

The Winston Churchill Memorial Trust of Australia

# **Review and Decision Making for Persons with a Serious Mental Illness: Achieving Best Practice**

A Cross-Jurisdictional Evaluation of  
Involuntary Mental Health Review and  
Decision-Making Systems

A Report prepared  
by

John Lesser  
2006 Churchill Fellow

28 September 2007

The Winston Churchill Memorial Trust of Australia

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Illness: Achieving Best Practice**

A Cross-Jurisdictional Evaluation of Involuntary Mental Health Review and  
Decision-Making Systems

A Report by John Lesser  
2006 Churchill Fellow  
on a study project:

**Aim:**

**To study and evaluate mental health review and decision making  
systems in England, Scotland, the Netherlands, Denmark, and  
Ontario, Canada.**

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Signed: John Lesser

Dated: 28 September 2007

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## 1. Acknowledgements

The Winston Churchill Memorial Trust of Australia (the Trust) awarded me a 2006 Churchill Fellowship, which provided financial support for an eight-week overseas study tour. I thank the Trust, and especially the relevant selection panels for Victoria, for selecting me, thereby providing me with an unparalleled opportunity to undertake a challenging, rewarding and educational study tour to further develop my knowledge of mental health review and decision-making systems in the broader context of mental health legislative frameworks and service delivery systems.

I would also like to acknowledge the support of the Victorian Government through the then Minister for Health, the Hon. Bronwyn Pike MP, and the newly appointed Minister for Mental Health, Hon. Lisa Neville MP. As well, the Victorian Department of Human Services (the Department) and the Mental Health Review Board (the Board) have provided me with all necessary administrative assistance and additional financial support. In particular, my special thanks go to all my colleagues at the Board, most particularly, Executive Officer, Mr Jan Szuba, Corporate Services Co-ordinator, Ms Linda Rainsford, and Executive Assistant, Ms Maria Jimenez, for their practical assistance and organisational support, as well as their wise counsel during all phases of the tour, and in preparing this report.

A comprehensive study tour of this nature could not have been undertaken without the hospitality and generosity demonstrated to me by numerous organisations and individuals during my time in the United Kingdom (UK), the Netherlands (Holland), Denmark, Germany, Italy, and Canada (the Churchill countries), as well as in Trieste, Italy and Los Angeles, USA, in terms of time, knowledge, information, advice, and practical support and assistance. In particular, I express my gratitude to my initial contacts in each country, with whose assistance I commenced my planning and because of whose efforts I made contact with such a rich pool of relevant experts and resources:

- England – Professor Genevra Richardson
- Scotland – Ms Eileen Davie
- Netherlands – Dr Remmers van Veldhuizen
- Denmark – Dr Kristen Kistrup
- Canada – Mr Joaquin Zuckerberg
- Italy – Dr Roberto Mezzina
- USA – Messrs Tim Dowell and Richard Luckham.

All of my contacts shared their professional and work expertise, experience and interest with me, which in itself far exceeded my expectations. Additionally, a number further enriched my Churchill experience by sharing something of their personal lives and culture through social activities such as joining me for refreshments, or inviting me into their homes. In every country I visited, I received gracious hospitality and friendship, and significant interest in Australia, which I sincerely appreciated and will long remember.

Most of what I learned professionally on this study tour came directly from observing hearings and other processes in practice and from holding detailed discussions with an extremely knowledgeable and experienced group of people. A contact list of key individuals and organisations visited and consulted is recorded in Appendix 3. In the process, numerous other valuable contacts were made informally, bringing my total individual contacts to around 200 people.

At my request, a number of individuals read parts of this report and gave me critical feedback and advice prior to publishing it, and I acknowledge their extremely valuable contribution to the final product. Mr Jan Szuba provided an invaluable sounding board as it developed.

Finally, to my wife, Jan, and family, thank you for your love, support and encouragement throughout this enriching professional and personal journey.

## 2. Background

The jurisdictions visited in this study tour were selected for several reasons, not least the variations in their approaches to the review of the detention and treatment of people with a serious mental illness, legislative frameworks and service delivery systems. I began with a number of broad objectives, but the specific focus of this report crystallised as the tour progressed. A chance invitation from Professor Phil Fennell to visit Cardiff Wales epitomised the unexpected opportunities to which a Churchill Fellowship gives rise. A perusal of the introduction to his 1996 study of the history of law, psychiatry and the treatment of the mentally disordered<sup>1</sup> laid the seed to what became my basic focus, namely seeking the appropriate balance between legalism and medicalism in the review of involuntary psychiatric treatment and decision-making. Relevantly, Professor Fennell observed:

"Law has always played a fundamental role in providing authority for detention and in conferring the power to make decisions affecting psychiatric patients on other people. A central concern of historians of English mental health legislation has been the debate about legalism and medicalism. Legalism focuses on the coercive aspects of psychiatry such as detention, forcible treatment and restraint, and seeks to regulate them by imposing due process safeguards. Medicalism seeks to take advantage of the ideological role of law to submerge these coercive dimensions of psychiatry, and encourage their perception as medical treatments whose administration should be a matter of clinical judgment rather than a subject for legal regulation."

My experience as the President of the Victorian Board since September 2000 consistently demonstrates how this dichotomy affects the daily work of the Board. The Board was established as an external independent review tribunal under the Victorian *Mental Health Act 1986* (MHA Vic), now the oldest piece of mental health legislation in Australia. It commenced operation in October 1987. Under my presidency, the Board has grown significantly in membership size and caseload, currently comprising the President and 89 sessional members who conduct in excess of 5,400 hearings each year.

All eight Australian States and Territories have similar legislative frameworks to regulate psychiatric practice and decision-making, as do many comparable overseas jurisdictions. Each attempts to strike an appropriate balance for that society between legalism and medicalism. Factors such as population size, composition and geographic distribution, culture, history, interaction between levels of government and responsibility for mental health service delivery systems, management of and relationships between inpatient and community treatment and care facilities and arrangements, and judicial and tribunal systems underpin the many variations that I observed as the response thought to best suit the situation in each individual jurisdiction.

Although I deliberately aimed for a broadly based investigation, the central focus of my study tour was on evaluating and benchmarking best practice in respect of both administrative and hearing processes for tribunals and courts charged with the legal responsibility to conduct hearings for, and make decisions about, people under compulsory treatment for a serious mental illness. In particular, with the impending implementation from January 2008 of the Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter), human rights law became an obvious lens through which to conduct my study and evaluation. However, review processes do

not operate in a vacuum, so for me an understanding of the legislative frameworks and service delivery systems was equally important.

Individuals (many representing organisations) visited and consulted as part of the study tour included tribunal and court leaders; senior administrators and members; psychiatrists and allied health professionals; lawyers and advocates; leaders of and workers in patient and carer support organisations; senior public servants and government officials; academics specialising, researching and writing in the mental health law field; and others more generally interested in mental health law and practice.

At the outset, it is important to acknowledge, and my Churchill experience reinforced, that the Victorian mental health service delivery system and review process is unique, fundamentally sound and generally human rights-compliant. By world standards, Victoria is well advanced in its community treatment focus, a fact constantly reinforced by comparisons throughout my study tour. For better or for worse, whether by design or otherwise, one of the mechanisms Victoria has developed to underpin this community focus is a far greater reliance on the use of involuntary treatment orders (ITOs), particularly community treatment orders (CTOs), than occurs in other jurisdictions. This aspect was a regular discussion topic during my tour.

The principal aim of my study tour was to observe in each jurisdiction the broad responses to the contextual factors mentioned above, with a view to evaluating the strengths and weaknesses from the review, legislative and treatment systems perspectives. By necessity, however, this report is more narrowly focused on my central interest, and I will report on the broader aspects in other reports and forums. From this, the Victorian and other Australian State and Territory systems can reflect on the strengths and weaknesses of their own regimes and, where possible, improve them by adopting any relevant lessons learned from overseas that can readily be transferred to their own legislative and treatment contexts.

The views expressed in this report are my own, based on my observations, discussions and research. I emphasise that they do not represent the views of the Board, the Department or the Victorian government.

### 3. Introduction

One of my enduring interests in leading an expert multidisciplinary tribunal has been to develop and improve the quality of our administrative and hearing processes, procedures and practices, particularly as they impact on the involuntary patient group. This is in no small part due to the fact that, historically, the Victorian Board's discharge rate has been consistently low and a significant percentage of involuntary patients choose not to attend Board hearings. Therefore, quality of the hearing process is unquestioningly a key objective of the Board in ensuring that involuntary patients who participate in hearings benefit from a pro-therapeutic experience, irrespective of the actual outcome, namely the decision about continuing involuntary treatment.

On 2 August 2006, on the occasion of the 30<sup>th</sup> anniversary of the Commonwealth Administrative Appeals Tribunal, the Chief Justice of the High Court, the Hon. Murray Gleeson, made this point far more elegantly and succinctly than I could:

“Decisions affecting human rights and, above all, personal liberty, are quintessential examples of cases where fairness of process is in itself part of the outcome to be expected from good government. If government does not deliver the appearance of justice, manifested in due process, in such cases, then it fails to deliver what is an essential aspect of a liberal democracy under the rule of law”.<sup>2</sup>

To assist in achieving this end, the Board has fostered relationships with its sister organisations in other States and Territories, through an annual meeting of presidents and registrars, and has supported several research projects designed to explore and evaluate mental health review processes, procedures and practices within the Victorian and wider Australian contexts. However, this Churchill project facilitated a broader and more comprehensive study in an international context, providing me with an unprecedented opportunity to evaluate and benchmark the Board's administrative and hearing processes, procedures and practices against those in comparable overseas jurisdictions, as well as to better understand differences in legislative frameworks and service delivery systems.

The information provided in this report, as well as that provided through other means of dissemination over the months ahead, should be beneficial not only for the Victorian Board, Department, Area Mental Health Services, patient and carer support organisations, advocacy organisations, and Government, but also for their counterparts in other States and Territories of Australia. It may also provide useful information to similar organisations in the countries visited, as well as in other overseas jurisdictions.

As part of the Churchill Fellowship study tour, I visited a number of jurisdictions – England, Scotland, the Netherlands, Denmark and Ontario, Canada. I also participated in two international conferences in Germany and Italy. Several additional opportunities to broaden my research and experience arose in England, Italy and California USA, which were financially supported by the Victorian Government. I also acknowledge my debt to Professor Fennell of the Cardiff (Wales) University Law School for sponsoring a side visit to Wales.

By necessity, this report focuses on the Churchill Trust-funded elements of my overall study tour. I will discuss the additional elements in other reports produced for the Victorian Board, Department and Government, and for other purposes.

## **4. Executive Summary**

### **4.1 Author's Contact Details**

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### **4.2 Highlights**

In each jurisdiction, I observed in practice hearings and other relevant processes. I also discussed a broad range of issues with many experts with different backgrounds, experiences and perspectives. Drawing on these wide-ranging observations, experiences and perspectives has facilitated a broad understanding of many of the factors that influence the way in which the complex mental health legislative, review and service delivery systems operate in these particular jurisdictions. Unsurprisingly, I found no systemic "magic answers" and few obvious advances in direct hearing procedures or processes to bring back to Victoria, reinforcing in my mind the fundamental soundness of the Victorian Board's processes, practices and procedures.

In particular, compared with all its counterparts, by a significant margin, the Board's administration proved itself to be the leanest, most efficient and cost effective. This was obviously a pleasing finding. Notwithstanding that, I did witness many excellent practices, policies and legislative arrangements that have the potential to improve Victoria's patients' rights and review processes, some of which would require a significant injection of funding and resources.

The contact list appended to this report provides a wealth of invaluable contacts for Australians interested in these issues. All were generous in their discussion and responses to my questions, and interested in fostering broader understanding and cooperation.

### **4.3 Recommendations**

In summary, based on the knowledge and experience gained on the study tour, the following are my key recommendations relating to the Board and the review process:

#### **4.3.1. Victorian Board and Review Process**

The Victorian Government should consider:

- (a) establishing in legislation and recurrently funding at an appropriate level an independent patients' rights advice, advocacy and support service
- (b) providing increased levels of funding to facilitate compulsory legal aid-funded legal representation at Board hearings
- (c) a legislative amendment to the composition of hearing panels to facilitate new members' involvement in hearings as part of induction training
- (d) providing increased funding to the Board to facilitate clerking services and an overall greater capacity to provide a higher level of administrative support for tribunal members at hearings
- (e) providing increased funding to the Board to ensure that listing practices are such that the maximum number of hearings that each Board division conducts

- per sitting facilitates more human rights-compliant, pro-therapeutic, high-quality and comprehensive review hearings than is currently possible
- (f) raising the importance of mental health review processes by treating Board members as a separate but recognised element of the Victorian court and tribunal system.

A broader and more detailed list of recommendations is provided at the end of this report, and in other reports I am in the process of completing.

#### **4.4 Dissemination**

I have already commenced, and intend to take every opportunity, to make available information about the role of the Trust, and about my study tour activities, findings and recommendations using the following methods:

- speaking at appropriate conferences, seminars and events, both by invitation and on my own initiative
- speaking to professional, community and other interested organisations and groups, both by invitation and on my own initiative
- writing reports to and holding discussions with Board members, the Department, and relevant Ministers of the Victorian government
- reporting to and holding discussions with heads of Australian mental health review tribunals, and other interested government, judicial, law reform, research and policy organisations
- writing articles for Australian and international academic journals and other relevant publications, including on the Board's website at [www.mhrb.vic.gov.au](http://www.mhrb.vic.gov.au).

As one example, I have been invited to present a report on my study tour activities, findings and recommendations to the annual general meeting of the New Zealand Mental Health Review Tribunal in Wellington New Zealand in November 2007.

## 5. Key Elements of the Victorian Jurisdiction

For comparative purposes, and to provide context for the findings and recommendations in this report, the following is a brief description of the key elements of the current Victorian mental health system as it affects involuntary review and treatment.

### Basic Demographic Comparison

Population: 5 million  
Health Governance Structure: Area mental health services (21)

### Legislative instruments

*Mental Health Act 1986* (as amended)

*Charter of Human Rights and Responsibilities Act 2006* (the Charter) (from 1 January 2008)

### Mental health service delivery system

Psychiatric services for Victorians with a serious mental illness, particularly psychotic and major mood disorders, are provided without cost through public mental health services run by 21 autonomous area mental health services and funded by the Victorian State Government. The Authorised Psychiatrist (usually the Director of Clinical Services) has the statutory responsibility under MHA Vic for the treatment services provided to involuntary patients. Each service manages small (up to 25 beds) adult acute units co-located with general hospitals, and one or more community-based clinics serving the local population. Services employ on a full-time or part-time basis medical personnel including consultant psychiatrists who often lead treating teams, trainee psychiatrists (registrars) and medical officers, supported by allied health clinical professionals including psychiatric nurses, social workers, psychologists and occupational therapists.

In hospital, the length of inpatient stays has steadily reduced in recent years, now averaging between 10 and 14 days. The emphasis is on stabilisation of acute symptoms and return to the community for follow-up by a local doctor (general practitioner (GP)) or a community mental health service. Where necessary, use of CTOs is commonplace.

Community mental health services use different team models, depending on geographic and demographic variables. However, the general pattern for most services is to have a crisis assessment and treatment (CAT) team which responds to critical incidents and provides mental health assessments; a mobile support and treatment (MST) team which provides intensive community follow-up; and continuing care team (CCT) clinical staff provide generic case management for the majority of case-managed patients, primarily involuntary patients.

Other non-treatment support services including rehabilitation, accommodation, life skills, return to work and day programs are provided by non-government psychiatric disability rehabilitation and support services (PDRSS) funded by the Victorian Government. By design, for the most part, the PDRSS sector operates separately from the treatment services.

Victorians suffering from high prevalence disorders such as anxiety and depression generally receive treatment through their local GPs or private psychiatrists or psychologists on a fee-for-service basis. Patients receive a partial rebate for these

services from the Australian (Commonwealth) Government through a tax-funded universal health insurance scheme called Medicare.

### **Involuntary detention/treatment legal framework**

In order to provide compulsory treatment for psychiatric patients under ITOs (for inpatient compulsory treatment) and CTOs (for outpatient compulsory treatment), all five criteria in s8(1) MHA Vic must be satisfied. They involve appearing to be mentally ill, requiring and being able to obtain treatment as an involuntary patient, risk to self or others, refusal or incapacity to consent, and provision of treatment in the least restrictive manner. Once made and confirmed, ITOs remain in effect for an indeterminate period, subject to discharge at any time by the authorised psychiatrist or on review by the Board when any one of the criteria no longer apply. The maximum period of CTOs is 12 months, and they can be extended any number of times. On becoming an involuntary patient, there is a requirement for the service to provide information about patient rights under the MHA Vic, and to develop a treatment plan in collaboration with the patient. MHA Vic contains no specific provisions regarding the role of carers.

Authorisation of involuntary treatment is based on the clinical decision of a doctor, confirmed by a psychiatrist. Admission to hospital is no longer automatically required as patients can be placed directly on a CTO in the community. Both orders (ITO/CTOs) automatically authorise compulsory treatment and are regulated by MHA Vic. The Board's role is to conduct hearings to determine whether the five s8(1) criteria continue to apply to each involuntary patient. Section 30 requires the Board to conduct statutory reviews within eight weeks (initial reviews), at least annually (periodic reviews), and on each occasion that a CTO is extended (CTO extension reviews). Under s29, patients have an unlimited right of appeal (appeals) to the Board, thereby triggering a review. If dissatisfied, patients can also apply to the Victorian Civil and Administrative Tribunal (VCAT) for review of Board decisions. Although almost never exercised, the Victorian Supreme Court retains a supervisory jurisdiction over both tribunals by way of judicial review.

### **Mental Health Review Board**

The administration supporting the Board comprises nine equivalent full-time staff, under the leadership of an executive officer. Review hearings are scheduled from data downloaded from RAPID, the Victorian statewide mental health database, whereas the Board generally receives patient appeals by fax from services. In 2006-2007, the Board listed and conducted 14,409 and 5,447 hearings respectively. In almost all hearings, patients and mental health services comprise the formal parties, who receive a notice of hearing. Hearings are conducted at the mental health service facilities, hospitals or clinics where treatment is provided to the particular patient. Each service provides a staff member who, among other duties, acts as a contact officer to facilitate scheduling and hearing arrangements by Board staff, and assists members on sitting days. Approximately two-thirds of the patients are on CTOs, and of these about 39% elect not to attend the hearing.

In respect of hearings, appeals and initial reviews are conducted by three-person multidisciplinary panels comprising a legal member as chairperson, a psychiatrist member and a community member. Periodic reviews can be conducted by a single member from any discipline. In practice, approximately 20% of hearings are conducted by single-members. Patients attend with legal representatives in only 5-10% of hearings. Services are generally represented by medical staff, sometimes supported by a case manager. Lawyers never represent services before the Board.

The Board has limited decision-making powers. Its function is primarily to determine whether the five s8(1) criteria are met. Further, the Board is required to review each involuntary patient's treatment plan. Historically, on an annual basis, the Board discharges 3-8% of patients from involuntary patient status at hearings, although the percentage is consistently higher for legally represented patients. Significantly, a further 20-30% is discharged on clinical review by consultant psychiatrists between the date of listing the hearing and the scheduled hearing date.

Policy and administration of MHA Vic is undertaken through the Mental Health branch within the Mental Health and Drugs division of the Department. Depending on the nature of a patient complaint, some are handled by the statutory office (within the Department) of the Chief Psychiatrist, while others are handled by an independent Office of the Health Services Commissioner or the Victorian Ombudsman.

## 6. Key Elements of the Overseas Jurisdictions

In the jurisdictions I visited, there are several different models of review of compulsory mental health detention and treatment. Several are very similar to Victoria's, whereas others are quite different in focus. What follows is a very brief description of the different jurisdictional arrangements. Greater detail about the legislative framework, mental health service delivery system and administrative practices and procedures is available in other reports, and can be obtained from the author.

### 6.1 England and Wales (E&W)

#### Basic Demographic Comparison

Population:	50.5 million (England) and 3 million (Wales)
Health Governance Structure:	Health boards/mental health hospital trusts and local authorities

#### Legislative instruments

*Mental Health Act 1983* (as amended) (E&W MHA)

*Human Rights Act 1998* (UK HRA) (incorporates the European Convention on the Protection of Human Rights and Fundamental Freedoms 1950 (European Convention))

#### Mental health service delivery system

In practice, National Health Service (NHS) Boards are required to provide medical treatment for people with a mental disorder, including the employment of registered medical practitioners and other medical and allied health staff. Local authorities have a duty to promote the well-being and social development of people with a mental disorder in the community, and to facilitate socio-cultural and recreational activities for those in hospital, including the appointment of sufficient numbers of Approved Social Workers (ASWs). Unlike in Australia, both consultant psychiatrists and ASWs have important and specified roles under the MHA with respect to the detention of involuntary patients.

Although well behind Australia, there is increasing emphasis on developing community treatment facilities. This is likely to increase further with the implementation of supervised community treatment under CTOs, with predictions in some quarters of an overall increase in the number of people being treated on involuntary orders, once CTOs are fully implemented. Whether this will be offset by a reduction in the length of inpatient stays, as has occurred in Victoria, only time will tell.

In England and Wales, psychiatric services for people with a serious mental illness, particularly psychotic and major mood disorders, are predominately provided without cost through public hospitals. Compared with Victoria, most are stand-alone facilities and have large bed capacity. However, public sector bed shortages have led to a significant increase in the number of private hospitals (mainly in the forensic and learning disability areas) funded through the NHS. Except for social workers, who are employed by local authorities, NHS Boards employ on the full-time or part-time basis medical personnel and allied health clinical professionals including psychiatric nurses, social workers, psychologists and occupational therapists, who provide a range of services in the community. Local authorities also provide other non-treatment support services including rehabilitation, accommodation, life skills, return to work and day programs.

### **Involuntary detention/treatment legal framework**

The UK HRA guarantees fundamental rights known as Convention Rights and requires public authorities to respect and comply with them. The E&W MHA is accompanied by detailed regulations and a code of practice. It does not contain a set of principles to guide interpretation and actions, but under recent amendments the code of practice will. It has been the subject of considerable interpretation by the courts, including the House of Lords, building a significant body of jurisprudence, supplemented by decisions of the European Court of Human Rights (ECtHR) on appeal from the UK under the European Convention.

Leaving aside the significant forensic jurisdiction under the E&W MHA, in relation to civil patients, compulsory orders can be applied to people with a "mental disorder", which includes mental illness, personality disorder or learning disability, but has led to protracted "law and order" debates. Other than emergency admissions, the E&W MHA establishes two basic types of order authorising compulsory treatment for psychiatric patients. Applications are generally made by an ASW and require two medical opinions. Section 2 establishes admission and detention in hospital for assessment and treatment for up to 28 days. The criteria for an application are that the person is suffering from mental disorder of a nature or degree which warrants the detention for assessment, and is justified for the person's own health or safety or the protection of others. Section 2 patients can apply to the MHRT for a hearing within the first 14 days, requiring a hearing within seven days.

Section 3 applications are also made by an ASW and require two medical opinions, but they authorise admission and detention for an initial period of six months, extendable by six months and then annually. The criteria are similar to the s2 criteria, with the addition that treatment "cannot be provided unless" the person is detained under the section. Section 3 patients can apply to the MHRT for a hearing once within each period of detention but, unlike for s2 hearings, there is no statutory time period within which hearing must be conducted.

Neither type of involuntary admission requires tribunal authorisation, but both are subject to statutory review under the E&W MHA. Where no review by the MHRT has occurred within the first period of 6 months or thereafter within a further period of three years (one year for a child), the treating service must refer the case to the tribunal. All detention is subject to the overarching ECtHR requirement of proportionality and evidence that it is the least restrictive environment in which the treatment can be effected.

Although yet to be implemented in England and Wales, the newly legislated community treatment provisions will be monitored with considerable interest by all stakeholders.

Under the E&W MHA, there is a Mental Health Act Commission (MHA Commission) whose role is to monitor the involuntary mental health service and social care systems. It operates as an independent body, arms-length from its funding source, the Department of Health (DOH), and reports to Parliament every two years. The MHA Commission has powers of inspection, complaints handling and complaints investigation around involuntary detention, but it lacks enforcement powers.

The UK Parliament passed a *Mental Capacity Act 2005 (MCA)*, which is to commence in October 2007, broadly to codify the common law and regulate incapacity issues across disabilities. One issue of considerable importance, now known as the "Bournewood Gap", arose directly from a decision of the ECtHR<sup>3</sup>. The case involved

consideration of an informal but mentally incapacitated patient in a nursing home, and has led to the development of a convoluted and complex government procedure (in MCA schedule A1) designed to address the ECtHR's concerns about "deprivation of liberty".

### **E&W Mental Health Review Tribunal**

Under the E&W MHA, the England and Wales MHRTs are required to review compulsory treatment of people with a mental disorder. Its procedures are laid down in formal regulations called the Mental Health Review Tribunal Rules 1983. They are currently under review. Where the Rules are silent, it must follow the rules of natural justice. Proceedings are inquisitorial in nature, and can be, and regularly are, challenged on application for judicial review.

Similar to the Victorian Board, the England and Wales MHRTs are designed to be informal, responsive, accessible, independent and impartial, conducting hearings to hear evidence relating to compulsory treatment. However, compared with Victoria, the MHRT's Rules seem prescriptive and legalistic, although flexible compared with normal court rules. In composition, procedures and methods of operation, the England and Wales MHRTs are very familiar to Australians. Of all the jurisdictions visited, on the surface, it is the most like Victoria in that it is a review tribunal with very similar panel composition, procedures and practices.

The English MHRT operates on a regional basis, with a southern and northern chairperson operating out of London and Preston respectively as the nominal head in each region. Despite the cooperation of the chairpersons in areas such as member training, concerns in some quarters about the lack of a national tribunal leader may result from regional variations in a variety of areas, including practices and procedures, discharge rates etc. Although unevenly distributed, the total membership numbers around 1,100. Members sit in panels of three comprising a lawyer (who acts as chairperson), a medical member, routinely a consultant psychiatrist, and a lay member who often has qualifications, skills and experience in the mental health or welfare fields.

Patients and, in limited circumstances, nearest relatives can apply for a tribunal hearing within each relevant period (depending on the type of application, 28 days or six months) and hospitals must refer cases to the tribunal at appropriate times (after six months, then three yearly), if patients have not applied themselves. Respectively, the English and Welsh MHRTs annually receive approximately 25,000 and 1,400 applications and conduct 14,000 and 800 hearings. In practical terms, usually two hearings are scheduled per panel per day, although on occasions the number may be up to three. Hearings routinely take in excess of 90 minutes, and it is not unusual for them to run for three hours

An unusual feature of the E&W MHRT's procedure is the dual role of medical members, who before the hearing are required to "examine the patient" and take such other steps considered necessary to form an opinion on the patient's mental condition. Before the hearing commences, the medical member summarises his findings for the other members in the absence of the parties. This practice has been found lawful by the courts, despite longstanding criticism of the potential of this procedure to offend rules of natural justice. The regional chairpersons have worked to improve hearing practices by ensuring that individual chairpersons commence hearings by providing the parties with a summary of the medical members' findings. I remain sceptical whether the positive effects of the procedure on the decision-making process outweigh its disadvantages in terms of perceptions of fairness.

On the administration side, the resources of each of the English and Welsh MHRTs fund a full Secretariat (administration) to provide their own separate administrations in support of the members. The respective staffing levels of the English and Welsh MHRTs are approximately 89 and 14. In Wales, staff undertakes clerking duties at hearings, whereas this valuable role is contracted out in England.

Despite its considerable budgetary and staff resources compared with the Victorian Board, the Secretariat has been widely criticised for many failings, including by tribunal members. A recent stakeholder survey conducted in January 2007 reinforced this perception.

### **Transferable Features**

Features of the English and Welsh system worth consideration by the Victorian government include:

- greater funding levels for the Board to facilitate fewer hearings per panel sitting, with a view to increasing the Board's capacity to undertake more thorough and robust reviews during hearings, and to support members with on-site and administrative clerking services
- adequately funding and promoting an independent patients' rights advice and advocacy service, established in legislation
- providing a funding model to achieve on a recurrent basis a considerably increased level of legal aid to facilitate free legal representation in appropriate cases before the Board
- passing a generic Mental Capacity Act broadly to regulate capacity issues across all disability sectors, including mental health
- facilitating a greater emphasis on social work skills to enhance the reporting to the Board on patients' social circumstances
- establishing with a legislative basis an independent Commission with a range of functions, including those of, but preferably more broadly based than, the E&W MHA Commission.

## 6.2 Scotland

### Basic Demographic Comparison

Population: 5.1 million  
Health Governance Structure: Health boards (14) and local authorities (32)

### Legislative instrument

*Mental Health (Care and Treatment) (Scotland) Act 2003* (MHA Scot)  
*Human Rights Act 1998* (UK HRA) (incorporates the European Convention)

### Mental health service delivery system

Mental health has been given a high priority by the Scottish Executive and the NHS. In practice, NHS Boards are required to provide medical treatment for people with a mental disorder, including the allocation of Responsible Medical Officers (RMOs). Local authorities have a duty to promote the well-being and social development of people with a mental disorder in the community, and to facilitate socio-cultural and recreational activities for those in hospital, including the appointment of sufficient numbers of Mental Health Officers (MHOs). Although behind Australia, there is a continuing shift to increase community treatment facilities. As this continues, there is likely to be an increase in the use of compulsory CTOs. Similar to Victoria, organisations in a very active voluntary sector provide a range of support services including home and crisis support, accommodation, training, employment and day programs for people with a serious mental illness.

### Involuntary detention/treatment legal framework

The UK HRA applies in Scotland, and guarantees fundamental rights known as Convention Rights and requires public authorities to respect and comply with them. Following partial devolution from the UK (Westminster) Parliament, the Scottish Parliament wasted no time in passing local legislation in the area of mental health. Based on a comprehensive community consultation and review of a wide range of mental health issues in the context of the previous 1984 Act by the Millan Committee<sup>4</sup>, MHA Scot was passed in 2003 and came into operation in October 2005, giving Scotland a mental health review and treatment framework that is arguably the most humane and consistent with current psychiatric practice in the world. In many respects, it is ground-breaking and modern legislation that it has attempted to positively address most of the issues that people involved in mental health generally argue for in mental health legislation. This has made it the subject of considerable interest in other jurisdictions.

Millan recognised the importance of striking a balance between the general interests of society and the protection of individual rights. As far as possible, his committee attempted to ensure that the provisions of MHA Scot were consistent with the European Convention. Like MHA Vic, MHA Scot establishes a set of principles to guide interpretation and actions, including the least restrictive alternative. Compulsory orders can be applied to people with a "mental disorder", which includes mental illness, personality disorder or learning disability, however caused or manifested. Unlike England, Scotland largely avoided protracted "law and order" debates.

MHA Scot is a long and complex Act, but the Scottish Executive issued a detailed Code of Practice (3 volumes), together with specific training manuals for staff and information for patients and families, to assist its implementation and interpretation. It establishes the Mental Health Review Tribunal for Scotland (MHTS) to authorise Compulsory Treatment Orders, a hybrid form of involuntary order that can be

exercised either in hospital or in the community. These orders are known in Scotland as CTOs, but in this report are referred to as "CompTOs" to contrast with the more common term "community treatment orders". Under the previous legislation, the Sheriff Court (equivalent to the Victorian County Court) exercised this power.

MHA Scot provides a strong and specific focus on patients' rights and representation. It establishes the position of a "named person", replacing the "nearest relative" in the 1984 Act. The named person may be chosen by the patient when competent, must take their views into account, and must represent and look after the best interests of the patient. The named person can independently apply to the MHTS, and take part in clinical and review processes. Further, NHS Boards and local authorities have a responsibility to ensure compulsory patients have access to an independent advocate, whose role is different from that of the named person as they are obliged to represent the wishes and views of the patient. As well, competent patients have the right to make an "Advance Statement", setting out the patient's wishes in respect of treatment for the mental disorder in the future, should their decision-making later become impaired. The treating team is required to ascertain the presence of such a statement, and "have regard to" preferences expressed in the statement. Decisions by the treating team or the MHTS to override a statement must be notified to the Mental Welfare Commission (MW Commission).

MHA Scot establishes three types of order authorising compulsory treatment for psychiatric patients: 72-hour emergency detention certificate (designed for rare urgent situations, without right of appeal), a 28-day short-term detention certificate (STDC), designed to be a "gateway order" for assessment and medical treatment (subject to a right of appeal), and a compulsory treatment order. The criteria for granting these orders are similar, but specific to their individual purposes, and the third category requires tribunal authorisation. In effect, an emergency detention certificate ought not to be extended, a STDC is capable of extension only for several days in the context of a pending or current application to the MHTS for a CompTO.

The criteria for a CompTO are:

- the patient must have a mental disorder
- medical treatment is available and would be likely to prevent the mental disorder worsening, or alleviate its effects
- if the person were not provided with medical treatment, there would be a significant risk to the health, safety or welfare of the person or to the safety of any other person
- because of the mental disorder, the patient's ability to make decisions about the provision of such medical treatment is significantly impaired (significantly impaired decision-making ability (SIDMA))
- it is (or continues to be) necessary for the person to be subject to a compulsory treatment order.

The term "mental disorder" is defined to include three broad categories, mental illness, personality disorder and learning disability. Categories of exclusion, similar to those found in MHA Vic s8(2), include sexual matters, dependence on and use of alcohol and drugs etc.

In practice, two doctors must examine the patient within a five-day period and confirm that the criteria are met before an application for a CompTO is made by a MHO, an approved social worker with appropriate training, to the MHTS, which determines whether to grant the application and make the order, initially for six

months. The tribunal can specify "recorded matters", which are particular types of treatment or services viewed as essential, and which must be provided. The RMO, who is a senior psychiatrist, must prepare a care plan, based on the proposed care plan submitted to the MHTS, which contains details of the medical treatment, community services and any other service or treatment to be given to the patient.

Like Queensland involuntary orders, a CompTO can authorise compulsory treatment in hospital or in the community, where this is a safe alternative to hospitalisation and voluntary community treatment has previously failed. The RMO has a power of recall in the event of non-compliance with the order.

The RMO must review CompTOs within the last two months of the six-month order, with the extensions possible for a further six months, and thereafter for 12 months. The patient or a named person can appeal to the MHTS for revocation of a CompTO at least three months after the imposition of the order, or for revocation of an extension.

The MHA Scot continued and extended the role of the MW Commission, the major role of which is to exercise protective functions for people with mental disorders, under both the MHA Scot and the Adults with Incapacity (Scotland) Act 2000 (AWIA). The AWIA is similar to the England and Wales Mental Capacity Act, in that it regulates broad incapacity issues across disabilities. Unlike the MHA Commission in England and Wales, the MW Commission has a broader responsibility to promote best practice, and monitor and report on the use of the Act in respect of all patients, voluntary or involuntary.

### **Mental Health Tribunal for Scotland (MHTS)**

Under the MHA Scot, MHTS took over responsibility for decision-making around compulsory care and treatment of people with a serious mental disorder. Previously these decisions were made by the Sheriff Court. It also has decision-making powers in respect of several types of forensic order relating to people with a mental disorder involved with the criminal justice system.

The tribunal is designed to be informal, responsive, accessible, independent and impartial, conducting hearings to hear evidence relating to compulsory treatment and care. Members are appointed by the Scottish Ministers and include lawyers as chairpersons, psychiatrists and people with qualifications, skills and experience in providing services to service users with a mental disorder.

In its civil jurisdiction, the MHTS can hear applications for the revocation of short term detention certificates. Its major role is to authorise CompTOs, facilitating detention in hospital, medical treatment, or a range of community-based measures. The MHTS must also review the proposed care plan and determine that it is adequate and appropriate in light of the principles of the MHA Scot, and can deal with (albeit rare) referrals from the MW Commission and the Scottish Ministers. It has an obligation to record decisions and reasons, and to inform parties of decisions.

Compulsory community-based measures are limited to circumstances where they provide a safe and viable alternative to hospital, the patient has previously relapsed whilst off medication in the community presenting a risk to themselves or others, all other means of negotiation with the patient and maintaining them in the community without compulsion have been tried and failed, and alternative less restrictive approaches have been impracticable. In the early stages after commencement,

community-based CompTOs have been used relatively infrequently, as noted in a recent independent review<sup>5</sup>.

The MHTS is not involved in the process of the RMO extending CompTOs unless there is a need to vary the measures or there has been no hearing for two years. However, the patient or the patient's named person can periodically apply to have the order revoked or varied.

Structurally, the MHTS consists of a full-time President and more than 300 part-time members, approximately 100 lawyers, 100 psychiatrists and 120 general members including 8 service users and 14 carers. In its first year, the MHTS conducted 3,500 hearings, which will significantly increase when the first two year reviews are required. Under the leadership of a chief executive officer and with an annual recurrent (converted) budget in excess of 10 times that of the Victorian Board, the MHTS has a generous level of administrative support comprising 70 equivalent full-time staff, a major role of which is scheduling and clerking for hearings. Clerks accompany each tribunal panel, using a purpose-designed trolley briefcase containing digital recording, computer and printer equipment and other necessary forms, papers and other materials required by the members to complete their functions. They also complete hearing summary forms setting out issues arising during the hearing. In practice, members have less need to focus on taking comprehensive notes in hearings.

At the end of each hearing, members prepare a statement of findings, decision and brief reasons of approximately 3 pages. Transcripts are provided at the cost of the parties and required only for appeals. In the first 18 months, there were approximately 10 appeals. Recordings are also used to investigate complaints about members. Security, when needed, is provided by an independent security company, and is organised by the venue assistant at the service.

A significant scheduling issue is the statutory requirement for CompTO hearings to take place within five days of the expiry of a 28-day STDC, because of a strict statutory time limit on the extension of available treatment time. Often, applications are received by the MHTS at the end of the 28 day period, creating critical time pressures on the administration to arrange Board members, venues, notification of parties, and making reports available to members and parties for the hearing.

### **Transferable Features**

Of all the legislative, service delivery and review systems that I studied, without doubt that the Scottish system provides the greatest scope for consideration by the Victorian government. This is not surprising, given that the MHA Scot commenced operation most recently in October 2005. In my view, among the most important features worthy of Victorian government consideration are:

- increased levels of recurrent resourcing for the Board (similar to the MHTS) to facilitate fewer hearings per panel sitting, with a view to increasing the Board's capacity to undertake more thorough, robust and pro-therapeutic reviews when necessary during hearings, and to provide increased staffing levels to support members with on-site administrative and clerking services
- despite the MHA Scot not being a particularly easy Act to work with, many of its provisions provide a good model for consideration, particularly its articulation of underlying principles, carefully expressed statutory criteria, up-to-date definitions e.g. medical treatment, and statutory acknowledgement and inclusion of most of the regularly debated current issues such as patient supports, advance statements/directives, carers' rights etc

- widespread use and acceptance of independent patients' rights advisors/advocates, established in legislation
- a statutory basis for patients to nominate a "named person", usually a close relative or friend, as a best interest advocate and for support during the review and treatment process
- wide availability of funded legal services for all patients appearing before the MHTS
- facilitating a greater emphasis on social work skills to enhance capacity to improve, and report to the Board on, patients' social circumstances
- a well resourced and broadly empowered MW Commission (with a broader remit than the English MHA Commission), with statutory roles, among others, in monitoring all mental health treatment, including compulsory treatment, improving service standards, handling complaints, regulating and arranging second opinions (including for long-term use of medication, ECT etc).

## 6.3 Netherlands

### Basic Demographic Comparison

Population: 16.6 million  
Health Governance Structure: Regions

### Legislative instruments

*Psychiatric Hospitals (Compulsory Admissions) Act 1994 (BOPZ)*  
Netherlands Constitution 1815  
European Convention

### Mental health service delivery system

Across the Netherlands, health care, including mental health treatment services, is arranged on an informal and unregulated regional basis. Most hospitals are privately run but funded through government at generous levels by world standards. The overall aim of mental health services in the Netherlands is to provide a flexible, well-integrated transmural<sup>6</sup> service between inpatient and outpatient sectors. This is still evolving. Voluntary treatment services in the community are generally provided in small clinics with multidisciplinary medical and clinical staff funded by local authorities. Involuntary hospital admission is primarily to prevent danger, rather than to provide treatment as such.

### Involuntary detention/treatment legal framework

BOPZ, the current mental health law, was passed in 1994 after almost 25 years of discussion and debate, commencing in 1970. Not surprisingly, it was a product of, and considerably influenced by, 1960s and 70s human rights thinking. It involves considerable complexity, requiring commentary in the form of two large looseleaf folders written by District Court Judge W. Dijkers and a colleague.

The third periodic review of BOPZ was recently completed with the government receiving the Evaluation Committee's recommendations during my visit on 25 May 2007. It made wide-ranging recommendations to the government, including the use of CTOs and a tribunal model of review of involuntary treatment in addition to, not instead of, court authorisation. In due course, the government will respond to the recommendations, establishing a consultation process by which the current BOPZ will be amended, or a new Mental Health Act drafted for Parliament's consideration.

Admission under BOPZ applies to a broad category of people suffering a "mental disorder", defined as "defective development or pathological impairment of the mental faculties". Under BOPZ, in order to admit a psychiatric patient to a BOPZ hospital against their will, the patient must be suffering from a mental disorder (determined on psychiatric opinion), resistant to interventions and pose a danger or acute danger to self or others. Where there is acute danger, the mayor of a local government district can make a provisional detention order, otherwise the admission requires court authorisation. Under Articles 38-41 of BOPZ, compulsory treatment, "means or measures" (restrictive practices, of which the most commonly used is isolation) in emergency situations, restriction of fundamental rights and a right of complaint are specified. Importantly, compulsory admission does not automatically authorise compulsory treatment, use of means or methods or restriction of fundamental rights.

Treatment of an involuntary patient generally requires informed consent to the treatment plan by the patient (or representative). Compulsory treatment can be provided when it is absolutely necessary to avert danger caused by a mental disorder

within the inpatient setting. In emergency situations, means or measures can be compulsorily applied for a maximum of seven days, including restraint, seclusion, isolation, medication, liquids or drip feeding. The Medical Director is responsible for the medical care in the hospital and compliance with BOPZ.

Formally BOPZ establishes a national Healthcare Inspectorate<sup>7</sup>, with a significant budget and wide powers (including access to information, rights of entry), which is charged with the responsibility for safeguarding the interests of all persons with mental disorder. It also conducts regular inspections of hospitals, investigates individual cases of involuntary treatment and provides advice to staff about treatment and practice issues, for example appropriate isolation facilities.

A strong adherence to human rights principles, particularly informed consent and protecting patients' rights, underpin BOPZ. Central to this is the Mental Health Care Patients' Advocate Foundation (Stichting Patientenvertrouwenspersoon (PVP)), a government-funded national advocacy organisation. The PVP provides patient advocates in each psychiatric hospital who are independent of the hospital, provide confidential advice and information, negotiate with hospital staff in an effort to resolve treatment and related issues and complaints on behalf of involuntary patients.

### **Court Authorisation of Mental Health Involuntary Admission**

Like most European countries, the Netherlands operates under a civil law system. Not surprisingly, all compulsory admissions to hospital must be authorised by a judge of the District Court (equivalent to the Victorian Magistrates Court), who conducts hearings and make orders under BOPZ. Until 2004, non-consensual treatment could be given only if the patient represented a "serious danger" to himself or others. The word "serious" was removed in 2004.

Requests for a court order can be made by service staff or caregivers, and usually are formally authorised and submitted to the court by the public prosecutor, whose actual role is limited. Other than in exceptional cases, prosecutors take no part in court hearings. Patients are provided with free legal representation funded through legal aid.

Hearing scheduling appears extremely efficient, with up to 10 hearings scheduled per judge per day, but the judge usually conducts five or six hearings, each of approximately half an hour and in several different locations, at hospitals or in the patients' homes. Provisional detention orders made by local mayors and submitted to the court by the public prosecutor must be heard within three days of receipt by the court. The judge is accompanied by a court administrative officer who makes all necessary arrangements, and takes and types up case notes, the decision, and any appeal documents. A signed decision is sent to the parties within a day of the hearing.

Hearing procedures are very informal compared with hearings conducted in the courtroom, and patients' lawyers tend to take a low-key, largely supportive, role. No written medical report or clinical file is provided to the judge. However, if the patient has previously been before the court, the judge can access previous dossiers. Decisions are made quickly and efficiently on the basis of evidence given orally at the hearing.

Standard court orders are the:

- IBS (inbewaringstelling), a provisional detention authorisation of 21 days, based on immediate danger requiring an emergency hospital admission within 24 hours
- RM (rechterlijke machtiging), a detention order for up to six months, which can then be extended for periods of up to one year. Discharge by the psychiatrist can take place at any time within the period of the order.

Other orders available to the judge include two new types of orders introduced in 2004, an observation order (authorising 21 days admission for observation (not compulsory treatment) purposes in the event of danger to self) and a conditional order (requires patient consent and is used as an alternative to compulsory admission to facilitate treatment in the community).

In 2005, there were 8,707 RM orders and 7,790 IBS orders. On 6,172 occasions, "means or measures" (restrictive practices) were used as a form of containment to defuse emergency situations for maximum of seven days.

Each hospital has, or a group of hospitals shares, an independent complaints committee comprised of a lawyer chairperson, psychiatrist and a third person, usually a clinician from another hospital or a nominee of a patient organisation. About 10% of complaints decisions are appealed to the District Court (three judges). Committee hearings average one and a half hours, lawyers are rarely involved, and complaints are upheld in approximately one third of cases. Surprisingly, each committee regulates its own procedures, including use of mediation, and the complaints system is largely unregulated by BOPZ. Non-BOPZ complaints can be dealt with "on the papers", whereas BOPZ complaints require a hearing.

### **Transferable Features**

Features of the Dutch system worth consideration by the Victorian government include:

- the PVP model of an independent patients' rights advice and advocacy service is established in legislation, well funded, effective and generally well accepted
- the higher (danger) threshold limits the involuntary patient population and arguably improves the likelihood of wider voluntary engagement of patients with treating services
- transmurial treatment services, underpinned by a proposal for a single involuntary order irrespective of changes in treatment setting (similar to Scotland and Queensland).

## 6.4 Denmark

### Basic Demographic Comparison

Population:	5.5 million
Mental Health Governance Structure:	Regions (5)

### Legislative instrument

*Psychiatric Care Act 1989* (Psykiatriloven) (Consolidated Act No 1111 of 1 Nov 2006)  
European Convention

### Mental health service delivery system

In Denmark, regions are responsible for delivering health care services in hospitals and community-based services. In general, psychiatric units are attached to general hospitals, other than high security and special rehabilitation facilities. Separate facilities exist for child and adolescent services. Bed levels across the country are two or three times that in Australia at 60/100,000, but are higher in Capital (Greater Copenhagen) Region at 110/100,000. In 2005, there were 24,490 psychiatric hospital admissions across Denmark. Average inpatient stays range between 22 and 25 days.

In recent years, emphasis has been placed on providing a greater level of services in the community, but it is still smaller than the inpatient sector. No compulsory treatment currently occurs in the community sector. Whereas hospitals are funded by the regions, some community services, such as rehabilitation and support services, including "social psychiatry", are funded and provided by local authorities (municipalities).

### Involuntary detention/treatment legal framework

Significant amendments to the Danish mental health legislation, originally passed in 1989, occurred in 1998 and 2006. They were designed to better secure patients' rights, to focus on interventions before compulsion, and to regulate the use of advance directives. The legislation is complex with the principle that all coercive interventions should take place in hospital. It requires psychiatrists to provide detailed paperwork for any type of coercion. Compulsory treatment is not allowed until every possible step has been taken to persuade the patient into accepting treatment. The use of compulsion must be proportionate to the goal pursued, and minor steps should be taken whenever possible.

In order to commit a patient to a psychiatric ward under compulsory detention or to provide psychiatric treatment against the patient's will, two conditions must be met:

- the patient must be psychotic or in a similar condition (consistent with the interpretation under the legislation of a mental illness (sindssyg (literally mentally sick))
- a requirement for treatment (worded as a double negative that "not sending the patient to treatment would be unjustifiable").

This occurs when:

- the prospects of recovery or a significant and vital improvement of the condition will otherwise be considerably reduced ("yellow papers"), or
- the patient is a substantial danger to self or others ("red papers").

The patient has a right to know why compulsory detention is necessary, and what impact the treatment is expected to have on their health condition. They are also required to be advised of the right to make a complaint. Involuntary admission

permits the commencement of involuntary treatment, except where the patient makes a formal complaint about compulsory admission or treatment, in which case treatment is postponed until a decision is made by the local (regional) Psychiatric Patients' Board of Complaints. Once authorised, treatment can continue despite a subsequent court appeal. Treatment can proceed in emergency situations.

In practice, psychiatrists must follow the underlying principle of "less radical treatment" which, in most cases, requires psychiatrists to observe patients for at least a one-week "motivation" period, during which time they must discuss and explain the proposed treatment with the patient before starting the treatment.

In Denmark, the restrictive practice most commonly used in psychiatry is forced immobilization (fixation) by the physical strapping of patients with a belt, hand and foot straps, or gloves. Fixation may be used only if and when it is deemed necessary to prevent:

- imminent physical danger to the patient or others,
- the patient from seriously molesting of other patients, or
- the patient committing serious vandalism.

Regional administrations (State County Prefects) employ both the local complaints boards and independent patient counsellor/advocates, who must be appointed within 24 hours whenever a patient is compulsorily hospitalised, detained, treated or restrained. The counsellor/advocate provides information about rights and also assists patients to make complaints.

### **Complaints against Involuntary Admission and Treatment**

Unlike most European countries that operate under a civil law system, which Denmark did until 1998, currently, compulsory admissions to hospital and treatment decisions are, in the first instance, clinical decisions. Review of involuntary admission decisions is not automatic, but is complaints-based. On being subjected to compulsory admission or treatment, or fixation, patients are required to be advised of their right to complain and receive advice and support from a patient advocate. Complaints made by patients, often with the help of patient advocates, are heard by a local (regional) Psychiatric Patients' Board of Complaints, comprising an independent three-person tribunal-style committee with a lawyer as chairperson, a doctor (not necessarily a psychiatrist) nominated by the Danish medical Association and a nominee of the major disability organisation, who in some cases may be a former or continuing patient. The board conducts hearings in the hospitals, often visiting several in one day. In 2005, across Denmark, there were 5,130 complaints about compulsory psychiatric admission and treatment, about 21% of all psychiatric admissions.

In practical terms, the administration of the local boards appears extremely efficient, with fixed days for lodging papers to ensure that the hearing will proceed six days later. Papers are sent to all parties in advance of the hearing. Board members are accompanied by a legally trained clerk/secretary, who makes the necessary arrangements on the sitting day, and prepares decisions, checked by the chairperson. Each local board hearing takes between 30 and 60 minutes, and an average of three hearings are scheduled per day. Procedurally, they are very similar to Victorian Board hearings. Although there are variations across the regions, on average, patients attend in about 90% of hearings, and are represented by patient advocates in more than 85% of hearings. Board decisions to reverse compulsory admissions average about 10% across the regions.

Patients can make a complaint to the local Psychiatric Patients' Board of Complaint about a wide range of matters, including treatment-related issues, even under compulsion, with a right of appeal to the National Patients' Board of Complaints. On appeal (approximately 100 per year) to the National Patients' Board of Complaints, the reversal rate rises to 20-25% because, unlike the local boards which have a 14-day time limit to organise a hearing, the National Board has no time limit and often takes many months to deliver its decision "on the papers". Not surprisingly, this has been a subject of significant criticism. Between the decisions, there is often new information and changes in practice that explain the different outcome.

By contrast, although extremely rare in practice, appeals from decisions on compulsory admission are heard by the lowest level of court (equivalent of the Victorian Magistrates' Court). Since 1 January 2007, appeals about fixation also go to the court.

### **Transferable Features**

Features of the Danish system worth consideration by the Victorian government include:

- an independent patients' rights advice and advocacy service, established in legislation, well funded and widely accepted
- a rigorous, transparent and inclusive patient complaints tribunal process involving a multidisciplinary three-person panel similar to the Victorian Board, with a well defined appeals system.

## 6.5 Ontario Canada

### Basic Demographic Comparison

Population: Ontario 12.6 million (Canada 33.4 million)  
Healthcare Governance Structure: Local Health Integration Networks (LHINs)

### Legislative instrument

Canadian Charter of Rights and Freedoms 1982  
Mental Health Act (Ont MHA)  
Health Care Consent Act (HCCA)  
Substitute Decisions Act (SDA)  
Personal Health Information Protection Act (PHIPA)  
Local Health Integration Systems Act 2006

### Mental health service delivery system

A newly established Mental Health Commission for Canada will develop a national mental health strategy framework. However, delivery of health care across Canada is subject to provincial variations as, similar to Australia, each provincial government provides health funding and regulation. In Ontario, until recently, psychiatric services for people with a serious mental illness, particularly psychotic and major mood disorders, were organised centrally through the Ministry for Health and provided without cost through provincial psychiatric hospitals, specialty hospitals and psychiatric units in general hospitals. A recent decision to change the provision of mental health service delivery at the local level to LHINs is designed to increase resources and better integrate services within local areas. The practical impact of this change will take time to assess, but the hospital and community services sectors are working together to build on existing partnerships.

As far as I could ascertain, for Greater Toronto's population of about 5.2 million, there are approximately 1,500 hospital beds. In the province, the numbers of general and long term beds are each in the vicinity of 2,300. Health care expenditure is C\$31 per head, with mental health accounting for 7.9%. Many psychiatrists, irrespective of the location of their practice, are remunerated on a fee-for-service basis. Others work on salary or a blended formula. This provides a strong incentive among most psychiatrists to practise wholly or partly in the public sector and improves the likelihood of high-quality psychiatric care across the community. Most psychiatric treatment is provided on a voluntary basis, including approximately 709 CTOs in the City of Toronto over a five-year period. In many areas, links between the inpatient (hospital) services and community (non-government sector) case management services appear to be generally well established and collaborative, following a social care approach.

In the community sector, most mental health care is provided by local doctors (family physicians or GPs) and allied health professionals. Canada has a strong tradition of non-government organisations providing a range of services to people with disabilities, including those with mental health issues. In fact, there are over 70 organisations providing mental health services in Toronto.

### Involuntary detention/treatment legal framework

In Ontario, psychiatric treatment is largely provided with a competent patient's consent or the consent of a substitute decision maker for an incompetent patient. Under Ont MHA, a physician (doctor) can order a person to be forcefully removed from the community and taken to a psychiatric facility against their will to be restrained, observed and examined for an assessment period of up to 72 hours. The

attending physician (psychiatrist) can further detain the person in the facility against their will for 14 days. This can be renewed for periods of one month, two months, and then subsequently three months at a time, with the patient having the right to make an application to the Consent and Capacity Board (CCB) once in each period.

In order to involuntarily detain a patient, one of two sets of involuntary admission criteria, Box A (s20(5)) (the dangerousness grounds) and Box B (s20(1.1)) (the need for treatment provisions), and several strict procedural requirements, must be met. Box A requires the attending physician to certify his opinion that (a) the patient is suffering from a mental disorder (defined as "any disease or disability of the mind", a broad definition which includes mental illnesses, personality disorder and substance related disorders) of a nature or quality that likely will result in serious bodily harm to the patient, serious bodily harm to another person or serious physical impairment of the patient unless the patient remains in the custody of a psychiatric facility; and (b) the patient is not suitable for admission or continuation as an informal or voluntary patient.

Box B requires the attending physician's certificate that the patient has previously received treatment for a mental disorder of an ongoing or recurring nature (that when not treated will result in one of the three risks outlined above); has shown clinical improvement with treatment; continues suffer from the same or similar mental disorder; based on history and current condition is likely to cause serious bodily harm to self or others or suffer substantial mental or physical deterioration or serious physical impairment; has been found incapable of consenting to treatment; and is not suitable for admission or continuation as an informal or voluntary patient. It is not uncommon for the CCB to be required to make a decision as to both involuntary status and the physician's finding of incapacity under the Box B criteria.

Limited by previous case law and constitutional constraints around consent to treatment, the Ont MHA includes unusual CTO provisions and review functions of the CCB. In practice, uptake of CTOs has been low largely because, compared with CTOs in Australian jurisdictions, some consider their voluntary nature adds little value, and they are seen as a considerable administrative burden by treating teams. The CTO requirements are:

- within three years, the patient has been in a psychiatric facility twice or more for a cumulative period of at least 30 days
- a collaboratively developed community treatment plan
- a psychiatric examination within 72 hours before entering into the community treatment plan
- the patient meets the 72 hour psychiatric assessment criteria
- the psychiatrist has consulted all health practitioners and others named in the community treatment plan
- the patient and their substitute decision maker consulted (or the patient refused to consult) with a rights advisor and were advised of their legal rights
- the patient or their substitute decision-maker consented to the community treatment plan
- a requirement for continuing treatment in the community, that the patient has the ability to comply with the community treatment plan, and that the proposed treatment and supervision are available in the community.

CTOs last six months, and can be renewed. The Ont MHA provides for a mandatory review by the CCB after 12 months.

The Psychiatric Patient Advocate Office (PPAO) provides rights advice to patients in hospital and persons in the community being considered for CTOs. Some general hospitals have retained the rights advice role. The Ont MHA sets out 8 mandatory rights advice situations, when the hospital must notify the rights advisor who must meet with the patient, explaining the significance of the change in the person's legal status and options if they disagree. On request, the rights advisor will assist with an application to CCB, obtaining a lawyer and applying for legal aid. However, budget restrictions limit the PPAO's capacity to provide advocacy services at CCB hearings. In many respects, the PPAO operates in a similar manner to the Dutch PVP. From time to time, individual advocates have been subject to criticism from clinicians for their overzealous approach and exceeding their mandate.

Unlike normal grants of legal aid under a means test, because of the vulnerability of psychiatric patients, free legal representation is provided for most persons applying to and appearing at CCB hearings generally directly through Legal Aid Ontario (LAO). Counsel, all of whom are members of an LAO panel of private practitioners who specialise in mental health cases, appears for the patient in close to 100% of hearings. Lawyers act on their clients' instructions, not in patients' best interests. Doctors are legally represented in approximately 20% of hearings.

Like the UK Mental Capacity Act, the HCCA aims to enhance autonomy by providing a statutory framework for competence and capacity decision-making, with relevant definitions, a legislative presumption of capacity and an outline of the elements of consent. To override the presumption of capacity, the CCB must find that either one or both of the two-part statutory test is displaced, namely, the ability to "understand information relevant to making a decision about the treatment" and the ability to "appreciate the reasonably foreseeable consequences of a decision or a lack of decision". Many CCB hearings involve long-term care and personal assistance decision-making, similar to the Victorian Guardianship List of VCAT.

Under the HCCA, there is a hierarchy of persons eligible to be made the substitute decision maker for an incapable person. Surprisingly, although the CCB deals with most issues involving substitute decision makers, it does not have the jurisdiction to appoint the person first in the hierarchy, namely a person's "guardian", as this is done by a court order under the SDA. However, where there is no appointed guardian or "attorney for personal care" (equivalent to an attorney appointed under an enduring power of attorney) appointed by the incapable person when previously competent to do so, family or friends can bring an application to the CCB to appoint a person as the incapable person's representative. Importantly, under rules set out in the HCCA, substitute decision makers must follow all applicable wishes previously expressed by the incapable person when they were capable, so long as they are applicable to the person's current circumstances, making advance statements important. However, problems have occurred in a number of instances because of the lack of formality of written and signed statement required under the HCCA, resulting in disputes about evidence and uncertainty about the capacity of the person at the time of expressing the wish.

Patients have an automatic right of appeal from CCB decisions to the Superior Court of Justice (equivalent to the Victorian County Court) in the first instance. There are approximately 70 appeals per year. An infrequently exercised further right of appeal to the Court of Appeal for Ontario exists, with one CCB case so far reaching the Supreme Court of Canada

## **Ontario Mental Health Decision-Making Bodies**

Like Australia, Canada is a provincial system under which lawmaking is divided between the Canadian (Federal) and provincial parliaments and governments. Health care is a provincial responsibility, and each province has different legislation and tribunal systems. Ontario, with 12 million people, more than a third of the national population, has several different decision-making bodies dealing with mental health issues. The CCB combines many of the roles of the Victorian Board and the Guardianship List of VCAT, dealing with civil commitment and capacity issues, although surprisingly the making of guardianship orders occurs through the court system. The Ontario Review Board has jurisdiction to review forensic orders, that is, orders affecting people with a serious mental illness involved in the criminal justice system. In both New South Wales and Queensland, Mental Health Review Tribunals retain a similar forensic jurisdiction that the Victorian Board had until 1998 when the Supreme Court of Victoria took over the jurisdiction under the *Crimes (Mental Impairment and Unfitness to Be Tried) Act 1997*. The Toronto Mental Health Court is a specialist court with power to order and monitor diversionary dispositions for offenders with mental health issues. Queensland and Western Australia have local versions, although their operations vary.

### **Consent and Capacity Board (CCB)**

Established in 2000 under the Ontario HCCA, the CCB replaced the previous Psychiatric Review Board and Consent and Capacity Review Board. Its jurisdiction has dramatically increased, although its main decision-making area remains applications brought by involuntary psychiatric patients in psychiatric facilities or psychiatric wards of general hospitals. Administratively, the CCB has 17 staff (all public servants) with a budget of C\$4.9 million. It has approximately 156 part-time members led by a full-time Chair, all appointed by Order in Council, generally for three-year terms. The three categories of members are lawyers, psychiatrists and public or community members. Unlike in Victoria, community members have no specific representative capacity, many having significant mental health clinical experience. Experienced lawyer members can sit on certain applications as single members, but not applications involving the liberty interests of patients, including CTOs.

In 2006-07, the CCB received 4,476 applications, of which 2,768 actually proceeded to a hearing. The CCB's statistics on cancellations of listed applications are similar to the Victorian Board's, more than half occurring because of changes of legal status authorised at the clinical level. 80% of hearings are conducted in psychiatric facilities (including psychiatric wards of general hospitals) and 20% in the other facilities or the community at large.

The CCB has a complex jurisdiction with over 20 individual types of applications, all reviewing initial decisions made on a clinical basis by psychiatrists and other health professionals. Under the Ont MHA, the most pertinent to the Victorian Board is its jurisdiction to review the involuntary status of persons suffering from a mental disorder. Under the HCCA, the main decisions occur in reviews of findings of a person's incapacity to consent to treatment. Time requirements under the HCCA are strict, requiring hearings to be scheduled within seven days, decisions within one day from the end of the hearing, and reasons for decision, on request of the parties within 30 days, provided within two "business days". Appeals must be filed within seven days of the receipt of a decision.

On average, members sit twice per month, with scheduling organised on a geographic basis by region. Case coordinators are assigned to arrange hearings in specific regions, with Greater Toronto making up almost half the applications

received. 60% of hearings involve involuntary status applications, 20% treatment incapacity hearings, with the balance a mixture of property incapacity, CTOs and other applications. The registry uses a Case Management Information System, a customised Access-based database, for scheduling and record-keeping purposes.

Procedurally, hearings are open to the public, unless a request for a closed hearing is made by counsel for the patient. They are routinely recorded, using a consultant court reporting service at considerable cost, although tapes are transcribed only in the event of an appeal. Although following an inquisitorial model similar to the Victorian Board, the CCB retains some elements of an adversarial model. For example, health practitioners carry a legal burden of proof that the statutory criteria for upholding their order are satisfied. Although decisions are based on the "balance of probabilities", case law has held that the CCB must have "clear and compelling evidence" to support involuntary detention because of the nature and seriousness of the issues in question, namely liberty and/or autonomy.

The length of CCB hearings averages about two hours. In more than 80% of hearings, patients have legal representation, though the percentage is much lower, approximately 20%, for the doctors. In many cases where the patient does not have legal representation, the CCB will order it. The majority of hearings take place in psychiatric facilities, more than half at the Centre for Addiction and Mental Health, with CTO hearings listed at the CCB office. As psychiatrists provide services to patients on a fee-for-service basis, they generally attend the CCB hearing in their own right, rather than as a representative of the hospital, although bigger hospitals provide in-house counsel who also attend. Because there is no billing for reports, it is rare for CCB members to be provided with a written medical report for hearings, requiring them to question doctors to elicit evidence.

### **Ontario Review Board (ORB)**

Established under of the (Federal) Criminal Code of Canada, the ORB is a provincial tribunal that reviews dispositions concerning accused persons found not criminally responsible by reason of mental disorder or unfit to stand trial. Those found unfit remain under the ORB's jurisdiction until a court finds them fit to stand trial or grants a stay finding permanent unfitness and no significant threat to the safety of the public. Accused who are not criminally responsible, formerly not guilty by reason of insanity, remain under the jurisdiction of the ORB until they are granted an absolute discharge by the ORB.

Each ORB panel consists of not fewer than five members: the chairperson (who must be a judge) or an alternate chair (who must be a judge or senior lawyer entitled to a judicial appointment), a psychiatrist, a psychologist, a lawyer and a public member. As at March 2006, the ORB had 146 members appointed by Order in Council, 31 alternate chairs, 23 lawyers, 51 psychiatrists, 14 psychologists and 26 public members. Except for initial reviews, up to four hearings per day are scheduled at the same venue.

Despite efforts to maintain informal hearing procedures, in practice, hearings retain a high level of formality, because of the seriousness of the issues and the size of the panel. Also, some hearings are conducted in court buildings. At hearings, accused persons who are declared unfit to stand trial are provided with free legal representation, and a high percentage of not criminally responsible accused are also represented by counsel. Also present will be a senior psychiatrist from the hospital and a representative of the Attorney General.

The workload of the ORB has grown annually over 20 years, conducting 1,430 hearings in the year to 31 March 2006. Those hearings involved 269 new accused (86 unfit and 183 not criminally responsible) and resulted in 131 absolute discharges (9.2%). Its annual budget was C\$4.52, and operated with 16 administrative staff. Appeals from the ORB go straight to the Court of Appeal (equivalent of the Victorian Supreme Court).

### **Toronto Mental Health Court (MHC)**

The Toronto MHC was established as a discrete court in the Ontario Court of Justice (equivalent to the Victorian Magistrates' Court) in 1998. Its operations and procedures have continued to evolve with experience. Its overall brief is to deal with mentally disordered offenders, many of whom appear regularly before the criminal courts, in a specialised manner with the aim of applying the principles of therapeutic jurisprudence to a very vulnerable and disadvantaged class of offenders and, thereby, improving their connection with the mental health service system and reducing the incidence of reoffending.

Despite no formal evaluation of its strengths and weaknesses, from my brief observation and discussion with participants, the Toronto MHC appears to have many strengths and few major weaknesses. Its major strength lies in its efficiency in the disposal of business involving mental disordered offenders in a humane, respectful and less legalistic manner than is generally possible in the normal criminal court streams, using a less adversarial legal process aimed at providing positive outcomes for mentally disordered offenders who come before the MHC. Experienced staff provides a high level of advice, support and services to mentally disordered offenders compared with what would generally be available in the normal criminal court streams. Experienced prosecutors, duty defence lawyers and judges operate independently, efficiently and effectively to make appropriate decisions in respect of proceedings and outcomes, but at all times aim to work cooperatively, including with mental health workers and the mental health service delivery system. Mentally disordered offenders are actively case managed through regular consultations and court appearances by both mental health workers and the court.

As well as at the MHC, there are court support programs in five Toronto area courts. These programs handle 50% of the mentally disordered offenders in Toronto and assist the courts by facilitating access to mental health treatment and support, and diversion from the criminal justice system. There is also an extensive network of community support services targeted at mentally disordered offenders including crisis prevention, safe beds, supportive housing, police-mental health worker teams and partnerships with the forensic service system.

### **Transferable Features**

Features of the Ontario system worth consideration by the Victorian government include:

- using the CCB as a model, bringing together into one tribunal an integrated and streamlined administration and the expertise of members around civil commitment, capacity and disability decision-making issues to deal with all involuntary treatment, capacity, guardianship and allied issues
- a legislative amendment to hearing panels' composition to facilitate new members' involvement in hearings as part of induction training
- the PPAO provides another good example of an arms-length, independent patients' rights advice and advocacy service.

- the Toronto MHC provides an excellent practical working model of a specialist mental health court to deal with fitness to plead and sentencing diversion issues in respect of mentally disordered offenders
- court support services and the mental health and justice network are good examples of leveraging and connecting the community mental health and justice systems
- although potentially more expensive and not without its own problems, the practice of psychiatry in Ontario on a largely fee-for-service or blended system of payment of psychiatrists, irrespective of practice location, provides a potential model to improve on the current Victorian public/private sector systems with a view to reducing the current high level of attrition of senior psychiatrists from, and retaining their long-term commitment to, the public sector.

## **7. Summary of Comparative Hearing and Administrative Arrangements**

Drawing on the comparison between the key elements of the Victorian and overseas jurisdictions, the following is a brief analysis of the similarities and differences between the hearing and administrative arrangements for the review of involuntary mental health detention and treatment.

### **7.1 Involuntary Population and Criteria**

Despite statutory variations in population definition and involuntary detention and treatment criteria, my impression was that the population of people being treated on an involuntary basis in each jurisdiction is almost identical with Victoria's. Without doubt, as it should be, in all jurisdictions, involuntary status is reserved for the people with the most serious levels of symptomatology, dysfunction and distress resulting from mental illness or mental disorder. Irrespective of differences in treatment systems, these people undoubtedly require the most consistent, intensive and coherent treatment regime to treat the symptoms of predominantly psychotic disorders, support daily functioning in society and assist overall recovery.

In terms of statutory definitions, Victoria limits its population to those with a serious mental illness. Approximately 90% of the Victorian Board's patient population has a primary diagnosis of a psychotic or major mood disorder. The five MHA Vic s8(1) criteria are broadly based, and potentially open to wide interpretation in their application to each individual's circumstances. They involve appearing to be mentally ill, requiring and being able to obtain treatment as an involuntary patient, risk to self or others, refusal or incapacity to consent, and provision of treatment in the least restrictive manner. The broad ambit of the s8(1) criteria may explain one feature of Victoria's system which is not replicated in the overseas jurisdictions I visited, namely the use of CTOs for the management of a significant group of chronically ill patients, whose symptoms are often stable for considerable periods, but who remain ambivalent about treatment.

In some jurisdictions, the Netherlands, Denmark and Ontario, the statutory definition of the involuntary population is framed in terms of "mental disorder", but is generally undefined. By contrast, in the case of the England and Wales, the term is defined to include mental illness, personality disorder and learning disorders. In England and Wales, there has been considerable debate about one unintended consequence, namely the potential stigma of involving people with learning disorders within mental health legislation. Another significant debate has been about the requirement of "treatability" to ensure that people with strictly non-psychiatric disorders obtain some benefit from involuntary detention in the context of increasing evidence of the use of mental health legislation as a means of containing people seen as dangerous and difficult to manage in the community.

Unlike Victoria, in most jurisdictions, risk and dangerousness, variously described, provide the primary criteria for compulsory intervention. The threshold level required varies considerably, creating the main differential in terms of overall involuntary patient numbers. England, for example, has a much higher number (per 10,000 population) of involuntary patients than Ontario or Scotland. Average bed stays are generally longer than in Victoria, but none has the high numbers of involuntary patients being treated in the community that Victoria has on a relatively long-term CTOs. This is largely because overseas mental health services are still

predominantly hospital-based, and human rights concerns predominate, leading to a slower acceptance of compulsory outpatient treatment than in Australia.

Since October 2005, when the MHA Scot commenced operation, the MHTS has authorised a steady but relatively small number of compulsory community treatment orders. However, so far, overall numbers of CompTOs (inpatient and community) have not increased. The Scottish Mental Welfare Commission and Scottish Executive are closely monitoring trends because of community concerns that numbers will increase as has occurred in Victoria over the last 20 years. After decades of debate, recent, but yet to be implemented, amendments to the E&W MHA will allow for supervised community treatment in England and Wales. Only time will tell how, and to what extent, CTOs will be used by English service providers, and their impact on average inpatient stays.

## **7.2 Tribunals and Courts; Membership Structure; Review, Authorisation or Complaint; Timing of Hearings**

Tribunal structures involving multidisciplinary panels similar to the Victorian Board, comprising at a minimum a lawyer member as chairperson, a psychiatrist or medical member and a "community" member (variously titled) are used in:

- England and Wales - the E&W Mental Health Review Tribunal - review of involuntary detention and treatment
- Scotland - Mental Health Tribunal for Scotland - authorisation of involuntary detention and treatment, including compulsory community treatment
- Ontario Canada - Consent and Capacity Board - review of involuntary detention and treatment, treatment capacity and CTOs; and Ontario Review Board - review of forensic patients' fitness for trial
- Netherlands – local independent patients' complaints committees - review of patients' complaints about involuntary detention and treatment
- Denmark - local (regional) Patient Boards of Complaints - review of patients' complaints about involuntary detention and treatment.

Court personnel (single judge) are used in:

- Netherlands – District Court - court authorisation of involuntary detention
- Denmark – District Court - review of involuntary detention and treatment (appeal)
- Ontario Canada - Mental Health Court - dispositions for mentally disordered offenders.

The multidisciplinary tribunal approach clearly offers the advantages of a team approach to decision-making, utilising the specific expertise and experience of different categories of members. This approach seems to be well accepted in the United Kingdom and Commonwealth countries, including Canada and Australia.

By contrast, the European civil law model historically has favoured a single judge for all legal decision-making that affects citizens' rights. The Netherlands currently has a hybrid model whereby an involuntary patient's external rights position (involuntary status) is authorised by the court, whereas their internal rights position (complaints about involuntary detention and treatment etc.) is decided by a multidisciplinary tribunal-like complaints committee. Interestingly, in their most recent legislative review, the Dutch evaluation committee has made a recommendation for a two-part process for involuntary status decisions that involves both a tribunal and court authorisation.

The actual authorisation of involuntary detention and/or treatment also varies. In Scotland and the Netherlands, it requires a tribunal or court decision respectively. In other jurisdictions, initially it is a clinical decision, generally reviewed by patient application or complaint, supplemented by periodic statutory reviews. In several places such as Denmark and Ontario, a patient application can delay the commencement or continuation of psychiatric treatment until the review is completed. In the Netherlands, except in emergency circumstances, court authorisation of involuntary detention does not automatically authorise treatment.

Another important contrast is the timing of hearings, which largely reflects the differences in the statutory frameworks relating to authorisation of involuntary detention or treatment. Under MHA Vic, once an ITO is confirmed, its operation is indeterminate, subject to discharge at any time by the authorised psychiatrist or at a hearing by the Board. However, at the same time, the MHA Vic has the most generous appeal provision, allowing involuntary patients unlimited appeal rights. By contrast, in most overseas jurisdictions, the patient's right to make an application (appeal) is limited to one per review period. The MHA Vic also establishes minimum statutory review periods (8 weeks and annual) that, compared with other Australian states and territories, mean people can be treated involuntarily for considerable periods between review hearings. However, quite surprisingly, there is considerable variation across the overseas jurisdictions as to the periods between statutory reviews. In some jurisdictions, they must be arranged very quickly after each authorisation period commences, whilst in jurisdictions like England and Scotland, if no patient applications are made within three years and two years respectively, referrals for a review hearing must be made to the tribunal by the treating service.

### **7.3 Procedures; Time Taken in Hearings; Privacy**

Hearing procedures, in general terms, are similar in all jurisdictions, with most tribunals and European civil law courts acting as inquisitorial bodies which can call for further information and investigate relevant issues, if required. By contrast, mental health courts operate under the adversary principle, essentially a contest between opposing parties. Even so, unlike Victoria where the Board must reach its own reasonable satisfaction as to the application of the statutory criteria for involuntary treatment in each case, in many jurisdictions there is a burden of proof on the detaining authority to establish sufficient evidence to satisfy the decision maker and to justify continuing involuntary detention and/or treatment.

Where significant variations arise is in the length of hearings. This is affected by the role of legal representatives and the number of people who attend hearings. In general, the more emphasis on legal issues and greater number of people involved in hearings, the longer the hearings take to complete. This phenomenon has both positive and negative consequences.

Unquestionably, in England, Scotland and Ontario where hearings routinely run in excess of two hours, there is a considerably more thorough review and robust testing of the available evidentiary material than occurs in the majority of hearings in Victoria. However, from a patient's perspective, particularly a patient who at the time of the hearing is adversely affected by the symptoms of their mental illness, lengthy hearings have the potential to be counter-therapeutic for a number of reasons. Clinicians also complain that excessive legalism in the approach of patients' legal representatives or tribunal members can potentially damage the therapeutic alliance between the treating team and patient. On the other hand, many patients feel empowered by a process which tests the treating team's position.

By contrast, in the Netherlands, hearings are routinely completed by the judge in a very efficient manner in 30 minutes, with less emphasis on a detailed review of all available evidentiary material. Hearings are very informal, almost roundtable discussions, yet are very patient-centred and, in general, pro-therapeutic. The role of the patient's lawyer appeared far less prominent. Complaints committees in the Netherlands and Denmark adopt procedures and conduct hearings in a very similar manner to the Victorian Board, with hearings completed in around 30 minutes.

In England and Scotland particularly, the hearings observed were also extended because of the number of people involved in giving evidence to the tribunal. Again, this has positive and negative consequences. In terms of patient support, the importance of which cannot be underestimated, Scotland's legislation provides for the most diverse range, namely legal representation, an independent patient advocate, a "named person" (a best interests advocate nominated by the patient) and, if required, a litigation guardian. Because involuntary patients spend longer periods on inpatient units in England and Wales, compared with Victoria, staff generally have greater involvement with patients and know them better, leading to more detailed clinical information being made available to the tribunal in separate medical and social work reports and at the hearing.

In Victoria, all Board hearings are closed to the public, other than in exceptional circumstances (the patient's and public interest) by order of the Board, with similar provisions in England and Scotland. The level of privacy varied across other jurisdictions with the Ontario CCB and Toronto Mental Health Court, at least in theory, conducting public hearings. Complaints hearings in the Netherlands and Denmark are held in private, but court hearings are generally publicly accessible. In practice, it is rare for anyone other than those directly involved in hearings to attend and, for obvious reasons, tribunals and courts do not publicise or encourage public involvement.

#### **7.4 Patient Support – Rights advice and (non-legal) advocacy**

In each jurisdiction visited, there was an independent rights advice, advocacy and support service available to involuntary patients. Individual models varied but, in many cases, they have a statutory basis and there is an obligation on the service provider to involve the independent advocate at an early stage of involuntary detention. Without doubt, in my view, these models are superior to, and better protect patients' human rights than, the Victorian regime under s18 of the MHA Vic which places a duty on the service provider to provide information to involuntary patients about patients' rights. There is significant variation in how, and how well, the s18 requirement is satisfied. One problem is that, arguably, staff of Victorian area mental health services is placed in a potential conflict of interest situation in fulfilling this statutory role, which may be seen to conflict with their treatment obligations to involuntary patients.

Although I heard several criticisms by clinicians of individual examples of overzealous patient advocates, in general overseas models appeared well accepted by most stakeholders. My observations were that they are a cost-effective means of providing a greater level of support for patients and, at the same time, facilitating an appropriate focus on involuntary patients' human rights.

In some jurisdictions, including England, Scotland and Denmark, independent advocates would regularly attend hearings, whereas in others, including the

Netherlands and Ontario, advocates would assist patients in their preparation for hearings, but would rarely attend, preferring to rely on the patient's legal representative. Importantly, in all jurisdictions, patients' advocates act as an independent, patient-centred, partial and trusted confidante, who explains rights to, expresses the views of, and advocates on behalf of, patients in respect of both external (involuntary status) and internal (individual and systemic complaints) rights.

Excellent examples of patients' rights advice and advocacy organisations include the Netherlands, Ontario Canada, Scotland and Denmark.

## **7.5 Patient Support - Legal Representation**

By an informal agreement between legal aid organisations, legal representation in Victoria is provided for involuntary patients by Victoria Legal Aid for inpatients and the Mental Health Legal Centre for patients living in the community on CTOs. Over recent years, the level of legal representation has reduced from around 10% to less than 6%, presumably as a result of available legal aid funding and priorities.

In every jurisdiction I visited, legal aid-funded legal representation appeared to be available to all involuntary patients as of right, resulting in legal representatives being involved in more than 90% of hearings. In many cases, the funding arrangements made for involuntary patients, because of their perceived vulnerability and disadvantage, are streamlined to avoid the normal means and merits tests usually associated with grants of legal aid for civil litigation.

This high level of legal representation has both advantages and disadvantages. From a patient's perspective, it facilitates timely legal advice and assistance, and ensures extra support at hearings. It also provides an opportunity to test the service provider's justification for involuntary detention and/or treatment in a way that many patients are unable to do themselves. This, of course, can also assist the decision maker by clarifying legal and evidentiary issues requiring determination.

However, from the decision-maker's perspective, if not the service provider's, legal representation can also impact on the hearings in less helpful ways. It often increases the level of formality of, and significantly lengthens the time taken to complete, hearings, can take the focus of the hearing away from the patient and the essential decision-making business to peripheral legal issues, and can create an unnecessarily adversarial and anti-therapeutic atmosphere. In jurisdictions like England and Ontario, occasionally service providers will engage legal representation for hearings that involve complex factual or legal issues, adding an additional layer of formality, legalism and adversarialism to hearings.

In most jurisdictions, a positive aspect of the regular use of legal representation for involuntary patient hearings has been the creation of small and active groups of lawyers who practise mental health law. Not surprisingly, despite the quality of individual legal representatives being variable, this has resulted in the development of a more robust mental health law jurisprudence than has been the case in Australia. Nonetheless, the impact of increased levels of legal representation on hearing outcomes is difficult to gauge, but my impression was that results across the board are similar, irrespective of the jurisdictional differences.

## **7.6 Evidence; Confidentiality**

In Victoria, under a Board practice direction, for each hearing, area mental health services provide a written report addressing each of the MHA Vic involuntary treatment criteria. In the UK, historically involuntary admissions mandated both psychiatric and social work involvement. Therefore, the English and Scottish tribunals both routinely receive separate medical and social circumstances reports, each with a level of detail generally greater than in the Board's reports. As in Victoria, these are supplemented by oral evidence of clinical staff, the patient and the patient's supporters.

By contrast, in the Netherlands, the judge receives no written report other than the original certification documents and any previous dossiers relating to the particular patient. The judge takes all evidence orally at the hearing. The same is true for the CCB in Ontario. By contrast, complaints committees generally have the initiating written complaint before them, but the interpretation of the written complaint and the refining of the issues in dispute are often among the first and the most difficult tasks that the committee members must undertake in order to direct the hearing and decision-making to the actual issues. The nature of complaints can often lead to a "scattergun" approach to issues, making the hearing and decision-making less focused than it is for tribunals and courts with a specific Mental Health Act decision-making function.

Unlike in Victoria where, from the beginning, the practice has developed that in hearings the Board has access to patients' clinical files, in most jurisdictions these are not available to the decision maker, unless they specifically require them. Therefore, issues of confidentiality and non-disclosure of information to the patient are rarely issues of concern. By contrast, the Board is bound by the rules of natural justice that require that all parties have access to the same information the decision-maker will consider to arrive at its decision. MHA Vic includes a specific provision setting out three specific grounds on which the Board can restrict patients' access to material that the Board will consider during a hearing. Fortunately, non-disclosure applications are relatively rare but, unfortunately, the procedures for handling them are not mandated, potentially leading to some uncertainty among stakeholders and inconsistencies in approach by Board members.

In contrast to the Victorian Board, the procedures of the English and Welsh MHRT are formally regulated by statutory rules. Rule 12 deals with disclosure of documents and provides broad discretion to the MHRT regarding non-disclosure to the patient ("the tribunal is minded not to disclose any document"), but requires disclosure to the patient's authorised representative. In other jurisdictions where written material is less commonly provided to the decision maker, the issue rarely arises.

## **7.7 Administration**

As was expected, levels of administrative support for tribunals and courts largely depended on whether they were stand-alone decision-making bodies like the England MHRT, MHT Scotland and the Ontario CCB, or were part of a multi-jurisdictional court system like the Dutch and Danish courts and the Ontario Mental Health Court. Of most relevance to Victoria were the England and Wales' tribunals as they most closely parallel the Victorian Board and other Australian tribunals. The contrast between their budgets, staff levels and facilities was stark indeed. The actual requirements for practical administrative operations, listing and scheduling procedures, liaison with service providers and other relevant processes to facilitate hearings are generally similar. However, in practice, and differences seem to arise from variations in the statutory framework and timelines under which involuntary

detention and treatment must be reviewed or authorised. In most cases, these are much more strict and shorter than in Victoria, creating much greater urgency and pressure on administrative staff.

As a general observation, in terms of overall timeliness, efficiency and effectiveness in these administrative support functions, the Victorian Board has no peer. This may be in part explained by the specific legislative requirements for arranging Board hearings (within eight weeks and then annually and on extension of CTOs under the MHA Vic) and the use of compatible technologies to obtain data on involuntary orders from which the Board staff lists and schedules hearings. Nonetheless, the fact that, over 20 years of ever-increasing caseloads, the Board has consistently maintained a capacity to provide high-quality and timely administrative support for the Board with so few staff numbers and such a comparatively small budget, when compared with overseas jurisdictions, speaks volumes for the organisational skills of its leaders and dedication of its staff, both past and present.

Having said that, there is no doubt that Victorian Board members receive less direct administrative support at hearings than the members of all overseas tribunals and courts that I observed. In these jurisdictions, significant importance is attached to facilitating a wider range of administrative support provided by their staff for members at hearings with the use of clerks, in some cases legally qualified. In my view, this also enhances in a very positive way the public perception of the status and importance of the role of the members and the decision-making work they undertake. This in turn can have a positive effect in reducing the stigma attached to mental illness. This is particularly the case in England and Wales where tribunal members are treated as members of the judiciary, with access to the same continuing education and training programs as court judiciary.

## **7.8 Hearing Support**

Without question, the most important administrative support role provided to tribunal and court decision-makers in undertaking mental health decision-making in all jurisdictions visited was the provision of hearing clerks to assist decision-makers throughout the sitting day. Although arrangements in different jurisdictions varied, routinely clerks liaise with venue staff, set up the hearing room, organise recording (all hearings are recorded in most jurisdictions except the Netherlands and Denmark) and other equipment, take notes during hearings, draft and/or provide computer keyboarding of reasons for decision, and undertake any other administrative functions decision-makers require. Importantly, this assistance allows decision-makers to concentrate on the evidence and the hearing process, rather than on notetaking and completing paperwork. Overall, this leads to higher quality processes that benefit parties, especially involuntary patients.

In most jurisdictions, tribunal or court staff provide clerking services as part of their duties. In Scotland, for example, on rotation, MHTS staff attend hearings with a very compact and complete briefcase containing all the necessary equipment (including recorder, laptop, printer, tribunal stationary etc.). Court officers provide similar services for judges in the Netherlands, and State Administration officers, often legally qualified, do the same for members of regional complaints boards in Denmark. In England, clerking services are provided by contractors and, unsurprisingly, their quality is reported to vary considerably. In Ontario, a professional court reporting service is contracted to record all CCB hearings.

Victorian Board hearings are not recorded, although hearings in some other states (for example, South Australia and New South Wales) are. There are arguments for and against the practice. In Victoria, there is a very small number of patients each year who request reviews of Board decisions. The Victorian Civil and Administrative Tribunal (VCAT) conducts a *de novo* hearing, requiring it to make a fresh determination of the application of the MHA Vic involuntary treatment criteria on the basis of the evidence before it at the VCAT hearing. As a result, I do not consider that the greater level of formality that recording creates is warranted or can be justified in Victoria.

Leaving aside the recording issue, there is no doubt that the provision of clerking services to members has a significant and positive effect on the overall quality of hearings, and how they are perceived by participants. The assistance provided to members facilitates concentration on high-quality, patient-centred and pro-therapeutic hearing procedures, which benefits all participants, because individual members do not have to concentrate their efforts on comprehensive note-taking and other tasks secondary to their main hearing and decision-making functions.

## 8. Conclusions

Most directly relevant to the Board's own administrative and hearing practices in conducting involuntary mental health patient hearings were my observations of the England and Wales MHRT (in several locations in England and Wales), the MHT Scotland, the Dutch regional complaints committees, the Danish regional Psychiatric Boards of Complaints, the Ontario Consent and Capacity Board, the Ontario Mental Health Court, and the Ontario Review Board. These observations reinforced the old adage that "a picture tells a thousand words". Nonetheless, I had the added advantage of many "thousands of words" in the form of descriptions and discussion with many knowledgeable and expert professionals to fill out the picture in a most comprehensive manner.

In summary, my overall impression was that the similarities were more striking than the differences, despite obvious variations in legislative frameworks, and treatment and service delivery systems. Having said that, however, each jurisdiction has developed innovations and good practices, from which we can learn a great deal. In my view, the successful introduction of a number of these in Victoria and Australia would lead to significant improvements.

In evaluating the mental health review, legislative and service delivery systems in each jurisdiction, I tried to remain constantly mindful of the local context, especially in attempting to translate that experience into our Victorian and wider Australian contexts. Key factors include:

- legislative framework, including the criteria for involuntary detention and/or treatment, human rights legislation, and review and complaints frameworks
- service delivery elements, particularly inpatient bed numbers, community facilities, forensic services, medical and allied health professional and other staffing
- population size, distribution and demographics
- funding levels and priorities
- public and private sector mental health service delivery systems
- specialist provision for particular groups of people, for example, those with personality disorder, forensic histories, complex needs, drug and alcohol issues, intellectual disability, brain injuries and cognitive impairment
- cultural and historical factors.

Everyone with whom I met demonstrated extraordinary generosity in the giving of their valuable time and expertise, and expressed considerable interest in my study project. Whatever else is achieved from my experience, important connections have been established with a wide range of counterparts of the Board in the jurisdictions visited that potentially may lead to important collaborations for other Victorian mental health organisations, as well as those in other States and Territories of Australia. Future exchanges and/or study tours should build on the goodwill created through my study tour, leading to wide-ranging improvement of processes, procedures and practices that may benefit involuntary patients worldwide.

The study tour also provided me with an opportunity to describe and explain to my contacts Victorian processes, procedures and practices, both at Board level and more broadly. I found it extremely affirming that, in many ways, Victoria is, and is seen to be, a leader in this field, acknowledged for its innovative and creative development of mental health legislation, policy and practice with a significant focus on treatment in community settings. Not surprisingly, however, many problems highlighted in the Victorian context are equally seen to a greater or lesser extent in overseas

jurisdictions, so it is clear that there is much we can all learn from each other, if only there is the will, innovation and appropriate government and other resources made available to ensure that the opportunities are grasped.

## **9. Future Directions - Translating Overseas Innovation into Local Best Practice**

It is clear from my experience of the jurisdictions I visited, which all have longstanding and established human rights cultures compared with Victoria (and Australia generally), that the full implementation of the Charter from 1 January 2008 provides a timely opportunity to comprehensively review the whole policy and legislative framework around the use and review of compulsion for treatment of people with a serious mental illness, as well as other groups of people with disabilities for whom compulsion is sometimes required.

My overseas experience demonstrates that, over time, a greater human rights focus will gradually create an inexorable cultural shift in Victoria which will demand this review. My experience suggests that the way forward for government is to lead from the front by creating a policy and legislative framework based on logical, coherent, comprehensive and human rights-based principles. Despite individual differences, I noted many similarities in the issues each jurisdiction attempts to deal with in the complex areas of involuntary mental health review and treatment. As a result, there is benefit in not "reinventing the wheel" any more than is necessary.

Therefore, in my view, there is much to be gained from the Victorian Government reviewing the high-quality research, policy and legislative work that has been conducted in the United Kingdom, Europe and Canada in recent years, and is easily accessible via the Internet and through the contacts I have listed. Adaptation of the best of their policy and legislative innovations and developments in Victoria will potentially facilitate many improvements, particularly in terms of compliance with human rights and the Charter.

What then are the essential features I observed that could provide innovative change in Victoria and Australia leading to "best practice" in mental health review processes?

The most compelling observation was that the human rights context provided by the UK Human Rights Act, the European Convention and the Canadian Charter of Rights and Freedoms is important in facilitating a greater practical focus on providing an accurate, timely and independent patient rights advice framework for involuntary patients, as well as increased advocacy and support services. There were examples in all jurisdictions, with the best models seen in the Netherlands (the PVP), Ontario Canada (the Psychiatric Patient Advocate Office) and Scotland (various independent advocacy organisations, under the umbrella of the Scottish Independent Advocacy Alliance). Although not without their critics among service providers, and requiring considerable care in their establishment and the selection of appropriate rights advisors and advocates, they clearly surpass our current, largely unsupervised and variable arrangements under s18 of the MHA Vic.

In terms of administrative support for tribunal members, with the view to improving the quality of hearings and the decision making of members, although requiring increased budgets to meet additional recurrent costs, the use of staff (or, less successfully in England's case, contractors) to provide clerking and administrative backup works exceptionally well, especially in Scotland, the Netherlands and Denmark.

In respect of the conduct of hearings themselves, the high levels (over 95%) of legal representation in jurisdictions such as England, Scotland and Ontario Canada creates a two-edged sword. On the one hand, it fosters a far more robust review process

but, on the other, at a considerable cost, not just in time, but also in the effect on informality and the non-adversarial nature of hearings, and pro-therapeutic outcomes. By contrast, in the Netherlands, judges completed legally represented hearings with the same efficiency and dispatch as the Victorian Board. At the end of the day, the different hearing systems employed did not seem to change the hearing outcomes in any significant way.

My observations of the English, Scottish, Danish and Ontario (CCB and ORB) arrangements reinforced the strength of the arguments in favour of multidisciplinary tribunal panels as the fairest and most expert decision-making model. Clearly the BOPZ Evaluation Committee in the Netherlands agrees. The recent changes in England to treat tribunal members as a separate part of the judiciary and to develop a separate Tribunals Service to provide knowledgeable, consistent, coherent and efficient administration also merit consideration. Having said that, I was also impressed with the efficient use of knowledgeable and experienced judicial officers in the Netherlands and the Toronto Mental Health Court.

## **10. Recommendations**

Based on the knowledge and experience gained on the study tour, and the best-practice elements observed overseas, the following are my key recommendations:

### **10.1. Victorian Board and Review Process**

The Victorian Government should consider:

- (a) establishing in legislation and recurrently funding at an appropriate level an independent patients' rights advice, advocacy and support service
- (b) providing increased levels of funding to facilitate compulsory legal aid-funded legal representation at Board hearings
- (c) a legislative amendment to the composition of hearing panels to facilitate new members' involvement in hearings as part of induction training
- (d) providing increased funding to the Board to facilitate clerking services and an overall greater capacity to provide a higher level of administrative support for tribunal members at hearings
- (e) providing increased funding to the Board to ensure that listing practices are such that the maximum number of hearings that each Board division conducts per sitting facilitates more human rights-compliant, pro-therapeutic, high-quality and comprehensive review hearings than is currently possible
- (f) raising the importance of mental health review processes by treating Board members as a separate but recognised element of the Victorian court and tribunal system.

### **10.2. Involuntary Patients**

The Victorian Government should consider:

- (a) establishing an independent, coherent, accessible and transparent complaints process
- (b) abolishing the Office of the Chief Psychiatrist, and establishing in legislation and recurrently funding at an appropriate level an independent mental health commission with powers, among others, to monitor the use of the MHA Vic and respect for patients' rights; monitor and report on the mental health services and service delivery; receive and resolve patient complaints; arrange independent second opinions; conduct research; and report regularly to Parliament
- (c) providing funding for legal services to conduct test litigation on human rights-related issues under the MHA Vic, the Charter and other relevant capacity and disability legislation
- (d) reviewing the interaction between, and coordination of, services provided by public area mental health services and non-government psychiatric disability and rehabilitation support services

### **10.3. Legislative framework**

The Victorian Government should consider:

- (a) a comprehensive review of the MHA Vic in light of the full implementation from 1 January 2008 of the Charter

- (b) the introduction of generic mental capacity legislation, including mechanisms (such as regulating the use of patients' advance statements or directives) for assisting those with impaired decision-making capacity
- (c) the integration of legislation regulating compulsory detention and treatment across disability sectors, including guardianship
- (d) the integration of expert review bodies and functions with respect to compulsory detention and treatment across disability sectors by establishing one mental health and capacity tribunal, dealing with all mental health and disability consent and capacity issues, including detention, treatment and guardianship
- (e) legislative acknowledgement of, and rights protection for, carers, family members and support persons of involuntary patients
- (f) establishing and appropriately funding a mental health court, either within the existing court framework or as an expert decision-making body.

## Footnotes

1. Fennell, P., *Treatment without Consent*, London, Routledge, 1996, p10
2. "30th anniversary 1976-2006: A Collection of Speeches", Administrative Appeals Tribunal, 2 August 2006, p11
3. See HL v UK [2005] 40 EHRR and R v Bournewood Community and Mental Health Trust ex parte L [1998] 3 All ER 289
4. "The New Directions", Report on the Review of the Mental Health (Scotland) Act 1984, chaired by Rt. Hon. Bruce Millan, laid before the Scottish Parliament in January 2001
5. Lawton-Smith, S., "Community-based Compulsory Treatment Orders in Scotland: The Early Evidence", King's Fund London, 2006
6. "Transmural" is a Dutch term describing the principle for a mental healthcare organisation providing continuity of care between hospital and community
7. See Inspect!, a Mental Disability Advocacy Centre report on Inspectorates of Mental Health and Social Care Institutions in the European Union, 2006

## Appendix 1

### Itinerary

<b>Week</b>	<b>Location</b>	<b>Broad Focus</b>
<b>UNITED KINGDOM</b>		
1. 20-27 April	London	MHR Tribunals, advocacy and Eng MH Act reform
2. 30 Apr-4 May	Wales, England	MHR Tribunals, advocacy and Eng and Welsh MH system
3. 7-11 May	Non-Churchill	Attend UK JSB Course
4. 12-18 May	Edinburgh	MHR Tribunals, advocacy and Scottish MH system
<b>NETHERLANDS</b>		
5. 18-27 May	Amsterdam	Court review, advocacy and Dutch MH system and MH Act reform
<b>DENMARK</b>		
6. 27 May- 4 Jun	Copenhagen	MH review system, advocacy and Danish MH system and MH Act reform
<b>GERMANY</b>		
7. 4-8 Jun	Dresden	WPA Thematic Conference
8. 10-20 Jun	Non-Churchill	Recreation Leave
9. 21-22 Jun	Non-Churchill	Trieste, Italy – Community MH system
<b>ITALY</b>		
10. 24-30 Jun	Padua	IALMH International Congress
11. 2-8 July	Non-Churchill	Recreation Leave
<b>CANADA</b>		
12. 8-17 July	Toronto	Consent and Capacity Tribunal, MH Court, advocacy and Canadian MH systems
<b>USA</b>		
13. 17-20 July	Non-Churchill	Los Angeles, USA - MH Court, review, advocacy and Californian MH system

## Appendix 2:

### Conferences Attended

20 April 2007, London England:

**Mental Capacity Act and Mental Health Bill Conference**, Central Law Training

6-8 June 2007, Dresden Germany

**Thematic Conference - Coercive Treatment in Psychiatry: A Comprehensive Review**, World Psychiatric Association

25-30 June 2007, Padua Italy

**30th International Congress on Law & Mental Health**, International Academy of Law and Mental Health

### Conference Papers Delivered

**World Psychiatric Association Thematic Conference - Coercive Treatment in Psychiatry: A Comprehensive Review**, Dresden Germany

7 June 2007 - Involuntary Treatment and Review and the Victorian Human Rights Charter: Uneasy Compatibility in the Antipodes?

**International Academy of Law and Mental Health, 30th International Congress on Law & Mental Health**, Padua Italy

26 June 2007 - Effectiveness of Victorian *Mental Health Act 1986* from the Review Perspective

27 June 2007 - Evaluating the Effectiveness of the Victorian Mental Health Review Board

28 June 2007 - An Australian Perspective on the Link between Treatment Capacity and Involuntary Status

Appendix 3:

## CHURCHILL FELLOWSHIP STUDY TOUR

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