in early intervention and de-escalation techniques, along with ensuring an adequate and appropriate ratio of staff to consumers.³⁷⁶

The last item reinforces a point made by the Australian Law Reform Commission: 'A key explanation for the use of restrictive practices may be the lack of resources for positive behaviour management and multi-disciplinary interventions to challenging behaviours.'³⁷⁷

Chapter Six: The duty to provide treatment

200. Modern Mental Health Acts increasingly represent a liberal concern with negative rights, guarding *against* arbitrary deprivations of liberty and autonomy, and this concern continues to find expression in new, more elaborate legal frameworks. As noted earlier, however, Article 25 of the CRPD affirms a right *to* the highest standard of physical and mental health, which is a positive right. It is elaborated by requiring governments to provide services 'as close as possible to people's own communities' which promote rehabilitation and 'early identification and intervention as appropriate'.³⁷⁸
201. This reflects a growing awareness that in contemporary mental health systems, the main issue is obtaining access to needed services, rather than avoiding restrictions on liberty.³⁷⁹ According to Dr Russ Scott, 'a fruitless discourse on the perceived benefits of the shift

³⁶⁹ Ministry of Health. 2012. *Office of the Director of Mental Health: Annual Report 2011*. Wellington: Ministry of Health, p. 24.

³⁷⁰ McSherry, Bernadette, 'Defining Seclusion and Restraint: Legal and Policy definitions versus consumer and carer perspectives', *Journal of Law and Medicine* (2015) 297, p. 302.

³⁷¹ National Mental Health Commission, above n 370, p. 17.

³⁷² Australian Law Reform Commission, above n 341, p. 243.

³⁷³ *Ibid.*, p. 243.

³⁷⁴ *Ibid.*, p. 247; Mendez, Juan E. 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment' (A/HRC/22/53, 1 February 2013) p. 15.

³⁷⁵ Melbourne Social Equity Institute, *Seclusion and Restraint Project: Report*, University of Melbourne (2014) p. 61.

³⁷⁶ National Mental Health Commission, above n 370, pp 5-9.

³⁷⁷ Australian Law Reform Commission, above n 341, p. 245.

³⁷⁸ CRPD Art. 25 b.

³⁷⁹ Carney, Terry, 'Involuntary Mental Health Treatment Laws' in McSherry, Bernadette and Weller, Penny (eds) *Rethinking Rights-Based Mental Health Laws* (2010) p. 273.

- away from paternalism towards more autonomy and self-determination for patients with mental illnesses causes the responsibility for their care and welfare to be overlooked.³⁸⁰
202. This view finds support from a set of interviews conducted with lawyers, judges, mental health professionals and consumer representatives by Kay Wilson. When asked their views on mental health law, 91% of interviewees spontaneously referred to resource problems in the sector, making it the most discussed topic in the study. Numerous examples were given of how resource constraints undermine the provision of early, effective intervention in accordance with the principles of best-practice treatment in the least restrictive manner. Instead, reactive, crisis-driven services were seen to be the norm (assuming services were available at all), with resource constraints driving the development of mental health law and policy, rather than the reverse. It was felt that those voluntarily seeking care are too often 'left to deteriorate in the community without treatment until they either commit a crime (and so enter the forensic system) or satisfy the criteria for involuntary treatment.'³⁸¹
203. Professor McSherry argues that the focus of mental health laws should be on positive rights that oblige governments to provide and fund services adapted to individual needs. On this reading, the CRPD advocates 'a midway point between treating people without their consent on the one hand, and leaving them without any care at all on the other.'³⁸²
204. For an individual to make use of a right to mental health treatment, it follows that there must be an enforceable duty on mental health services to provide it. This duty varies widely in its operation, where it does exist.
205. In a landmark US case concerning the unconstitutional treatment of involuntary patients – *Wyatt v Stickney* – a court compelled precise levels of care, including treatment plans and minimum staffing ratios.³⁸³ In many European countries, courts also have similar control over resource allocation. In Australia, as mentioned, all the Acts mandate treatment for involuntary patients, but courts and tribunals cannot determine what should be provided. A 1989 attempt by the Victorian Mental Health Review Board to compel better care for involuntary patients was met with an amendment to the Act by the state government that prevented courts and tribunals following the US lead.³⁸⁴ This was confirmed in an ACT Supreme Court decision.³⁸⁵
206. No Australian Mental Health Act ensures that persons can be voluntary outpatients,³⁸⁶ although several provide for people to become voluntary inpatients. For example, the SA Act *allows* people to be voluntarily admitted or discharged where no inpatient order applies,³⁸⁷ but this is not framed as an enforceable *duty* on the service to admit them.
207. Other Acts go further. When a NSW practitioner refuses to admit a person as a voluntary patient, the person may apply to the medical superintendent for a review of that decision.³⁸⁸ The NT allows any person aged 14 years or older (or their parents, on their behalf) to seek admission. A psychiatrist must examine them within 72 hours and may admit them if satisfied that the person has given informed consent and will benefit. If the psychiatrist refuses, the patient must be informed of the grounds for that refusal, the right to apply to the tribunal to get it reviewed, and the review procedure.³⁸⁹ The tribunal may then order admission of the voluntary patient.³⁹⁰

³⁸⁰ Scott, Russ, 'Rights-Based Mental Health Legislation and the Right to be Treated', *Journal of Law and Medicine* 15 (2008) p. 682.

³⁸¹ Wilson, Kay, 'Law reform or Systemic Reform? Stakeholder Perceptions of Resource Constraints in Mental Health in Australia, New Zealand and Canada', *Psychiatry, Psychology and Law*, 20:4 (2013).

³⁸² McSherry, Bernadette, 'Mental Health Laws: Where to From Here?' *Monash University Law Review* (2014) p. 177.

³⁸³ 325 F.Supp. 781 (M.D. Ala. 1971).

³⁸⁴ Carney et. al., above n 86.

³⁸⁵ *Ibid*, citing *J v V* [1995] ACTSC 66.

³⁸⁶ McSherry, Bernadette, 'Voluntary Treatment and the Role of the Law' in McSherry, Bernadette and Weller, Penny (eds) *Rethinking Rights-Based Mental Health Laws* (2010) p. 385.

³⁸⁷ *Mental Health Act 2009* (SA) s8.

³⁸⁸ *Mental Health Act 2007* (NSW) s11.

³⁸⁹ *Mental Health Act 1998* (NT) s25.

³⁹⁰ *Ibid*, s127 (5).

208. The former Tasmanian Act required medical practitioners to inform a patient as to why admission was refused and how to obtain appropriate medical services elsewhere. The patient was also to be informed of their right to a second opinion by an approved medical practitioner, who could request admission and give further advice and direction about treatment and care.³⁹¹ The new Act has removed these provisions, although those refused admission can appeal to the Health Complaints Commission.³⁹² In parliamentary debates it was noted that ‘for people with mental illness who may be very unwell, such a process may be beyond their capabilities and sometimes could be too late.’ The Minister responded that this appeal provision – combined with police powers to put people into protective custody in mental health facilities – met that concern.³⁹³ This is clearly a long way from the ‘early identification and intervention as appropriate’ sought by the CRPD.
209. In contrast to Australia, the New Zealand Act states that ‘every patient is *entitled* to medical treatment and other health care appropriate to his or her condition,³⁹⁴ but a ‘patient’ is defined as a person subject to compulsory assessment and treatment.³⁹⁵ Legally, then, this does nothing for people seeking voluntary admission, but in practice, ‘patient’ is given its ordinary meaning, ensuring that ‘voluntary hospital admissions are common and treatment is offered to all’³⁹⁶ with the resources that are available.
210. The entitlement implies that a clinician imposing involuntary status must ensure that the best available treatment is administered.³⁹⁷ In combination with the Guidelines and the Health and Disability Commissioner’s *Code of Health and Disability Services Consumers’ Rights Regulation*, it also places a duty on providers to work together to ensure the quality and continuity of services.³⁹⁸
211. This right can have unintended results when interacting with an under-resourced mental health sector. If suitable facilities are not available in the community, the presumption of the Act in favour of community treatment can be rebutted. An inpatient order might then be made, contrary to the principles of the Act; alternatively, a tribunal may opt to end compulsory status altogether, leaving the patient free but untreated. Sacha Wallach surveyed tribunal and court decisions which have grappled with this dilemma.³⁹⁹

Chapter Seven: Regulated treatment

Compared to the preceding topics, recent academic literature on the law of regulated treatments is scarce. A survey of the provisions concerning electroconvulsive therapy (ECT) and psychosurgery follows, incorporating major recent changes, before a brief discussion of some practical issues raised.

7.1 Electroconvulsive therapy

212. None of the Acts define ECT in precisely the same way. Acts in NSW, SA, the NT and New Zealand do not define the term at all, although NSW, SA and New Zealand (along with the ACT and Victoria) do specify the maximum number of treatments that may be administered during a *course* of ECT (this ranges from nine in the ACT – or three in emergencies – to roughly 12 in New Zealand).⁴⁰⁰ Tasmania is the exception here, as the Act contains no reference to ECT at all, leaving it subject to the same regime as other psychiatric treatment.

³⁹¹ *Mental Health Act 1996* (Tas) ss20-21.

³⁹² *Health Complaints Act 1995* (Tas) s23 (1)(a).

³⁹³ Rockliff, Jeremy, ‘Second reading Speech’ (24 October 2012) *Mental Health Bill 2013* (Tas)

³⁹⁴ *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s66.

³⁹⁵ *Ibid*: s2.

³⁹⁶ Dr Norris, Julie, *private communication*, 23 March 2016.

³⁹⁷ McKillop, above n 98.

³⁹⁸ Wallach, Sacha, ‘Resource Constraints and the Right of the Mentally Disordered to Receive Appropriate Treatment’ *Victoria University of Wellington Law Review* Vol 31.3 (2000) 525.

³⁹⁹ *Ibid*.

⁴⁰⁰ *Mental Health 2015* (ACT) s148; New Zealand Ministry of Health, Ministry of Health. 2012. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health: 10.4.

213. There is a trend in the new Acts towards including more detail in the definition. In the older ACT legislation, we see ECT defined as ‘a procedure for the induction of epileptiform convulsion’.⁴⁰¹ In the Queensland Act, it is defined as ‘application of electric current to specific areas of the head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent for the treatment of a mental illness’.⁴⁰² The additions are clearly intended to ensure ECT is performed in a safe manner and a clinically appropriate context.
214. All the Acts require informed consent to be obtained. Most also have special provisions addressing capacity to consent to ECT, or the matters which the patient must be informed about, or both. NSW is an example of a jurisdiction that contains both. A patient is to be presumed incapable of giving informed consent if affected by medication that impairs their ability to give it. The patient must receive a fair explanation of the treatment, full description of any possible risks or discomforts, and any alternative treatments; full disclosure of any financial interests involving practitioners and the facility; and notice of a right to obtain legal or medical advice, withdraw at any time, and have any inquiries answered (and the answers must appear to have been understood).⁴⁰³
215. The WA Guidelines go further and note that a lack of protest is not consent. Out of pocket expenses and other matters must be discussed, and the patient, family and doctor must be consulted before and during an ECT course.⁴⁰⁴
216. Where the patient lacks the capacity to give or withhold informed consent, an application may be made to obtain substituted consent. In Victoria, WA, the ACT and New Zealand, a single psychiatrist (or sometimes simply ‘a medical practitioner’) may make this application. In Queensland it is preferable – but not mandatory – that a second psychiatrist supports the application.⁴⁰⁵ In NSW and the NT two medical practitioners must apply. In SA, the second psychiatrist is required if the doctor recommending treatment is uncertain, or none of the seven main indications apply.⁴⁰⁶
217. Previously in WA, a second psychiatrist heard the application; now it is the tribunal. All other jurisdictions also use a tribunal for this role, although in New Zealand the Review Tribunal appoints a second psychiatrist independent of the treating team to hear the application.⁴⁰⁷
218. The issue of capacity has different implications in different jurisdictions. In Victoria, for example, an application may *only* be made if the person lacks capacity and there is no less restrictive way to treat the patient. Establishing if it is the least restrictive way requires extensive consultation.⁴⁰⁸ In NSW, the tribunal may also approve ECT if the patient ‘is capable of giving informed consent to the electroconvulsive therapy but has refused, or has neither consented nor refused, to have the treatment administered’.⁴⁰⁹ However, a unique provision allows the medical superintendent to prohibit ECT even after tribunal approval.⁴¹⁰
219. All the jurisdictions (with the exception of New Zealand, Tasmania and NSW) have separate regimes for regulating emergency ECT. The least stringent is that of SA, which allows a psychiatrist to administer it if it is urgently needed for the patient’s well-being and it is not practicable to obtain the patient’s consent. The Chief Psychiatrist must be notified within 1 business day afterwards.⁴¹¹
220. The most stringent is found in the ACT, where the treatment must be necessary to save the patient’s life or prevent the likely onset of a risk to the patient’s life within 3 days. The Chief

⁴⁰¹ *Mental Health (Treatment and Care) Act 1994* (ACT) s55; this definition has been retained in the new Act: *Mental Health Act 2015* (ACT) s145.

⁴⁰² *Mental Health Act 2015* (Qld) Schedule 3.

⁴⁰³ *Mental Health Act 2007* (NSW) s91.

⁴⁰⁴ Chief Psychiatrist for Western Australia, *Guidelines for the use of ECT 2006*.

⁴⁰⁵ Queensland Health, *Guideline for the Administration of ECT 2012*: 4.3.4; *Mental Health Act 2000* (Qld) s139, 229; *Mental Health Bill 2015* (Qld) s505.

⁴⁰⁶ Office of the Chief Psychiatrist (SA) ‘Electroconvulsive Therapy Standard’ (1 July 2014), p. 4.

⁴⁰⁷ *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s60 (b).

⁴⁰⁸ *Mental Health Act 2014* (Vic) s93.

⁴⁰⁹ *Mental Health Act 2007* (NSW) s96 (3).

⁴¹⁰ *Ibid*: s90.

⁴¹¹ *Mental Health Act 2009* (SA) s42 (7).

Psychiatrist and a doctor must jointly apply to the tribunal, which may make the order if it is necessary and all other reasonable forms of treatment available have been tried but have not been successful, or the treatment is the most appropriate reasonably available. The tribunal must determine that the patient has mental illness, lacks capacity to consent, and has not made a relevant advance statement refusing ECT; the views of the patient and their carers must be taken into account.⁴¹²

221. Recent Acts and Guidelines explicitly allow for a patient to give or withhold informed consent in an advance statement.⁴¹³ In Victoria, the psychiatrist must consider a pre-emptive refusal, but other factors must be regarded when deciding if there is no less restrictive way to provide treatment.⁴¹⁴
222. Where ECT is administered without genuine or substituted consent, the penalties vary widely. Acts in NSW, Tasmania and Victoria set out no special penalties, while other states impose a range of fines and/or prison terms. The most severe are found in SA: a maximum of \$50,000 or 4 years jail.⁴¹⁵
223. Professor Colleen Loo has discussed the clinical implications of legislating a maximum number of treatments per course of ECT. Instead of achieving optimal outcomes by starting with moderate doses, 'practitioners are likely to prescribe relatively high-dose bilateral ECT for all patients at the outset of treatment, or to move to this form of ECT prematurely' to avoid leaving the patient partially and inadequately treated at the end of the approved course. While the legislation does allow extensions to be sought from the tribunal, there are practical issues here. At the hearing, the patient may be showing signs of improvement, leaving the tribunal reluctant to approve further ECT, although it may be required to avoid a high risk of relapse. Moreover, these hearings can be 'adversarial and emotionally traumatic for all involved', putting strain on the therapeutic relationship.⁴¹⁶

7.2 Psychosurgery

224. Definitions of psychosurgery are less varied than ECT, although some Acts refer to it as 'neurosurgery for mental illness' or simply 'brain surgery'. In NSW, it is defined as 'the creation of one or more lesions, whether made on the same or separate occasions, in the brain of a person by any surgical technique or procedure, when it is done primarily for the purpose of altering the thoughts, emotions or behaviour of the person', or the use of electrodes within the brain to produce lesions, or to influence or alter the brain through stimulation.⁴¹⁷
225. Most Australian Acts define it in very similar terms. The New Zealand Act refers to 'treatment intended to destroy any part of the brain or brain function'.⁴¹⁸ This would presumably exclude deep brain stimulation (DBS) through the use of electrodes.⁴¹⁹
226. Psychosurgery to treat mental illness is prohibited in NSW and the NT.⁴²⁰ Psychosurgery is prohibited under the Queensland Act, although non-ablative procedures such as DBS are allowed.⁴²¹ Other jurisdictions allow psychosurgery if the patient gives informed consent, at least one psychiatrist recommends it, and a tribunal approves.⁴²¹ SA permits psychosurgery upon application to the tribunal 'if consent cannot be given by the patient.'⁴²²

⁴¹² *Mental Health Act 2015* (ACT) s160-162.

⁴¹³ For example: SA Health, above n 312, p. 5.

⁴¹⁴ *Mental Health Act 2014* (Vic) s93 (2) (b).

⁴¹⁵ *Mental Health Act 2009* (SA) s55 (8).

⁴¹⁶ Loo, Colleen, 'The NSW Mental Health Bill 2007: implications for the provision of electroconvulsive therapy', *Australasian Psychiatry* Vol 15 (6) (2007).

⁴¹⁷ *Mental Health Act 2007* (NSW) s83.

⁴¹⁸ *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s61.

⁴¹⁹ Loo, Colleen, 'Mental Health Legislation and psychiatric treatments in NSW: electroconvulsive therapy and deep brain stimulation' *Australasian Psychiatry* Vol 18 (5) (2010) p. 420.

⁴²⁰ *Mental Health Act 2007* (NSW) s83; *Mental Health and Related Services Act 1998* (NT) s58.

⁴²¹ *Mental Health Act 2016* (Qld) ss239 and 241.

⁴²¹ For example: *Mental Health Act 2014* (Vic) ss100-102.

⁴²² *Mental Health Act 2009* (SA) s43 (1) (c) (ii).

227. A unique provision exists in the ACT allowing the Supreme Court to order the treatment if the patient lacks decision-making capacity and has not refused, either orally or in writing, to consent. The court must be satisfied that a substantial benefit to the person is likely, and all alternative forms of treatment reasonably available have failed, or are likely to fail, to benefit the person.⁴²³ Penalties across Australia for performing psychosurgery without consent are similar to those for ECT.
228. The ban on psychosurgery imposed by the new NSW Act has also been discussed by Professor Loo. While the older forms of psychosurgery 'have not been part of psychiatric practice for decades', she argues that DBS should be, as it is an evidence-based treatment that is reversible, fully adjustable, causes no lesions, and is currently permitted in NSW for the treatment of Parkinson's disease. The prohibition unduly restricts experimentation and treatment, and complicates the treatment of persons from outside NSW who need ongoing care and monitoring of their implants. The risks are the same whether DBS is used to treat Parkinson's or psychiatric disorders, so 'the prohibition cannot be based primarily on risks'; instead, it may reflect a perceived boundary between neurological and psychiatric disorders that is becoming less tenable, given recent developments in neuroscience and neuroimaging.⁴²⁴

Conclusion

Despite convergence in many areas dealing with involuntary commitment, capacity and regulated treatments, as well as seclusion and restraint, the legislated tests still vary a great deal, as do the results that flow from them. The rate of change is also an issue; the NSW provision governing Mental Health Inquiries has been amended 17 times since it was enacted in 2007, for example.⁴²⁵ This context poses obvious challenges to the identification of bi-national best practice. The key consideration is to become familiar with the logic of these changes, which flows from international law into domestic laws aiming at collaborative clinical relationships and stronger consumer rights. Where practitioners believe they need to substitute their decision, they often still can, but they need to be familiar with the changing tests and committed to exploring less restrictive options beforehand. They also need to bear in mind that much of this is new terrain for patients, support persons and other health-care workers. The more successful practitioners are in acquainting themselves with the new mental health legislation and the philosophy that underlies it, the better placed they will be to educate others, foster collaboration, and provide the best treatment.

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⁴²³ *Mental Health Act 2016* (ACT) s173.

⁴²⁴ Loo, above n 419.

⁴²⁵ *Mental Health Act 2007* (NSW) s25.

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REVISION RECORD

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