

LEARNING FROM THE PAST, LOOKING TO THE FUTURE: IS VICTORIAN MENTAL HEALTH LAW RIPE FOR REFORM?

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A. Introduction

History tells us that we have a tendency to re-write our mental health laws once every generation. Victoria's mental health laws have been significantly re-written on seven occasions over the past 140 years.¹ As it is now 21 years since the current *Mental Health Act*² was enacted, and almost 30 years since the policy which underpinned that legislation was first developed by the Myers Committee,³ it may be time to legislate again.

The conditions that the current *Mental Health Act* originally sought to regulate no longer exist. The 1980s was still an era of the large stand-alone psychiatric hospital. Once significant institutions such as Willsmere, Larundel, Mont Park, Royal Park, Mayday Hills, Aradale, Brierly, and Lakeside are now nothing more than names in the history books, albeit names which conjure up strong memories for those of us who worked, or lived, at one of those hospitals.

While it may well be time to think about legislating again, I suggest we do so with realistic expectations. On previous occasions I have cautioned against expecting too much from new mental health laws⁴ and I am certainly not alone in suggesting that we must constantly remind ourselves of the limits of the law to bring about change in this area.⁵ It is almost trite to suggest that new mental health legislation can neither prevent nor cure mental illness, that it does not have the capacity to dramatically alter the way in which mental health services are delivered, and that new laws, no matter how well-intentioned, cannot alleviate most of the significant difficulties which many people with a mental illness will continue to face on a daily basis when seeking to live with their illness. It is also sobering, especially for those of us who are lawyers, to be reminded that the 'great' changes in the delivery of mental health services over the

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¹ The most important statutes are as follows: *Lunacy Act 1867* (Vic); *Lunacy Amendment Act 1888* (Vic); *Lunacy Act 1903* (Vic); *Lunacy Act 1928* (Vic); *Mental Hygiene Authority Act 1950* (Vic); *Mental Health Act 1959* (Vic); *Mental Health Act 1986* (Vic). Most of these Acts were amended on many occasions before they were repealed.

² *Mental Health Act 1986* (Vic).

³ *Report of the Consultative Council on Review of Mental Health Legislation*, December 1981 (Dr D Myers, Professor R Ball and Ms D Fitzgerald); generally known as the 'Myers Report'.

⁴ See eg N Rees, 'Model Mental Health Legislation in Australia', Centre for Health Law, Ethics and Policy (University of Newcastle), *Mental Health For All: What's the Vision?* (1997) at p 87.

⁵ This point is made by numerous commentators; see eg K Jones, 'The Limitations of the Legal Approach to Mental Health' (1980) 3 *International Journal of Law and Psychiatry* 1.

past few decades did not come about because of legislative change. It is the executive branch of government, rather than the legislature, that determines the manner in which public mental health services are delivered. Invariably, legislation is enacted at some later date in order to signify parliamentary approval for completed actions and entrenched practices.

A few examples should suffice. Both compulsory community treatment and deinstitutionalisation occurred without an express legislative mandate. Prior to the commencement of the current *Mental Health Act* in 1987, which introduced the notion of community treatment orders, there were literally thousands of people receiving compulsory treatment in the community as patients on trial leave under the pre-existing legal regime.⁶ The community treatment order provisions in the 1986 Act simply ratified and formalised this pre-existing practice. Deinstitutionalisation – the movement of long-term patients into community accommodation accompanied by the closure of large stand-alone psychiatric hospitals in which they had lived – was an administrative act. There is nothing in the original 1986 Act, or in important associated documents such as the Minister’s second reading speech, which reveals that the large hospitals which housed most of the people to whom the Act was directed would be closed within a matter of years and without one stroke of the legislator’s pen.

Perhaps the only laws that have the capacity to profoundly influence the manner in which mental health services are delivered are those which are enacted on an annual basis by the Commonwealth and State parliaments: annual budgets or, as they are more formally known, *Appropriation Acts*. This is not the occasion, however, to debate the proportion of our annual governmental expenditure which should be devoted to mental health care and to research. Nor is it the occasion to consider whether, as part of a new era of federalism, responsibility for the provision of mental health services should pass from the states to the Commonwealth, particularly as it is the Commonwealth which possesses the financial power in our system of government.⁷

If my thesis that legislative change usually follows rather than precedes real change is correct, some of the reform proposals discussed in this paper could be implemented on a trial basis now in the knowledge that, if they prove to be successful, they may become law in due course.

B. A brief history of Victorian mental health legislation

What lessons may we learn from past exercises in mental health law reform? It is not an exaggeration to suggest that mental health services appear to have been in almost perpetual crisis for most of the past 150 years and that mental health law reform has often been advocated as a way out of crisis. Indeed, has there ever been a period of more than a few years when the quality of public mental health services has been widely praised and when the clamour for mental health law reform has been stilled?

⁶ This practice was ostensibly supported by s 87 *Mental Health Act 1959* (Vic).

⁷ Arguably, no Constitutional change is necessary for the Commonwealth to enact mental health laws and to directly administer mental health services because s 51(xxiiiA) of the *Constitution* permits the Commonwealth to legislate with respect to “medical and dental services”.

A review of the historical material reveals that earlier generations grappled with many of the problems which still confront us today. At their core, the problems that lead to public disquiet were usually associated with over-crowding of institutions, poor quality of services, and morale difficulties among staff who worked in those institutions.

Not surprisingly, our forebears often devised solutions that are not far removed from those which attract support today. The historical material also discloses a recurring pattern of law reform. Public disquiet about the poor quality of mental health services forced the government of the day to establish some form of commission of inquiry which recommended, amongst other things, the passage of new legislation in order to overcome the ills which the inquiry had revealed. Inevitably, some later disclosure concerning the poor quality of services lead the government of the day to set up the next commission of inquiry which reported that the legislative response to the findings of the last inquiry had wholly or partially failed to alleviate the problems that had been earlier identified.

Victoria's first institution for people with a mental illness, the Yarra Bend Lunatic Asylum, opened its doors in 1848, a mere 13 years after the first European settlement in Melbourne.⁸ In 1867, only 11 years after the Victorian Parliament first met, the Minister responsible for the carriage of the Bill which was to become the *Lunacy Act 1867*, commented that the need for new lunacy laws had "long been felt" and that "successive Governments...[had] been impressed with the necessity for securing improved treatment for the unfortunate creatures who are the victims of lunacy".⁹ The Government's response to these concerns was a massive statute which illustrates that prolixity in legislation is not a modern phenomenon. The 1867 Act contains 190 sections which occupy 99 pages of the statute book.

This first Victorian mental health statute fulfilled the same broad legal purpose as all subsequent mental health legislation: it authorised the loss of two important freedoms or liberties – those of movement and of bodily integrity¹⁰ – for some mentally ill people in some circumstances and it established administrative machinery that dealt with matters associated with these incursions upon freedom. Those administrative matters in the 1867 Act ranged from the manner of admission to a public asylum, to the processes to be followed when determining whether a public official should manage the property of an alleged lunatic.

Despite the optimism of the 1860s the now familiar cycle of 'crisis, followed by inquiry, followed by legislation' ensued, leading in the early 1880s to the establishment of a royal commission into mental health care. Buoyed by the recommendations which emerged from the Zox Royal Commission, which included the mainstreaming of mental health services, the Victorian Parliament legislated again in 1888. The Chief Secretary, Mr Alfred Deakin, who was to become a towering figure in Australian public life, introduced the Bill that became widely known as the Deakin Act. Two of the reforms which commended themselves to parliamentarians in

⁸ Prior to 1851, NSW law applied in the Port Phillip District. There is a useful summary of early NSW mental health law in J McClemens and J Bennett, 'Historical Notes on the Law of Mental Illness in NSW' (1962) 4 *Sydney Law Review* 49.

⁹ Victoria, Parliamentary Debates, Legislative Assembly, (1867) p 470 (Mr McCulloch).

¹⁰ In this early legislation there was less emphasis upon involuntary treatment than upon involuntary detention.

1888 were the privatisation of some mental health services and treatment in the community. One member of the Legislative Assembly was bold enough to suggest that “the chief requirement in connexion with the treatment of [mentally ill people] was not physic, but rest, quiet and care. The less mere doctoring they got the better”.¹¹

By 1903 the Government felt it necessary to legislate again. The responsible Minister reported to the Legislative Assembly that the hopes of the Deakin Act had not been realised.¹² In the opening years of the 20th century some of the major concerns of the legislators were the large and steady increase in the prevalence of mental illness,¹³ the failure of privatisation of some mental health services, and the need for proper checks and balances so that people who were not insane did not languish in public asylums or private institutions. Early intervention was seen as an effective means of responding to the increasing demands being made for assistance. A number of additional reforms were proposed. It was felt that mental health legislation should become more intelligible. Private licensed houses for rich mentally ill people were permitted. In 1914 the law was amended in order to allow people to admit themselves to asylums and licensed houses as voluntary patients in order to advance the cause of early intervention.¹⁴

By 1928 our forebears had decided to legislate again. The First World War had created the need for new facilities to care for returned soldiers who had developed a mental disorder as a consequence of their war service.¹⁵ A few years later the government of the day decided that it was time to abandon old-fashioned nomenclature and to cautiously embrace the notion of community treatment by legislating to permit trial leave.¹⁶ Under the *Mental Hygiene Act 1933* the Lunacy Department became the Department of Mental Hygiene and the Inspector-General of the Insane became the Director of Mental Hygiene.¹⁷

Within a decade the newspapers were criticising the work of the Department of Mental Hygiene. Two inquiries were held in the late 1940s in order to find a way forward.¹⁸ In 1950 Parliament legislated again.¹⁹ The Minister for Health reported that there were 8000 patients in Victoria’s ‘mental establishments’ and he referred to the estimate advanced by the head of the second inquiry, Professor Kennedy from Durham University, that it would take 10 years to put the State’s mental institutions on a proper footing.²⁰ Much of the *Mental Health Act 1950* was devoted to the

¹¹ Victoria, *Parliamentary Debates*, Legislative Assembly, 28 November 1888, p 2209 (Mr Officer).

¹² Victoria, *Parliamentary Debates*, Legislative Assembly, 20 October 1903, p 699 (Mr Murray).

¹³ At that time Victoria had over 4,500 psychiatric beds with a population of 1,208,854 (*Victorian Year-Book 1903* at p 117). The Chief Secretary, Mr Murray, told Parliament: “Never in the history of our country was there such a large proportion of insane to the population, and the proportion to the population grows greater year by year. The causes of this great increase of insanity I will not even attempt to seek at the present time...” (Victoria, *Parliamentary Debates*, Legislative Assembly, 20 October 1903, p 705 (Mr Murray)).

¹⁴ Section 8 *Lunacy Acts Amendment Act 1914*.

¹⁵ See M Lewis, *Managing Madness: Psychiatry and Society in Australia 1788-1980*, AGPS, Canberra, 1988 at p 39.

¹⁶ See the Second Reading Speech of the Chief Secretary for the Mental Hygiene Bill 1933, Victoria, *Parliamentary Debates*, Legislative Assembly, 5 December 1933, p 3170 (Mr MacFarlan).

¹⁷ Section 2 *Mental Hygiene Act 1933*.

¹⁸ See Lewis, above n 15, at pp 79-80.

¹⁹ *Mental Hygiene Authority Act 1950*.

²⁰ Victoria, *Parliamentary Debates*, Legislative Assembly, 18 October 1950, p 1379 (Mr Fulton).

establishment and structure of the new Mental Hygiene Authority as better administration was seen to be the way forward.²¹

In 1952 Dr Eric Dax arrived in Victoria to become the head of the new Authority. In his now famous book Dax wrote about “a dismal picture of the conditions in 1952” with the various institutions “mostly in a state of utter neglect and far below the standard of the oldest and most backward hospitals at the time in Great Britain.”²² As Lewis points out, “Victoria was the first State to come to grips with the legacy of neglect and parsimony”²³ for, somehow, Dax managed to achieve an almost 400% increase in public funding on mental health services over a decade.²⁴

In 1959 the Victorian Parliament legislated again, this time to update the terminology and to consolidate the numerous amendments that had been made to the existing legislation. The *Mental Health Act 1959* contained few safeguards concerning loss of liberty and of bodily integrity, probably because this was an era of great confidence in the ability of the medical profession to treat and care for people with a mental illness. The superintendent of any hospital and the authorised medical officer were empowered to consent to any surgical or medical treatment on behalf of any patient, whether recommended (involuntary) or voluntary, and without any need to determine whether the patient was competent to express a view about his or her proposed treatment.²⁵ The only external review of any decision to detain and treat a person as an involuntary was by way of statutory habeas corpus proceedings in the Supreme Court.²⁶

The *Mental Health Act 1959* remained in force for 25 years.²⁷ Agitation for new mental health laws commenced in the late 1970s but it was not until 1986 that new legislation made its way through Parliament. The original Bill, which was prepared in response to the Myers Report,²⁸ was introduced into the Victorian Parliament in the mid 1980s. It was subjected to over 100 amendments before it became the *Mental Health Act 1986*. The most significant change effected by that legislation was regular external review of involuntary patients. The Mental Health Review Board entered a relatively closed world in which the superintendents of large hospitals, who exercised significant powers, had seldom been challenged or overruled.

Our current mental health legislation has now been in operation for 20 years. That Act has been amended on 52 separate occasions. While the Act was a reasonably ‘user friendly’ document when freshly minted, it has become an almost impenetrable legal porridge for all but the legally trained and mental health law aficionados. For this reason alone, it may be timely to re-visit the legislation.

²¹ See Lewis, above n 15, at p 81.

²² E Dax, *From Asylum to Community: The Development of the Mental Hygiene Service in Victoria, Australia*, Cheshire, Melbourne, 1962.

²³ Lewis, above n 15, at p 81.

²⁴ See Dax, above n 22, at pp 222-223.

²⁵ Section 102 *Mental Health Act 1959*.

²⁶ Section 99 *Mental Health Act 1959*.

²⁷ The Act commenced operation on 1 November 1962. It was repealed by the *Mental Health Act 1986* which commenced operation on 1 October 1987.

²⁸ See n 3.

There are, however, other reasons to do so as well. Inevitably, our shared community values change over time. In Victoria we have recently identified and codified some of those values in the *Charter of Rights and Responsibilities Act 2006*. Two relevant rights, when mental health laws are under consideration, are found in sections 10 and 21 of the *Charter*. Both sections support the values of autonomy and respect for human dignity. Section 10 of the *Charter* stipulates that a person “must not be subjected to medical...treatment without his or her full, free and informed consent”, while s 21 declares that “[e]very person has the right to liberty and security”. The Victorian Parliament has also acknowledged that these values may be curtailed at times for s 7(2) provides that the human rights recognized in the *Charter* “may be subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom...”

C. The values which have underpinned mental health legislation

Express statements of legislative objectives and principles are a relatively recent phenomenon. Consequently, we are required to surmise in order to determine the community values which earlier legislators were seeking to implement when they passed new laws. It is highly likely that, until quite recently, the values which drove our mental health laws were paternalism, protection of the community, and a desire to minimise family shame and suffering. In the earlier times there was some legislative emphasis upon ensuring that freedom of movement was not lightly lost, but that emphasis appeared to fade in the middle of the 20th century when psychiatric treatment improved dramatically. While there is no evidence that protection of the right of bodily integrity was ever a dominant value, the enduring legislative official visitor provisions are evidence of the fact that some external oversight of treatment and care has long been considered desirable.²⁹

D. Some values which may guide new mental health laws

The values which we seek to incorporate within our mental health laws have clearly been evolving. There appears to have been considerable movement in those values in the 21 years since the passage of the *Mental Health Act 1986*. In 1986 we were primarily moved by beneficence, by concern to protect the community from harm, and by the desire to ensure that liberty was not lost without appropriate checks and balances. Those liberty concerns transcended the interests of people with a mental illness, as has always been the case. People without any mental illness have always had a strong and understandable desire to ensure that they would not lightly be adjudged mentally ill and deprived of their liberty.

Twenty years ago we still accepted that in-patient treatment would be the norm for many people. We wanted people to have the opportunity to access that treatment as quickly as possible, but, being mindful of the numerous failings and negative side effects of placement in a psychiatric hospital, we wanted, in our beneficence, to ensure that periods in hospital would be as brief as possible. Hence, the notion of the

²⁹ Official visitors appear to date from the *Lunacy Act 1903*.

'least restrictive environment' found in the objects of the Act.³⁰ Because of our strong reliance upon the notion of beneficence, we did not directly confront the issue that compulsory treatment for involuntary patients is a huge incursion upon their freedom of bodily integrity. Things started to change within the space of a decade, however. In 1995 the Act was amended to include principles of treatment and care. Two of the many principles listed in the Act are that "the provision of treatment and care for people with a mental disorder should promote and assist self-reliance" and that "every effort that is reasonably practicable should be made to involve a person with a mental disorder in the development of an ongoing treatment plan".³¹ The great challenge, of course, is to translate those values into measures which actually work in practice.

The changes in international instruments also reveal how our shared values evolve over time. In the early 1990s the values espoused in the United Nations' *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*³² gained widespread support in many countries, including Australia.³³ Principle 11, which is concerned with consent for treatment, was soon the subject of criticism because it comes down so clearly on the side of beneficence rather than autonomy when dealing with the issue of psychiatric treatment for involuntary patients.³⁴ The pendulum has now swung, however, with the recent adoption by the United Nations of the *Convention on the Rights of Persons with Disabilities*.³⁵ The first of the general principles in the Convention is "respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons".³⁶ Australia was one of the first nations to sign the Convention and the Government is currently considering ratification.³⁷ In the international arena, as in Victoria under the new *Charter*, the values of autonomy and respect for human dignity are coming to the fore.

E. Possible areas for reform

In this paper I have dealt with seven possible areas for reform of our mental health laws. No doubt, I have simply scratched the surface. Most if not all of the matters on my list of possible reforms are not recent inventions. They are recycled means of dealing with perpetual challenges. Some of the matters clearly overlap. I do not have concluded views in relation to any of them. I offer them for public discussion.

³⁰ See s 4(2)(b) *Mental Health Act 1986* (Vic).

³¹ Section 6A(d) and (j) *Mental Health Act 1986* (Vic).

³² General Assembly Resolution 46/119; Report A/46/721 (1991), generally referred to as the 'UN Principles'.

³³ See eg E Rosenthal and L Rubenstein, 'International Human Rights Advocacy under the "Principles for the Protection of Persons with Mental Illness"' (1993) 16 *International Journal of Law and Psychiatry* 257.

³⁴ See eg C Gendreau, 'The Rights of Psychiatric Patients in the light of the Principles announced by the United Nations: A Recognition of the Right to Consent to Treatment?' (1997) 20 *International Journal of Law and Psychiatry* 259.

³⁵ The full text is available on the United Nations' website: www.un.org/disabilities/. The Convention was adopted on 13 December 2006.

³⁶ Article 3(a) *Convention on the Rights of Persons with Disabilities*.

³⁷ The Australian Government has commenced the 'pre-ratification' process which includes consultation with various stakeholders and an assessment of whether ratification is in the national interest. See Australian Government Attorney General's Department website: www.ag.gov.au

I have not included any matters concerning the criminal law and forensic patients in the list because issues of criminal responsibility, and associated matters such as the disposition of offenders with a mental illness and the gate-keeping powers of judicial officers for forensic beds, are so complex that they merit separate consideration. Consequently, all of my comments are directed towards civil mental health laws. These are the laws which govern people who have committed no wrong but who have, or are thought to have, a mental illness and for whom we have special laws which render it lawful for them to be deprived of their liberty and to be given treatment under compulsion in some circumstances.

1. Advance directives

Our current law takes an absolutist position when dealing with psychiatric treatment for involuntary patients. This statement requires explanation by reference to the body of law that governs consent to medical treatment. Unless a person is an involuntary patient, the law deals with psychiatric treatment in precisely the same way as it deals with any other medical intervention. The patient must consent to the treatment and be provided with a reasonable amount of information for it to be lawful.³⁸ This broad principle is supported by the torts of trespass to the person³⁹ and of negligence.⁴⁰ In extreme cases, it is also supported by the criminal law of assault. However, when a person becomes an involuntary patient – and this term includes people on community treatment orders – the need for consent is removed, absolutely. After stipulating that an involuntary patient must be given treatment for his or her mental illness,⁴¹ the *Mental Health Act* provides as follows:

If an involuntary patient refuses to consent to necessary treatment or is unable to consent to treatment for his or her mental illness, consent in writing may be given by the authorised psychiatrist.⁴²

This power may be characterised as a form of ‘clinical guardianship’ because the treating doctor becomes the substitute decision-maker for psychiatric treatment. Because reliance upon the ‘refusal’ limb of this treatment power is often seen as being clinically undesirable, patients who actively indicate lack of consent for a particular form of psychiatric treatment may be deemed to be unable to consent to treatment due to lack of insight. Whichever limb of the power is used, however, it represents a significant incursion upon an important freedom – that of bodily integrity – and it involves an important allocation of substitute decision-making power to a person who is a complete stranger.

Perhaps it may be time to reconsider both the absolutist nature of this loss of what has been an important common law freedom – and what is now a *Charter* protected

³⁸ See *Rogers v Whitaker* (1992) 175 CLR 479.

³⁹ See *Secretary, Department of Health and Community Services v JWB (Marion’s case)* (1992) 175 CLR 218.

⁴⁰ See *Rogers v Whitaker* (1992) 175 CLR 479. When discussing points of principle the majority of the High Court (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ) quoted with approval the following statement from an earlier case: “the paramount consideration [is] that a person is entitled to make his own decisions about his life” (175 CLR 479 at 487).

⁴¹ Section 12AD(1) *Mental Health Act 1986* (Vic).

⁴² Section 12AD(2) *Mental Health Act 1986* (Vic).

human right⁴³ - not to be subjected to medical treatment without consent, as well as the identity of the person who becomes the substitute decision-maker when an involuntary patient is unable to consent to treatment. There may be circumstances in which the wishes of an involuntary patient should influence both the content of psychiatric treatment decisions, clinically and legally, and the identity of the person who makes those decisions.

Current Victorian law permits an adult person to take various legal steps in order to ensure that his or her wishes concerning medical treatment are followed if at some stage in the future that person is unable to inform the people responsible for his or her treatment of those wishes. Those wishes concerning medical treatment may be both positive and negative in the sense that the person concerned may have wishes concerning types or forms of treatment that he or she wishes to have in certain circumstances, and wishes concerning treatment that he or she does not wish to have in certain circumstances. The legal mechanisms by which these wishes may be put into effect are relatively recent additions to the statute book.⁴⁴ In the international literature they are generally referred to as ‘instructional directives’, ‘proxy directives’ and ‘hybrid directives’.⁴⁵ The meaning of these terms is self-evident: an ‘instructional directive’ permits a person to record his or her wishes concerning medical treatment in the future, a ‘proxy directive’ permits a person to appoint someone else to make decisions about his or her medical treatment in the future, and a ‘hybrid directive’ permits a person to appoint another person to make decisions about future medical treatment armed with instructions which record the wishes of the person giving the directive.

With one exception, Victorian law does not authorise ‘instructional directives’. Under the *Medical Treatment Act 1988* a person who “is of sound mind and has attained the age of 18 years”⁴⁶ may give a written direction, known as a ‘Refusal of Treatment Certificate’, in which he or she refuses any treatment, or refuses treatment of a particular kind, for a medical condition which the person has at the time of making the direction.⁴⁷ There are two legal mechanisms by which a person may appoint an agent, or a proxy, to make medical decisions on his or her behalf at some time in the future. The *Medical Treatment Act* permits a person to appoint an agent to make future medical treatment decisions by preparing a document known as an ‘Enduring Power of Attorney (Medical Treatment)’.⁴⁸ It is also possible to bring about the same result by appointing an enduring guardian pursuant to the provisions of the *Guardianship and Administration Act 1988*.⁴⁹ This provision effectively permits a ‘hybrid directive’ to be made because the guardian must exercise his or her

⁴³ Section 10(c) of the *Charter of Human Rights and Responsibilities Act 2006* provides that ‘a person must not be subjected to medical treatment without his or her full, free and informed consent’. Section 7(2) of the same Act declares that rights of this nature ‘may be subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society...’

⁴⁴ The status of advance directives at common law is not clear: see C Stewart, ‘Advance Directives: Disputes and dilemmas’ in I Freckelton and K Petersen (eds), *Disputes and Dilemmas in Health Law*, Federation Press, Sydney, 2005 at p 38; J Atkinson, *Advance Directives in Mental Health: Theory, Practice and Ethics*, Jessica Kingsley Publishers, London, 2007

⁴⁵ See eg J Peay (ed), *Seminal Issues in Mental Health Law*, Ashgate, Aldershot, 2005 at p xxvi.

⁴⁶ Section 5(1)(d) *Medical Treatment Act 1988* (Vic).

⁴⁷ Section 5 *Medical Treatment Act 1988* (Vic), known as a ‘refusal of treatment certificate’.

⁴⁸ Section 5A *Medical Treatment Act 1988* (Vic)

⁴⁹ Section 35B *Guardianship and Administration Act 1988* (Vic).

powers taking into account, as far as possible, the wishes of the person being represented.⁵⁰ Informed commentators have questioned the sheer complexity of this overlapping legal regime concerning substitute decision-making.⁵¹

The manner in which these advance directive mechanisms interact with current mental health laws is not particularly clear. It appears to have been assumed that s 12AD(2) of the *Mental Health Act*, which empowers the authorised psychiatrist to consent to treatment on behalf of an involuntary patient, overrides any earlier directives given by that patient, whether pursuant to statute, or at common law. Whether the assumption is in fact correct is open to question, but, absent a Supreme Court ruling, we are unlikely to learn the proper legal hierarchy of substitute decision-making powers under the *Mental Health Act*, the *Guardianship and Administration Act* and the *Medical Treatment Act*.

If two of the values which should be at the forefront of our minds when new mental health laws are devised are autonomy and preservation of dignity, there are strong grounds for suggesting that legally supported advance directives which have the potential to govern, or at least seriously influence, psychiatric treatment decisions when a person is not competent to make them merit serious consideration. This possible reform, which has been championed by the Mental Health Legal Centre, will require close attention to detail if it is to have any meaningful chance of success.

Issues which require careful consideration include: the test for capacity at the time an ‘advance directive’ is made, the identity of the person or persons who must attest to the person’s capacity at the time the ‘advance directive’ is made, the means by which an ‘advance directive’ is drawn to the attention of relevant clinicians, the scope of an ‘advance directive’, the circumstances (if any) in which a person’s clearly expressed wishes in an ‘advance directive’ may be overridden, and the identity of the person (or body) who (or which) may be invested with the power to override an ‘advance directive’. Before any attempt is made to grapple with the detail of these issues by considering matters such as the steps which have been taken in other places, for instance Scotland⁵² and the United States,⁵³ where statutory provision has been made for ‘advance directives’, it is important to identify two preliminary issues which warrant debate.

First, the use of ‘advance directives’ is likely to divert some resources from the provision of clinical care to the preservation of rights and freedoms. Secondly, there is a distinct possibility that potentially efficacious treatment may be delayed, or not given, in some instances if the laws governing ‘advance directives’ permit them to be something more than mere statements of wishes that may be easily swept aside. In some circumstances it may be necessary to balance or prioritise competing values: should the value of autonomy be permitted to trump the value of beneficence? It is

⁵⁰ Section 28(2)(e) *Guardianship and Administration Act 1988* (Vic).

⁵¹ See eg comments made by the former Victorian Public Advocate and President of the Mental Health Review Board, Julian Gardner, in *Justice Review*, June 2007 at p 16.

⁵² See ss 275 and 276 *Mental Health (Care and Treatment) (Scotland) Act 2003*.

⁵³ US federal legislation (the *Patient Self-Determination Act*) has permitted advance directives in some circumstances since 1991. See J Swanson et al, ‘Psychiatric Advance Directives among Public Mental Health Consumers in Five US Cities: Prevalence, Demand and Correlates’ (2006) 34 *The Journal of the American Academy of Law and Psychiatry* 43.

sufficient at this stage to indicate that there are strong and complex arguments on both sides of the debate.⁵⁴ Over thirty years ago the phrase ‘dying with their rights on’ was coined by an American doctor to describe the circumstances in which a person sustained harm because preference was given to the value, or right, of autonomy over all others.⁵⁵ Also, according to an argument attributed to Nikolas Rose, “in the tussle between autonomy and coercion, a short period of coercion may be a precursor to a long period of autonomy. Non-intervention may mean a perpetual loss of autonomy”.⁵⁶ However, as Atkinson has pointed out, “[m]aking an advance directive is as much about taking responsibility as it is about exerting autonomy”.⁵⁷

The time has come to examine the potential benefits of using advance mental health directives.

2. The interaction of mental health and guardianship laws

For the past 21 years mental health laws and guardianship laws have operated side by side, but separately, in Victoria. Guardianship laws have the broader operation: they provide for substitute decision-making for people with a disability who have lost competence and who are in need of a person to make decisions for them. The people with a ‘disability’ to whom guardianship legislation is directed include people with a mental illness.⁵⁸ With an appropriate grant of powers, a guardian may determine where a person will live and whether that person will or will not have particular forms of treatment. Despite the obvious similarity with the powers which may be exercised by the authorised psychiatrist in relation to involuntary patients under the *Mental Health Act*, it has never been considered appropriate to permit a guardian to direct that a person be admitted to and detained at a psychiatric unit, or to direct that a person be given non-consensual psychiatric treatment, either when a patient in hospital or when living in the community. While there is nothing in the statute book which directs this outcome, the provisions in the *Mental Health Act* which govern involuntary detention and treatment have always been seen to be the only coercive powers which should be used in relation to people with a mental illness.

Various commentators, perhaps most notably Professor Tom Campbell,⁵⁹ have drawn attention to the discriminatory nature of a legal regime which permits people with a mental illness to be treated quite differently to other people with a disability by having a separate body of law – a *Mental Health Act* – which permits interference with the liberty and bodily integrity rights of people who have a particular medical condition. In Campbell’s own words:

There is therefore a strong argument for requiring that there should be non-discriminatory legislation which refers only to the grounds which justify

⁵⁴ See E Gallagher, ‘Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals (1998) 4 *Psychology, Public Policy and Law* 746.

⁵⁵ D Treffert, ‘Dying with Their Rights On’ (February, 1974) *Prism* 1.

⁵⁶ J Peay, above n 44 at xxii. These statements summarise an argument made in N Rose, ‘Unreasonable Rights: Mental Illness and the Limits of the Law’ (1985) 12 *Journal of Law and Society* 199.

⁵⁷ Atkinson, above n 43, at 113.

⁵⁸ The word ‘disability’ is defined in s 3 of the *Guardianship and Administration Board Act 1986* to mean ‘intellectual impairment, mental disorder, brain injury, physical disability or dementia’.

⁵⁹ See eg T Campbell and C Heginbotham, *Mental Illness: Prejudice, Discrimination and the Law*, Dartmouth, Aldershot, 1991.

detention: either a need for care that the person will not or cannot accept, or dangerousness to others...

In a less discriminatory and more logical system, not only would the same rules apply to all citizens, but the two rationales for detention – paternalistic and protectionist – would be institutionally recognised. In the case of paternalistic detention the rationale must involve (1) a need for treatment, (2) the proven efficacy of that treatment and (3) the inability of the individual to apprehend the need for treatment.⁶⁰

While Campbell did not descend to the detail of suggesting that mental health laws be repealed and replaced by guardianship legislation, others have suggested that there are numerous benefits to be had by following this course.⁶¹ Why is it that if your disability is anything other than mental illness, a family member, a friend, or the Public Advocate may make important decisions for you when you are incapable of making them yourself, whereas if your disability is mental illness these decisions are entrusted to a complete stranger, the authorised psychiatrist, who, in practice, is highly likely to delegate the day-to-day decision making responsibilities to a relatively junior medical practitioner? Why don't guardianship laws govern the treatment of people with a mental illness when those people are incapable of making decisions for themselves? Why does the *Mental Health Act* permit a raft of people, including a guardian appointed under the *Guardianship and Administration Act*, to be a substitute decision-maker for a person in an approved mental health service in relation to non-psychiatric treatment⁶² but not in relation to psychiatric treatment?

The reasons why guardianship has not been used as a legal device for making substitute placement and treatment decisions in relation to psychiatric patients have not been openly articulated in relevant policy documents, such as Ministers' second reading speeches. It appears to have been assumed that when circumstances arose which caused clinicians to believe that it was necessary to deprive patients of their liberty and to require them to accept psychiatric treatment, the coercive powers in the *Mental Health Act* were the only ones that should be used.

Statutory guardianship is a relatively recent Victorian phenomenon, having been introduced in 1986 at the same time as the current *Mental Health Act*.⁶³ English law has known statutory guardianship for a much longer period.⁶⁴ It appears that statutory guardianship was originally designed for use when providing for the care and treatment of people with an intellectual disability or mental illness in the

⁶⁰ T Campbell, 'Mental Health Law: Institutionalised Discrimination' (1994) 28 *Australian and New Zealand Journal of Psychiatry* 554 at 557.

⁶¹ See eg S Rosenman, 'Mental health law: an idea whose time has passed' (1994) 28 *Australian and New Zealand Journal of Psychiatry* 560. This view was expressed more recently by the President of the Western Australian Mental Health Review Board, Mr Murray Allen. See M Allen, 'Why specific legislation for the mentally ill?' (2005) 30(3) *Alternative Law Journal* 103.

⁶² See s 85 *Mental Health Act* 1986.

⁶³ The original legislation was the *Guardianship and Administration Board Act* 1986.

⁶⁴ See the *Mental Treatment Act* 1930 (UK). There were some limited guardianship provisions in the *Mental Deficiencies Act* 1913 (UK). Prior to this time there were various statutes and common law rules which permitted the appointment of substitute decision-makers in some circumstances (see P Bartlett and R Sandland, *Mental Health Law: Policy and Practice*, (3rd ed), Oxford, Oxford, 2007 at p 488).

community.⁶⁵ While guardianship appointment powers are still found in the English *Mental Health Act*,⁶⁶ they are not widely used because of enforcement difficulties.⁶⁷

Despite this English history, guardianship does not appear to have been used in Victoria as a legal means for compulsory psychiatric treatment and placement, either in the community or in a mental health service. Perhaps it is time to consider whether guardianship should be used as a means for directing where people with a serious mental illness should live, be it in hospital or in particular accommodation in the community, and also as a way of providing substitute decision-making about psychiatric treatment. Interestingly, this notion has received support from Professor Genevra Richardson,⁶⁸ the chair of the committee which prepared a White Paper on mental health law reform in England and Wales a few years ago.⁶⁹ If the suggestion that we are now more interested to promote the autonomy of people with a mental illness than we have been in the past is correct, the increased use of guardianship, which in Australia has always been based on respect for autonomy, may be a very effective means of promoting this value.⁷⁰

In the past I have argued that there are a number of reasons why guardianship laws should not be used in this fashion. Those reasons include the potential for conflict between the guardian and the person under guardianship, especially when the guardian may be a friend or family member, and the need for transparent and ‘arm’s length’ decision-making when the loss of important liberties, such as liberty and bodily integrity, is at stake.⁷¹ While these considerations continue to be important, there are other steps that may be taken, such as permitting external review of individual decisions made by guardians, which may cause the balance to tilt in favour of using guardianship rather than mental health legislation in some instances when formal legal power is needed to direct where a person should live or whether they must accept treatment.

This is an important reform proposal which requires a considerable amount of discussion and research.

3. Information to family and friends about treatment and care

The privacy rights of patients and the responsibility of health professionals to maintain the confidentiality of patient information have become important values in recent times. The current *Mental Health Act* contains extensive secrecy provisions preventing the disclosure of information about people who have received psychiatric

⁶⁵ See N Glover-Thomas, *Reconstructing Mental Health Law and Policy*, Butterworths LexisNexis, London: 2002 at p 73.

⁶⁶ See s 8 *Mental Health Act 1983* (UK).

⁶⁷ See Glover-Thomas, above n 64, at 78-80.

⁶⁸ G Richardson, ‘Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions’ (2002) 65 *Modern Law Review* 702.

⁶⁹ *Reforming Mental Health Act Parts I and II* (London: HMSO, 2000) Cm 5016.

⁷⁰ Richardson, above n 67, at 716.

⁷¹ See eg N Rees, ‘The Future of Mental Health Law’ in V Carr (ed), *Twenty-twenty vision: Mental health in the 21st Century*, Novartis: Sydney, 1997 at p 38.

services governed by the Act.⁷² There is also a Victorian statute of general application⁷³ and a general law rule⁷⁴ that render it unlawful, subject to limited exceptions, to disclose information about a person's health to a third party.⁷⁵ Unless consent has been forthcoming, these various legal provisions prevent clinicians from providing information to family members and friends of the patient. It is possible that one of the community values that has changed over the past 20 years is the extent to which we believe the interests of carers should be taken into account when important decisions are made about a family member or friend with a mental illness.

The *Mental Health Act* also provides that hearings of the Mental Health Review Board are closed to the public unless the Board determines that it is in the best interests of the patient, or in the public interest, that the hearing be open.⁷⁶ This means that carers do not have an automatic right to hear the information that the Board will take into account when reaching a decision. By way of contrast, Mental Health Review Tribunal hearings in NSW have always been open to the public⁷⁷ and carer access to patient information has been one of the major reforms introduced by the *Mental Health Act 2007* (NSW). Part 1 of Chapter 4 of the new Act is headed 'Rights of patients or detained persons and primary carers'. One of the principles of care and treatment referred to in the Act is that "the role of carers for people with a mental illness or mental disorder and their rights to be kept informed should be given effect".⁷⁸

What this principle means in practical terms is that a patient's 'primary carer' is entitled to receive notification from the authorised psychiatrist⁷⁹ of various matters such as admission to hospital, medication regimes, forthcoming magistrates and tribunal hearings, unauthorised absences from hospital, and discharge plans. A patient may nominate a particular person to be his or her 'primary carer', but if no nomination is made there is a default list which includes a guardian, a spouse, and a close friend or relative. A patient may also make a negative nomination in the sense that a particular person may be excluded from the list of people who may be characterised as the 'primary carer' but, interestingly, a young person between the age of 14 and 18 cannot exclude a parent.⁸⁰

There was strong support from some parts of the community for these changes. In the Second Reading Speech for the Bill, the Minister Assisting the Minister for Health (Mental Health), Ms Cherie Burton, stated:

⁷² Section 120A *Mental Health Act 1986*. There are some exceptions to the secrecy provisions in this section which are discussed in K Clark and A North, 'Legality of Disclosure by Victorian Psychiatrists of Patient Information to Carers' (2007) 14 *Psychiatry, Psychology and the Law* 147.

⁷³ See s 141 *Health Services Act 1988* (Vic).

⁷⁴ See *W v Edgell* [1990] Ch 359.

⁷⁵ In cases of conflict between these various legal rules, the provisions in the *Mental Health Act* prevail: see Clark and North, above n 71, at 153-154.

⁷⁶ Section 33 *Mental Health Act 1986*.

⁷⁷ Section 151(3) *Mental Health Act 2007* (NSW).

⁷⁸ Section 68(j) *Mental Health Act 2007* (NSW).

⁷⁹ This is the title of the equivalent Victorian official. The person who carries these responsibilities under the NSW Act is the 'authorised medical officer of a mental health facility'.

⁸⁰ See ss 71-79 *Mental Health Act 2007* (NSW).

The reform agenda for the Act has been guided by the establishment of important goals that have received widespread support from the community and health professionals. First, there is the recognition and support of the greater participation of carers, families and friends. The legislation does this by providing for the sharing of information relevant to the care and treatment of the patient so that carers can be notified when patients are admitted, transferred, absent or discharged. The bill provides a balance between the consumer and carer interest by providing consumers with the right to nominate or exclude persons as a primary carer...

Recognition that carers and family members need greater access to patient information was one of the key issues arising from the Parliamentary Select Committee on Mental Health Services. The submissions to the review recognised the importance of carers, including family members, being given access to information that would assist them in providing care.⁸¹

This is an important, but contentious, reform. It merits debate in Victoria because, as Marilyn McMahan has suggested,⁸² it is time to re-think confidentiality.⁸³

4. The extended use of community treatment orders

Community treatment orders were one of the many innovations introduced by the *Mental Health Act 1986*. They permit compulsory treatment in the community coupled with a relatively easy power of recall to hospital in the event that a person relapses or declines to accept treatment. Community treatment orders formalised a practice that had been in existence for some time by reason of widespread use of the trial leave provisions in earlier legislation.

The clinical and legal significance of community treatment orders has increased markedly over the past 20 years. They are now the major legal route for compulsory treatment⁸⁴ and it appears, at least from anecdotal evidence, that placement on a community treatment order greatly enhances a person's chances of actually receiving community mental health services.

The current law permits community treatment orders to be made for a period of up to 12 months.⁸⁵ These orders require a person to accept treatment for mental illness, invariably medication, and they may also specify where a person must live, such as in some form of supported accommodation, if such a direction is considered necessary for the treatment of the person's illness.⁸⁶ A community treatment order may be

⁸¹ NSW Parliamentary Debates (Legislative Assembly), 22 November 2006 at p 4611.

⁸² M McMahan, 'Re-thinking confidentiality' in I Freckelton and K Petersen (eds), *Disputes and Dilemmas in Health Law*, Federation Press: Sydney, 2005 at p 563.

⁸³ Professor Bernadette McSherry and others are preparing guidelines to assist mental health professionals about the circumstances in which they may properly breach confidentiality: see A Kampf and B McSherry, 'Confidentiality in Therapeutic Relationships: The Need to Develop Comprehensive Guidelines for Mental Health Professionals (2006) 13 *Psychiatry, Psychology and the Law* 124.

⁸⁴ The Mental Health Review Board's most recent Annual Report reveals that it deals with more than twice as many involuntary patients on community treatment orders as it does people who are involuntary hospital in-patients (see Mental Health Review Board, *Annual Report 2007*, p 45).

⁸⁵ Section 14(3)(a) *Mental Health Act 1986*.

⁸⁶ Section 14(3)(b) *Mental Health Act 1986*.

extended before it has expired⁸⁷ and “there is no limit to the number of times a community treatment order can be extended”.⁸⁸ These provisions create the potential that a person may be required to live under the constraints of a community treatment order for 10 or 20 years, or perhaps for life. Indeed, there may be people who have been living under a community treatment order since the *Mental Health Act* commenced operation in October 1987.

While the clinical reluctance to remove the ‘safety net’ of a community treatment order is understandable, there may be grounds for suggesting that we should erect some more stringent safeguards if a person has been on continuous community treatment orders for a lengthy period, such as five or ten years. Otherwise, we run the risk that compulsory community treatment may become, almost by default, the preferred means for delivering public mental health services. The protective safeguards could include an assessment by a different team of clinicians, an assessment by the Chief Psychiatrist, or an extended Mental Health Review Board review which started from the presumption that the community treatment order should cease unless there was clear and compelling evidence of its continued need.

The legal purpose of such a regime is self-evident: it is to provide an opportunity, at reasonable intervals, to make sure that interference with autonomy is kept to a minimum. The clinical purpose would be to ensure that people with a long-term illness who have not always been treatment compliant are comprehensively and externally assessed at reasonable intervals. This may be one mechanism which assists in ensuring that some of the ills which accompanied the old hospital ‘back wards’ of not too long ago do not return, at least for a number of people living in supported accommodation in the community, via the inadvertent overuse of community treatment orders.

5. The grounds for civil commitment

The grounds for civil commitment in mental health legislation are always contentious. While there has been considerable controversy in the past surrounding the threshold question concerning identification of the people who may be eligible for involuntary detention in hospital – most notably, whether people with a personality disorder can be the subject of civil commitment – that issue appears to have receded into the background for the time being. Interestingly, eligibility for involuntary treatment appears to have been narrowed in England because of recent amendments to the *Mental Health Act* which have added the requirement to the civil commitment grounds that there be appropriate medical treatment available for the person in question.⁸⁹

Two of the most contentious aspects of the current Victorian grounds for civil commitment concern the degree of dangerousness to self or others which is necessary before involuntary detention becomes possible⁹⁰ and the apparent stipulation that a competent person who refuses treatment may become an involuntary patient.⁹¹ The

⁸⁷ Section 14B(1) *Mental Health Act 1986*.

⁸⁸ Section 14B(3) *Mental Health Act 1986*.

⁸⁹ Section 4 *Mental Health Act 2007* (England and Wales).

⁹⁰ Section 8 (1)(c) *Mental Health Act 1986* (Vic).

⁹¹ Section 8 (1)(d) *Mental Health Act 1986* (Vic).

precise language of the dangerousness criterion is that “involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person’s physical or mental condition or otherwise) or for the protection of members of the public”. There are two quite distinct policy limbs to this ‘dangerousness’ criterion. They are protection of the public and the beneficent aim of bringing therapeutic benefit to a person who is unwell. The language of the statute is extremely broad, thereby providing significant scope for variation in discretionary decision-making both at the clinical level and by members of the Mental Health Review Board. While the Board has tried valiantly over the past 20 years to explain the operation of this criterion, it is difficult, in practice, to do anything other than repeat the words of the statute when asked for a description of the precise circumstances in which a person with a mental illness may become eligible for involuntary detention and treatment.

In NSW the statutory language has long set the bar for the ‘dangerousness’ criterion far higher than it is in Victoria. There was no change to the relevant wording when new mental health laws were enacted in NSW earlier this year. In that state it is necessary to establish that “there are reasonable grounds for believing that care, treatment or control of the person is necessary: (a) for the person’s own protection from *serious* harm, or (b) for the protection of others from *serious* harm”.⁹² The use of word ‘serious’ suggests that the dangerousness criterion is quite different to that in the Victorian legislation and that a significant level of harm must be reasonably expected before a person can be detained as an involuntary patient.

While there is no Australian empirical research which may confirm the local validity of the assertion made by Professor Paul Appelbaum in response to various United States’ longitudinal studies that the wording of the statutory criteria doesn’t really affect ‘street level’ decisions concerning involuntary detention,⁹³ my own personal experience after five years as a member of the Victorian Board and nearly 15 years as a member of the NSW Tribunal is that the difference in wording in the civil commitment between the two States makes absolutely no difference in practice, either clinically or upon external review, to the selection of people who become involuntary patients. Research to test the validity of this assertion would be useful.

The consent criterion in the Victorian Act – it must be established that “the person has refused or is unable to consent to the necessary treatment for the mental illness” – is not always found in mental health legislation in other similar jurisdictions.⁹⁴ Concern about this criterion is centred on the fact that the use of the word ‘refused’ appears to allow the wishes of a competent person to be overridden. In order to deal with this issue, it is of course necessary to deal with the vexed question of what is meant by competence.⁹⁵

It may be time to allow the broader community to re-examine the civil commitment criteria.

⁹² Section 14(1) *Mental Health Act 2007* (NSW) (emphasis added).

⁹³ See P Appelbaum, *Almost a revolution: mental health law and the limits of change*, Oxford University Press

⁹⁴ There are no equivalent provisions, for example, in either the English or the NSW legislation.

⁹⁵ The issue of competence is one of contemporary significance in the UK following the passage of the *Mental Capacity Act 2005*: see eg Bartlett and Sandland, above n 63, at p 497.

6. The jurisdiction and hearing processes of the Mental Health Review Board

At the conference to mark the 15th anniversary of the Board I considered the international human rights obligations of mental health review tribunals.⁹⁶ I suggested that the fundamental function of mental health review tribunals was to engage in timely, external review of decisions to deprive people of their liberty and of their freedom of bodily integrity. It may be useful to revisit the notions of timeliness and externality, and to consider how the Board should conduct itself when conducting reviews and performing other hearing functions. These three matters are strongly linked.

In Victoria most people who are admitted to hospital as involuntary patients do not have their loss of liberty reviewed by an external body because the *Mental Health Act* stipulates that such reviews must take place within eight weeks of the initial order.⁹⁷ Originally, these reviews took place within four to six weeks of admission to hospital⁹⁸ but the Act was amended in 1993 to push this initial review back to the current period of within eight weeks of admission.⁹⁹ In practice, this means that reviews are not scheduled until a person has been an involuntary patient for at least six weeks. Most involuntary patients have left hospital well before this time. Most people on community treatment orders who may have sustained some loss of liberty as a result of being directed where to live and who have lost their freedom of bodily integrity because of the direction that they must comply with a treatment regime do not have these losses reviewed until nearly eight weeks after the initial order was made.

The enactment of the Victorian *Charter of Human Rights and Responsibilities Act* may give us cause to reconsider the timeliness of external reviews of involuntary patients, particularly because s 21 of the *Charter* emphatically speaks of “the right to liberty and security” which may only be compromised “in accordance with procedures followed by law”. Should those procedures established by law involve external review as soon as practicable, as is the case in NSW?¹⁰⁰

It is fascinating to reflect upon the reasons why every person admitted to a psychiatric hospital in NSW as an involuntary patient is reviewed by an external body within less than seven days and why most involuntary patients in Victoria are not externally reviewed at all. Similarly, why is it that in NSW a community treatment order may be made by an external review body only, whereas in Victoria a community treatment order may be in existence for up to eight weeks before it is externally reviewed? Undoubtedly, interference with busy clinical schedules and cost were among the reasons why decisions were taken, initially in 1986 and later in 1993, to effectively limit the number of people whose detention in hospital as an involuntary patient was externally reviewed by the Board and to extend the period of time before a

⁹⁶ N Rees, ‘International Human Rights Obligations and Mental Health Review Tribunals’ (2003) 10 *Psychiatry, Psychology and the Law* 33.

⁹⁷ Section 30(1) *Mental Health Act 1986*.

⁹⁸ Section 30(a) *Mental Health Act 1986*.

⁹⁹ The amendments to the *Mental Health Act* were made by the *Health and Community Services (General Amendment) Act 1993*.

¹⁰⁰ Section 27(d) *Mental Health Act 2007* (NSW); previously s 41 *Mental Health Act 1990* (NSW).

community treatment order is reviewed. While these clinical and financial concerns are quite valid, the human rights issues ought not be ignored. If there is to be more external review the challenge is to do so in a manner which is just, quick, cheap and, possibly, therapeutic.¹⁰¹

There may be strong grounds for re-thinking the manner in which some Board hearings are conducted. Would we enhance the goals of therapeutic jurisprudence by altering the way in which the Board conducts its business? Five years ago I suggested that “[t]he hearing is a lawyers’ decision-making process that may not be particularly well suited to the function of reviewing involuntary patients”.¹⁰² I do not resile from that view.

The Board has done a great deal over the past 20 years, within the limits of its statutory powers, to render its hearings “informal, inclusive and non-adversarial”.¹⁰³ It has recently produced Hearing Guidelines which add to a suite of practice directions and guidelines concerned with the hearing process.¹⁰⁴ The Board has also agreed to participate in an important study which aims to study mental health review tribunals in three Australian jurisdictions – Victoria, New South Wales and the Australian Capital Territory from a therapeutic jurisprudence perspective.¹⁰⁵ One of the many objects of this study is to consider the ‘fairness’ of tribunal procedures.¹⁰⁶

There is an extensive body of law – that concerned with natural justice, or procedural fairness as it is now more appropriately called – which accompanies the notion of a fair hearing by a quasi-judicial body such as the Board. The Board is bound by the rules of natural justice.¹⁰⁷ These rules are notoriously imprecise,¹⁰⁸ perhaps in order that the superior courts have some room to manoeuvre when supervising the activities of tribunals and inferior courts. Regrettably, the imprecision of these rules tends to stifle innovation.

At their core, the rules of natural justice require a body such as the Board to ‘act judicially’ in its approach to matters such as impartiality and fairness.¹⁰⁹ While impartiality and fairness are clearly necessary attributes for a body such as the Board, the practical operation of these rules of natural justice may inhibit the capacity of the Board to exercise its jurisdiction in a manner which is unobtrusive, economic and therapeutically beneficial. The inviolability of the right to be heard by an impartial decision-maker, the right to be informed of the evidence and submissions which are contrary to one’s own interests, and the right to lead evidence and present submissions in support of one’s own interests are not in question. What may merit consideration is

¹⁰¹ I acknowledge the extraordinary amount of scholarship that has taken place in the field of therapeutic jurisprudence over the past few years: see eg K Diesfeld and I Freckelton (eds), *Involuntary Detention and Therapeutic Jurisprudence*, Ashgate, Aldershot, 2003.

¹⁰² Rees, above n 95, at 39.

¹⁰³ Mental Health Review Board, *Annual Report 2007*, p 26.

¹⁰⁴ See Mental Health Review Board, *Annual Report 2007*, p 59.

¹⁰⁵ See T Carney, D Tait, D Chappell and F Beaupert, ‘Mental health tribunals: “TJ” implications of weighing fairness, freedom, protection and treatment’ (2007) 17 *Journal of Judicial Administration* 46.

¹⁰⁶ See Carney et al, above n 104, at 54.

¹⁰⁷ Section 24(1)(b) *Mental Health Act 1986*.

¹⁰⁸ See eg M Aronson, D Dyer and M Grove, *Judicial Review of Administrative Action* (3rd ed), Lawbook Co, Sydney, 2004 at p 471.

¹⁰⁹ See eg Gleeson CJ in *Plaintiff S157/2002 v Commonwealth* (2003) 211 CLR 476 at [25].

the manner in which those rights are exercised. At present, it is probably necessary for the Board to conduct ‘hearings’ which, apart from exceptional circumstances, involve all of the relevant parties being present in the same room at the same time hearing all of the evidence. It is probably unlawful for the Board to conduct meetings with the relevant parties in private and to convey the substance of those meetings to others before reaching its decision.

Traditional hearings, no matter how skilfully conducted, often tend to an unnecessary level of formality and they have the potential to create needless confrontation between clinicians and patients. Any move away from the traditional legal mode of conducting fact-gathering exercises and giving rights of audience to interested parties prior to decision-making is anathema, however, to many lawyers. Perhaps some trials are needed in order to test the thesis that in some cases the Board can exercise its jurisdiction impartially and fairly without relying upon the traditional legal ‘hearing’, thereby opening up the possibility of there being more timely, external reviews of involuntary patients in order to safeguard the human rights of those people. A reform that would permit such trials is a statutory qualification to the Board’s ‘natural justice’ directive which permitted it to meet the parties privately and informally as long as the substance of those meetings was conveyed to other interested parties.

The degree of ‘externality’ which the Board enjoys continues to be a challenging issue. Since its inception, the Board has been administratively connected to the Department of Human Services and appointments are made by the Governor in Council on the recommendation of the Minister responsible for mental health services.¹¹⁰ Interestingly, the Board is one of the few tribunals that was not drawn within the new super tribunal established a decade ago, the Victorian Civil and Administrative Tribunal (VCAT).¹¹¹ While the inclusion of the Mental Health Review Board within VCAT merits consideration, especially in light of the Western Australian precedent,¹¹² there may also be grounds for establishing a separate mental health and guardianship tribunal if some of the reforms suggested in this paper attract widespread support.

After 20 years it may be time to re-consider the jurisdiction and hearing processes of the Board.

7. A body to co-ordinate research and planning for the delivery of mental health services

The delivery of mental health services is now a major industry. Since the National Mental Health Policy¹¹³ was devised in 1992 in response to the Burdekin Report,¹¹⁴ public expenditure upon mental health services has increased markedly. After referring to the fact that national spending on mental health had increased by 65% since the first National Mental Health Plan commenced in 1993, two important

¹¹⁰ Schedule 1, *Mental Health Act 1986*.

¹¹¹ *Victorian Civil and Administrative Tribunal Act 1998*.

¹¹² The former Western Australian Mental Health Review Tribunal is now part of that state’s ‘super tribunal’, the State Administrative Tribunal: see *State Administrative Tribunal Act 2004* (WA).

¹¹³ *National Mental Health Policy: Australian Health Ministers*, April 1992, Canberra, AGPS, 1992.

¹¹⁴ *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, Canberra, AGPS, 1993.

participants in the National Mental Health Strategy, commented that “little attention has been given to ensuring efficiency in public mental health service delivery”.¹¹⁵ As responsibility for the manner in which those services are delivered is split between Commonwealth, State and Territory governments, regional health services, and private providers, it is not surprising that there has been a chorus of calls for a national mental health commission to co-ordinate research and planning for the delivery of mental health services. It is strongly arguable that there is a need for a national body which gathers data, engages in long-term planning for the delivery of mental health services, researches existing delivery programs, and publishes its findings so that ‘service level’ policy makers can best decide how to expend their resources and political leaders can determine which programs should be given funding priority.

Numerous commentators have advocated a national mental health commission over the past 15 years.¹¹⁶ While the original proponents of the idea viewed the Scottish Mental Welfare Commission, which has a general duty to safeguard the welfare and interests of people with a mental illness, as a model which could be imported to Australia,¹¹⁷ more recent proponents of a national commission have envisaged a broader accountability role which appears to encompass the functions that I have suggested.¹¹⁸ Hickie and others recently concluded an article about Australian mental health reform with this observation: “[c]ontinuing to monitor systematically and then report annually the experiences of those receiving care should be a fundamental aspect of all government-funded mental health systems”.¹¹⁹ As two of the priority themes of the current National Mental Health Plan, are ‘strengthening quality’ and ‘fostering research, innovation and sustainability’,¹²⁰ it may be that a national mental health commission is an idea whose time has come.

D. Conclusion

Thirty years ago, a very perceptive woman called Patricia Allderidge, the archivist at the Bethlem and Maudsley Hospitals, gave a public lecture about the history of psychiatry in which she said:

[The evidence] has forced me to conclude that we have all been going round in circles for at least the last 750 years; that there are very few, if any, ideas on the public and institutional care of the mentally disordered which have not been around at least once before; and that on the evidence of past experience

¹¹⁵ H Whiteford and W Buckingham, ‘Ten years of mental health service reform in Australia: are we getting it right?’ (2005) 182(8) *Medical Journal of Australia* 396.

¹¹⁶ See eg S Zifcak, ‘Towards 2000: Rights, Responsibilities and Process in the Reform of Mental Health Law’ (1997) 4 *Australian Journal of Human Rights* 1.

¹¹⁷ See eg Centre for Health Law, Ethics and Policy, The University of Newcastle, *Report to the Australian Health Ministers’ Advisory Council National Working Group on Mental Health Policy on Model Mental Health Legislation* Vol I, Newcastle, 1994 at p 155.

¹¹⁸ See eg I Hickie, G Groom, P McGorry, T Davenport and G Luscombe, ‘Australian mental health reform: time for real outcomes’ (2005) 182(8) *Medical Journal of Australia* 401.

¹¹⁹ Hickie et al, above n 117 at 405.

¹²⁰ Australian Health Ministers, *National Mental Health Plan 2003-2008*, Canberra, Australian Government, 2003.

the likelihood that we are yet at the millennium, if only we had the money, seems remote.¹²¹

I suspect that there is probably a little more than a grain of truth in what Patricia Allderidge said and that her comments may have some resonance in the field of mental health law.

There is little that is new in most of the law reform suggestions that I have advanced this evening. But, in an era that sees the benefit of recycling there may be real value in exploring ideas which have been around before because our shared values do change.

¹²¹ P Allderidge, 'Hospitals, Madhouses and Asylums: Cycles in the Care of the Insane' (1979) 134 *British Journal of Psychiatry* 321 at 321.