

Pushing the Boundaries: Realising Rights Through Mental Health Tribunal Processes?

TERRY CARNEY, DAVID TAIT & FLEUR BEAUPERT*

Abstract

Mental health jurisprudence traditionally was more concerned to protect negative or 'liberty' rights than to advance positive rights of access to needed mental health care and treatment. North American test case litigation has contributed to advances in the quality of mental health and other services in some instances, but the record is patchy. Socio-legal studies of mental health tribunal operations in England and Wales suggest that health paradigms are dominant, and that legal norms and standards may be weak reeds in this setting. This article reviews the diverse legislative models in three main Australian jurisdictions before examining fieldwork data on the extent to which Australian mental health tribunals 'push the boundaries' of the law in order to obtain favourable treatment outcomes. It argues that, contrary to overseas experience, Australian tribunals merely 'nudge', rather than disturb, the legal boundaries.

1. Introduction

Legal regulation of psychiatric care in Western societies has passed through numerous phases in an attempt to keep up with evolving understandings of mental illness. One constant, however, since the mid-19th century, has been the use of coercive measures by the state to 'manage' madness, initially by confining 'the insane' in institutions, but more recently (following wide-scale de-institutionalisation), through the more diffuse — but no less real — power represented by the conditions laid down in community treatment orders.¹

* Terry Carney, Professor of Law, the University of Sydney; David Tait, Associate Professor, School of Law, University of Canberra; Fleur Beaupert, doctoral student, University of Sydney. (Professor Duncan Chappell, Sydney, and Dr Christine Coumarelos, NSW Law and Justice Foundation, are the other Investigators on the three-year ARC Linkage grant project from which this paper is derived).

1 Milton Lewis, *Managing Madness – Psychiatry and Society in Australia 1788–1980* (1988) at 2. De-institutionalisation in Australia saw mental health beds fall from around 30,000 to around 8,000 over three decades: Harvey Whiteford & William Buckingham, 'Ten Years of Mental Health Services Reform in Australia: Are We Getting it Right?' (2005) 182 *Medical Journal of Australia* 396 at 396. Community treatment orders have now become the new *site* for debate about human rights and treatment for the mentally ill: Vanessa Pinfold & Jonathan Bindman, 'Is Compulsory Community Treatment Ever Justified?' (2001) 25 *Psychiatric Bulletin* 268; Marvin Swartz & John Monahan, 'Special Section on Involuntary Outpatient Commitment: Introduction' (2001) 52 *Psychiatric Services* 323.

Mental health jurisprudence has traditionally been concerned with establishing minimum objective criteria to be satisfied before an individual with a suspected mental illness may be involuntarily detained and fair processes in decision-making about involuntary detention. Legal safeguards were introduced to protect better the *negative* (civil and political) right of people with mental illnesses to freedom from arbitrary deprivation of liberty.² Australian mental health legal frameworks now provide for individuals to receive compulsory institutional care, in a psychiatric ward or hospital, as well as compulsory treatment in a community setting under a community treatment order ('CTO').³ This newer form of compulsory psychiatric care took shape in Australia in the context of the de-institutionalisation movement, which saw the location of service delivery shift away from institutions and into the community.

The National Mental Health Policy of 1992 identified community-based care as a basic human right.⁴ Mental health policy now aims to minimise restrictions on freedom and maximise consumer participation in decisions about their treatment, in part through early intervention when a person becomes unwell and the use of community-based care where consistent with the provision of appropriate treatment.⁵ Contemporary public debates, however, suggest that mental health service users have yet to achieve full access to the *positive* (social, economic and cultural) right to mental health care and treatment in a way which enables them to participate as equals in the wider community as far as possible.⁶

Mental health tribunal ('MHT') processes form one critical layer of decision-making in mental health care. MHTs are specialist tribunals of multi-disciplinary membership, empowered by mental health statutes to make a range of decisions concerning the treatment of people with mental illnesses. The primary function of MHTs in conducting mandatory external review of compulsory psychiatric care is a negative one: to prevent the use of compulsory treatment unless the relevant statutory criteria are satisfied. Observation of the MHT operations, however,

2 *International Covenant on Civil and Political Rights* (hereafter 'ICCPR'), opened for signature 16 December 1966, 999 UNTS 171, art 9 (entered into force generally 23 March 1976 and for Australia 13 August 1980).

3 Community treatment orders (known by other names internationally), are more widely used as intermediate or early intervention orders in Australia and New Zealand than is the case in many overseas jurisdictions, where they tend to be confined to a modern form of 'trial leave' from institutional care: John Dawson, *Community Treatment Orders: International comparisons* (2005); Heathcote Wales & Virginia Hiday, 'PLC or TLC: Is outpatient commitment the/an answer' (2006) 29 *International Journal of Law and Psychiatry* 451.

4 Australian Health Ministers, *National Mental Health Policy* (1992).

5 Australian Health Ministers, *National Mental Health Plan 2003–2008* (2003).

6 Mental Health Council of Australia, *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia* (2005) (hereafter MHC 'Not for service...'); Select Committee on Mental Health, *Mental Health Services in New South Wales Final Report* (The Committee, 2002) (hereafter 'NSW Select C'tee 2002'). The *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 999 UNTS 3 (entered into force generally 3 January 1976 and for Australia 10 March 1976), art 12(1) recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.

indicates that MHTs may sometimes perform a broader role, consistent with the overriding statutory objective of mental health legislation to provide the best possible care in the least restrictive environment, enabling such care and treatment to be effectively given.⁷ The utility of this broader role is heightened in the current climate of service ‘crisis’ documented in recent years in the media, government inquiries, academic literature and numerous reports.⁸

The central issue in this article, based on preliminary findings of a three year study on Australian MHTs, is whether MHT processes are used to extend human rights in the mental health context (including to some extent ‘positive’ rights to access care), and whether their rights-realisation potential might be more effectively harnessed.⁹ We discuss examples of the ‘strategic’ use of MHT processes to facilitate the realisation of positive human rights in the mental health context, using observational and interview data collected in New South Wales (‘NSW’), Victoria and the Australian Capital Territory (‘ACT’), where the majority of the fieldwork for the present study is being conducted.

First, though, we provide a brief overview of the functions of MHTs and their relationship to health care outcomes for mental health service users. In the second section we place our discussion of MHT processes in the broader context of ‘institutional litigation’ in which courts adjudicate on the administration of public institutions. We then turn to consider rights which have been recognised specifically in the mental health context through litigation in the United States and Canada, and compare developments in those jurisdictions to Australian mental health legal frameworks. The final two sections of the article present and discuss four examples from data collected through observation of MHT hearings in NSW, Victoria and the ACT.

7 For example, the objects of the *Mental Health Act* 2007 (NSW) (‘NSW MHA 2007’) include provision of care, treatment and control for people with mental illness ‘through community care facilities’ (s 3(a), (b)). Among the ten ‘principles for care and treatment’ contained in section 68, the legislation endorses the principles ‘(a) ...the best possible care and treatment in the least restrictive environment ... (b) ...timely and high quality treatment and care in accordance with professionally accepted standards, (c) [treatment] designed to assist people with a mental illness or mental disorder, wherever possible, to live, work and participate in the community, (d) [medication] should be given only for therapeutic or diagnostic needs and not as a punishment or for the convenience of others [and] (e) ...[provision of] appropriate information about treatment, treatment alternatives and the effects of treatment...’. Objectives stipulated for the public health system in section 105 provide, among other things, that mental health services should ‘(c) develop, as far as practicable, standards and conditions of care and treatment for persons who are mentally ill or mentally disordered that are in all possible respects at least as beneficial as those provided for persons suffering from other forms of illness...[and] (e) ...[be] comprehensive and accessible...’.

8 Gavin Andrews, ‘The Crisis in Mental Health: The Chariot Needs One Horseman’ (2005) 182 *The Medical Journal of Australia* 372; Maria Karras *et al*, *On the Edge of Justice: The Legal Needs of People with a Mental Illness in NSW* (2006); MHC ‘Not for service...’, above n6; ‘NSW Select C’ttee 2002’, above n6.

2. *Decision-making and Treatment Outcomes from Mental Health Tribunals*

A mental health tribunal hearing generally involves a multi-disciplinary panel, comprising a legal member, a psychiatrist member and a 'community' member,¹⁰ synthesising incommensurable narratives of patients, families, clinicians and lawyers¹¹ and ascribing them with a legal meaning. However, the formal legal outcome of the hearing continuation of compulsory treatment in the majority of cases tells us little about what actually happens in the hearing encounter. Perkins, who conducted a landmark government-commissioned study of MHTs in England and Wales, found that hearings often provided an opportunity to improve therapeutic outcomes for patients:

The hearing allowed the patient's treatment and progress to be examined in detail by a group of people not connected with the hospital. The hearing also provided patients with a controlled setting in which they could talk to their RMO [Registered Medical Officer] through an advocate. And some members commented that the hearing is one of the first or few occasions when the consultant and the patient actually communicate clearly about what is going to happen and what the future looks like.¹²

Regardless of the formal decision of the tribunal, the hearing may provide a chance for treatment procedures to be discussed. This has led some commentators to suggest that mental health hearings may sometimes become case conferences.

9 The question of the 'fairness' and the therapeutic impact (or otherwise) of mental health tribunal review as postulated by 'therapeutic jurisprudence' scholarship is canvassed elsewhere: Terry Carney *et al*, 'Mental Health Tribunals: "TJ" implications of weighing fairness, freedom, protection and treatment' (2007) 17 *Journal of Judicial Administration* 46. See also Kate Diesfeld & Brian McKenna, 'The Therapeutic Intent of the New Zealand Mental Health Review Tribunal' (2006) 13 *Psychology, Psychiatry & Law* 100; Kate Diesfeld & Brian McKenna, 'The Unintended Impact of the Therapeutic Intentions of the New Zealand Mental Health Review Tribunal: Therapeutic jurisprudence perspectives' (2007) 14 *Journal of Law and Medicine* 566; Ian Freckelton, 'Mental Health Tribunal Decisionmaking: A therapeutic jurisprudence lens' (2003) 10 *Psychiatry, Psychology and Law* 44; Bruce J Winick, *Civil Commitment: A Therapeutic Jurisprudence Model* (2005). Alternative perspectives meriting attention include the 'empowerment' or 'facilitation' of autonomy and actual or latent capacity of people with mental illness, drawing on parallels with adult guardianship laws: Genevra Richardson, 'Autonomy, Guardianship and Mental Disorder: One problem, two solutions' (2002) 65 *Modern Law Review* 702. Grounded in part in theories of 'social citizenship' rights (Terry Carney, 'Protection, Populism and Citizenship' (2000) 17 *Law in Context* 54), these frameworks are attracting increasing international attention: John Dawson & Annegret Kampf, 'Incapacity Principles in Mental Health Laws in Europe' (2006) 12 *Psychology, Public Policy, and Law* 310; John Dawson & George Szmukler, 'Fusion of Mental Health and Incapacity Legislation' (2006) 188 *British Journal of Psychiatry* 504. An aspect of this for the purposes of the present project is explored in: Fleur Beaupert, Terry Carney, David Tait & Vivienne Topp 'Property Management Orders for the Mentally-ill: Protection or empowerment?' (Unpublished 2008).

10 The third member category is 'community member' or 'other member' depending on the jurisdiction. This category comprises members who have skills or experience in the provision or receipt of mental health services outside psychiatry, including social workers, psychologists and, less frequently, carers or consumers.

Such a criticism alludes to the oft-asserted division between clinical decision-making, on the one hand, and adjudication by civil commitment judges or MHTs, on the other. We argue that the wording of mental health legislation precludes a strict division between these two types of decision-making. If a MHT panel recommends that clinicians revise the treatment plan they have prepared for an individual appearing before them, to take into account the individual's wish to live as close as possible to their family, would that panel be overstepping legal boundaries and entering into the clinical domain of diagnosis and treatment? Would the answer be any different if the clinicians were *ordered* to change a treatment plan in this way to protect better the autonomy of a patient? These are complex questions, the answers to which depend on the precise statutory rules in each jurisdiction.

A careful examination of the provisions of Australian mental health statutes shows that tribunals should certainly consider the adequacy of the treatment that is or will be provided to an individual under an order for compulsory treatment,¹³ and thus take steps to remedy inadequacies where possible. This role is a necessary adjunct to their primary function of preventing unjustified deprivation of liberty. As Genevra Richardson and David Machin have commented:

The tribunal has to determine a legal question, but it is a legal question set in a health-care context and dependent for its interpretation on a clinical opinion. Thus, an examination of the statutory criteria can lead almost inexorably to a wider discussion of the patient's care and future plans.¹⁴

Judicial adjudication which has an impact on political or administrative policies has been a feature of the law since its inception. Realisation of rights through mental health tribunal processes, in ways which have an impact on clinical decision-making, is simply one manifestation of a tradition which may be traced back to the Roman law origins of Western legal systems. The Twelve Tables of Roman law codified only a basic set of legal rights and duties; the college of pontiffs were compelled to flesh out and clothe this skeleton as they encountered new disputes for which the codes failed to provide remedies. They 'could "interpret" the law in a progressive way, even to produce a new institution which had been quite unknown to the earlier law'.¹⁵

11 Stephanie du Fresne, 'Therapeutic Potential in Review of Involuntary Detention' in Kate Diesfeld & Ian Freckelton (eds), *Involuntary Detention and Therapeutic Jurisprudence* (2003) 203.

12 Elizabeth Perkins, 'Mental Health Review Tribunals' in Kate Diesfeld & Ian Freckelton (eds), *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment* (2003) 221 at 239. At the same time, she questioned whether they were an effective legal safeguard: at 238-239.

13 Some mental health statutes contain a relatively high threshold treatment efficacy prerequisite, such as the *Mental Health (Treatment and Care) Act 1994* (ACT) ('ACT MHA'), which requires that the treatment to be provided under an order for compulsory treatment will actually *improve* the person's condition: s 28(c).

14 Genevra Richardson & David Machin, 'Doctors on Tribunals: A Confusion of Roles' (2000) 176 *British Journal of Psychiatry* 110 at 113.

Before turning attention to judicial recognition of rights in the mental health context, we therefore consider the broader phenomenon of the use of court processes as a tool to seek realisation of human rights.

3. *Institutional Litigation: New Rights, Not New Remedies*

If mental health tribunals do indeed display signs of judicial activism, they would be joining a long-standing politico-legal tradition of judicial (and quasi-judicial) re-ordering of the affairs of institutions. From the mid 1960s to the mid-1980s, judicial determinations played a significant role in reforming the administration of prisons in the United States. In a similar fashion to the pursuit of racial equality through litigation, prisoners and their advocates enlisted the assistance of the courts to alter practices and policies in correctional institutions, arguing that prison conditions violated their constitutional rights.¹⁶ The prohibition on cruel and unusual punishment in the United States Constitution became the legal basis for the decisions in *Estelle v Gumbelle*,¹⁷ establishing prisoners' limited right to medical care; and, in *Hutto v Finney*,¹⁸ for endorsing the authority of district judges to issue remedial orders to prisons.¹⁹

The prison reform cases are part of a broader category of litigation, termed 'institutional litigation', which has seen the courts scrutinising the operation of an array of institutions (including prisons, schools, hospitals and mental institutions) and making determinations which effectively re-order the affairs of such institutions.²⁰ Institutional litigation has attracted the criticism that it involves judges exercising 'new' powers (reform of institutions) which are meant to belong exclusively to political decision-makers.²¹ Theodore Eisenberg and Stephen Yeazell argue that what makes institutional litigation appear extraordinary is, in fact, not the types of powers asserted by the courts, but the *nature of the entitlements* they are purporting to protect previously unimagined affirmative rights which are a product of recent social history.²²

15 Peter Stein, *Roman Law in European History* (1999) at 7. As Stein puts it: 'The Romans had a strong feeling that their law was of long standing and had been in essentials part of the fabric of Roman life from time immemorial. *At the same time they expected it to allow them to do what they wanted to do, so long as that seemed reasonable.*' [emphasis added.] During the first half of the republic, this was where the pontiffs could step in, to 'interpret' the law (such as finding ways to 'emancipate' children from the rule vesting absolute ownership power in their father).

16 See Christopher E Smith, 'The Governance of Corrections: Implications of the Changing Interface of Courts and Corrections' (2000) 2 *Criminal Justice* 113.

17 429 US 97 (1976).

18 437 US 678 (1978).

19 Smith, above n16 at 122.

20 Theodore Eisenberg & Stephen C Yeazell, 'The Ordinary and the Extraordinary in Institutional Litigation' (1980) 93 *Harvard Law Review* 465.

21 Id at 516. See for compelling arguments as to the limitations of 'judicial policy making' in the health care context from a Canadian perspective: Christopher P Manfredi & Antonia Maioni, 'Courts and Health Policy: Judicial Policy Making and Publicly Funded Health Care in Canada' (2002) 27 *Journal of Health Politics, Policy and Law* 213.

22 Eisenberg & Yeazell, above n20 above at 510–511.

Eisenberg and Yeazell place institutional litigation in perspective as part of a long standing politico-legal tradition, pointing out that the complex remedies developed in this apparently 'new' form of litigation are simply 'the latest products of a social development that produced our most venerable common law writs'.²³ MHTs are a discrete, specialised subset of this tradition, having express functions to supervise the administration of public health institutions in order to further the rights-protection goals of mental health legislation. They have a range of powers at their disposal to this end. In addition to simply authorising or refusing to authorise compulsory treatment, an MHT may, for example:

- defer a person's discharge for a period of time;²⁴
- order the revision of a treatment plan;²⁵ or
- order a psychiatrist to make a CTO or vary a CTO.²⁶

Health services may be compelled to rethink their priorities and re-allocate their resources in order to give effect to these various orders.

Of particular interest for our ensuing discussion about MHT operations is the fact that United States prison and other institutional litigation was not necessarily viewed with hostility by the administration, and a number of cases had a distinctly collaborative and consensual flavour. Judges had to be creative in pressuring and negotiating with State officials over lengthy periods, because their decisions demanded changes in public expenditures.²⁷ Furthermore, prison litigation was often used by judges *and correctional officials alike* as a form of 'bargaining' to gain the resources necessary to improve the conditions in correctional institutions over time.²⁸

We now turn attention to specific advances in the recognition of rights in the mental health context.

4. Mental Health Rights and the Boundaries of Decision-making in Mental Health Care

North American mental health advocacy cases have compelled the courts to examine processes of civil commitment in mental institutions to decide whether the standards and procedures for initiating commitment, and conditions of treatment during commitment, violate constitutional rights. Since the 1960s, as part of the broader civil rights movement, United States lawyers have instituted court actions arguing for the recognition of constitutional rights, such as the rights

²³ Id at 512.

²⁴ NSW MHA 2007 s 38(6) (Cf *Mental Health Act* 1990 (NSW) ('NSW MHA 1990') ss 57(5), 59(5)).

²⁵ *Mental Health Act* 1986 (Vic) ('Vic MHA') s 35A.

²⁶ Vic MHA ss 36(4), 36C(3)(a).

²⁷ Smith, above n16 at 124.

²⁸ Ibid.

to liberty and due process, in the mental health context.²⁹ Canada is another jurisdiction in which judicial decisions have been central to reform of mental health laws.

By contrast, there is little Australian jurisprudence in the mental health field, no doubt owing in part to the fact that no Bill of Rights has been adopted in national law, and only Victoria and the ACT have very recently adopted charters of rights and responsibilities.³⁰ Gradual changes to mental health laws have, rather, almost exclusively been the result of conventional reform by state and territory legislatures. Nonetheless, Australian mental health statutes have gradually developed to incorporate a number of mental health rights and duties now recognised in international human rights law, as government policy has attempted to keep pace with contemporary values.³¹

In parallel with the development of mental health laws with a stronger human rights focus, new adult guardianship laws have emerged to protect the rights of people with decision-making disabilities, including those with psychiatric disabilities. This legislation asserts autonomy rights even more strongly than mental health legislation, by limiting the scope and duration of legal interventions, providing substitute decision-makers independent of medical authorities, and establishing independent public agencies (typically 'public advocates') as a watchdog over the operations of the legislation.

United States and Canadian courts have developed jurisprudence establishing: (1) minimum criteria for civil commitment; (2) a qualified right to refuse treatment for competent patients; and (3) a limited 'right to treatment' for those who are detained. The United States is unique in its choice of a judicial model for the civil commitment hearing, to determine whether commitment is appropriate, either before commencing commitment, or shortly afterwards in emergency situations.³² Like Canada and most Western developed nations, Australia chose a tribunal model for review (or advance screening) of such decisions. Australian mental health statutes have above all established a range of *procedural* safeguards to protect the individual's right to freedom from arbitrary detention, including:

29 Nancy Rhoden, 'The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory' (1982) 31 *Emory Law Journal* 375 at 385.

30 The Australian Capital Territory has implemented a *Human Rights Act* 2004 (ACT), and Victoria has implemented a *Charter of Human Rights and Responsibilities Act* 2006 (Vic), both of which recognise various civil and political rights, and provide mechanisms for enforcing them. Further: Terry Carney and Fleur Beaupert, 'Mental Health Tribunals: Rights drowning in un-"chartered" health waters?' (2008) 14, *Australian Journal of Human Rights* forthcoming.

31 Some convergence of laws and practices was promoted around international human rights benchmarks: see Terry Carney, 'Mental Health in Postmodern Society: Time for new paradigms?' (2003) 10 *Psychiatry, Psychology and Law* 12; Neil Rees, 'International Human Rights Obligations and Mental Health Review Tribunals' (2003) 10 *Psychiatry, Psychology and Law* 33. This was stimulated by the first joint Ministerial mental health plan: see Helen Watchirs, *Application of Rights Analysis Instrument to Australian Mental Health Legislation: Report to Australian Health Ministers' Advisory Council Mental Health Working Group* (2000); Helen Watchirs & Greg Heesom, *Report on a Rights Analysis Instrument for Use in Evaluating Mental Health Legislation* (1996).

32 Winick, above n9 at 141.

- minimum objective criteria to be met before an individual can be subject to compulsory treatment;
- regular review of the compulsory treatment of individuals by a MHT; and
- the ‘least restrictive alternative principle’ as a guiding principle for decision-making and final criterion for compulsory treatment.

On the other hand, laws in a majority of Australian jurisdictions are sparse or non-existent as regards *enforceable* ‘rights within the institution’ or rather, treatment-related rights which would come into play once an order authorising compulsory treatment has been made, such as rights to adequate treatment and to refuse treatment. It is these affirmative rights which may instead be advanced as a direct or indirect outcome of MHT processes in line with the statutory objectives of mental health legislation, as we will argue below.

Decision-making in mental health care concerning compulsory treatment in hospital or community settings may be divided into three relevant categories for the purposes of considering how to maximise protection of mental health rights:

1. *Assessment*: Assessment of an individual’s need for compulsory treatment;
2. *Admission and compulsory treatment*: Decisions authorising the provision of treatment on a compulsory basis, either through involuntary admission to hospital or by making a CTO allowing the provision of compulsory treatment to an individual while they are living in the community;
3. *Treatment decisions*: Decisions about the specific medical treatments a person is to receive once they have become an involuntary patient, either in hospital or under a CTO.

In the following sections, we examine how Australian approaches measure up to United States and Canadian approaches within these categories of decision-making, considering: firstly, assessment, admission and compulsory treatment; secondly, treatment decisions; and, finally, the extent to which a positive right *to* treatment has been recognised and implemented. We also draw more detailed comparisons between the NSW, Victorian and ACT legal frameworks, as a precursor to the discussion of observational data that follows.

A. *Assessment, Admission and Compulsory Treatment: Freedom from Arbitrary Detention*

Article 9 of the *International Covenant on Civil and Political Rights* (‘ICCPR’) recognises the right to liberty and security of the person and, by extension, provides:

No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.³³

33 ICCPR, above n2, art 9(1); see also art 9(4).

As compulsory psychiatric care impinges on an individual's fundamental liberty-related interest in freedom from external restraint,³⁴ it is essential that processes of entry into, and decisions to authorise, such treatment should afford due process and be based on objective criteria.

Judicial determinations that civil commitments based solely on medical assessment of a person's need for treatment were a breach of the constitutionally protected right to freedom from arbitrary detention, led to the inclusion of an objective test for compulsory treatment criteria in mental health legislation in United States jurisdictions and Canadian provinces. In *Thwaites v Health Sciences Centre Psychiatric Facility*,³⁵ for example, the Manitoba Court of Appeal in Canada, which found that the province's civil commitment standard breached section 9 (freedom from arbitrary detention) of the *Canadian Charter of Rights and Freedoms*, commented:

In the absence of objective standards, the possibility of compulsory examination and detention hangs over the heads of all persons suffering from a mental disorder, regardless of the nature of the disorder, and the availability and suitability of alternative and less restrictive forms of treatment.³⁶

The Manitoba legislature, and eventually all provincial legislatures, amended their mental health statutes to conform to these Charter requirements, inserting a new objective test in place of the former clinical judgment test.³⁷

In the influential case *Lessard v Schmidt*,³⁸ a United States Federal District Court held that: (1) civil commitment could only be based on a finding of 'dangerousness', which required evidence of a recent overt act, and a likelihood of immediate harm without intervention; and (2) due process rights must be applied as stringently in the civil commitment context as in criminal proceedings because the same liberty interests are at stake in both cases. This meant that processes of entry into compulsory treatment should include procedural protections such as notice of the reasons for detention, a right to legal representation, and consideration of less restrictive alternatives.³⁹

In most Australian jurisdictions, as in the United States and Canada, the presence of mental illness and consequent need for some form of treatment judged by clinical standards alone is no longer considered a sufficient justification for the

34 *Foucha v Louisiana* 504 US 71 (1992) at 78–79.

35 (1988) 51 Man R (2d) 196.

36 *Id* at 206; Mona Gupta, 'All Locked up with Nowhere to Go: Treatment Refusal in the Involuntarily Hospitalised Psychiatric Population in Canada' in Kate Diesfeld & Ian Freckelton (eds), *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment* (2003) 155 at 161–162.

37 Gupta, above n36 at 162.

38 F Supp 1078 (ED Wis 1972).

39 Jennifer Fischer, 'A Comparative Look at the Right to Refuse Treatment for Involuntarily Hospitalized Persons with a Mental Illness' (2006) 29 *Hastings International and Comparative Law Review* 153 at 158. Appelbaum notes that the more stringent procedural rules recognised in *Lessard v Schmidt* were subsequently rejected by a number of courts and legislatures: Paul S Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change* (1994).

severe curtailment of liberty involved in compulsory psychiatric care. The statutory tests for compulsory treatment generally consist of a number of objective criteria, superimposing a dangerousness or harm prerequisite over a need for treatment prerequisite, although there are significant differences in formulation of these tests depending on the jurisdiction.

The *Mental Health Act 2007* (NSW) ('NSW MHA 2007'), for example, is more emblematic of the dangerousness standard in its requirement that 'care, treatment *or control* of the person' [emphasis added.] must be necessary in order to prevent 'serious harm' likely to flow from their mental illness.⁴⁰ This formulation suggests that need for control alone to avert dangerousness without a baseline element of need for treatment satisfies these prerequisites. The Victorian and ACT provisions, on the other hand, place slightly more emphasis on the person's need for treatment and the benefits that are likely to flow from such treatment.⁴¹ Yet the Victorian test is more stringent in its requirement that the person's illness must require *immediate* treatment (in line with the standard preferred by the court in *Lessard v Schmidt*),⁴² while the NSW and ACT tests do not confine the need for treatment criterion by reference to immediacy.⁴³

(i) *Referral and Assessment*

Entry into compulsory treatment in Australian jurisdictions must comply with a number of procedural requirements laid down in State and Territory mental health statutes.

First, there is a gateway period during which candidates for compulsory treatment are referred to a mental health service and, subsequently, a period during which clinical assessments are carried out to determine whether compulsory treatment is indeed warranted. Coercive measures, such as police assistance to convey an individual to a hospital and detention following admission to hospital, may be employed during this time. Following the referral stage, one or more clinical assessments must be made within a limited period of time, and in any case 'as soon as practicable', in order to continue detaining the person on an interim basis. Various professionals and lay participants such as clinical staff, police and ambulance officers, the relatives, carers or friends of people with mental illnesses are generally able to facilitate involuntary admission to a hospital without the intervention of a legal body. The *Mental Health (Treatment and Care Act) 1994* (ACT) ('ACT MHA'), however, provides for the alternative of assessment ordered by the ACT Mental Health Tribunal for a period lasting up to 14 days.

The NSW MHA 2007 and ACT MHA mandate more stringent procedural protections during the assessment stage than the *Mental Health Act 1986* (Vic) ('Vic MHA'):

40 NSW MHA 2007 s 14(1) [cf NSW MHA 1990 s 9(1)].

41 Vic MHA s 8(1)(b); ACT MHA ss 28(c), 36(c).

42 Vic MHA s 8(1).

43 See NSW MHA 2007 s 14; ACT MHA ss 28(c), 36(c).

- Clinical assessment must be carried out relatively quickly following involuntary admission, within four hours in the ACT where emergency detention is required, and clinician-ordered involuntary treatment cannot last for longer than three days;⁴⁴
- In NSW, more than one clinical assessment must be carried out to continue detaining a person following involuntary admission, but an initial assessment must take place within 12 hours and subsequent assessments ‘as soon as practicable’ thereafter;⁴⁵ and
- The Victorian MHA, on the other hand, allows up to 24 hours before a psychiatrist must either discharge or confirm an interim involuntary treatment order and Victorian psychiatrists are able to order a generous period of involuntary detention for up to eight weeks prior to a mandatory initial review by the Mental Health Review Board (‘the Board’).⁴⁶

An important means of affording due process during the assessment stage is the statutory obligation for health services to provide individuals with notification of their legal rights shortly after admission or before their initial hearing.⁴⁷

B. Compulsory Treatment and Review Procedures

The primary means of ensuring individuals are not arbitrarily detained pursuant to mental health legislation for an indefinite period is the requirement of mandatory review by a MHT at set points in the trajectory of a person’s contact with the mental health system.

(i) Victoria

The Victorian approach leans towards a ‘clinical model’ in that it confers substantial determinative powers on psychiatrists, including the authority to initiate a generous period of detention prior to initial mandatory review by the Board,⁴⁸ and to make CTOs lasting up to 12 months without the prior approval of the Board.⁴⁹ After the initial review, the Board must conduct annual reviews of involuntary treatment orders.⁵⁰

While this model may be subject to the criticism that it does not contain sufficient procedural protections, the fact that it allows clinicians greater flexibility to respond to an individual’s treatment needs more rapidly may also be viewed as an advantage.

44 ACT MHA ss 16–18.

45 Two medical practitioners, including one psychiatrist, must be of the opinion that a person is a mentally ill person to continue their detention: see NSW MHA 2007 ss 18, 19, 27(a)–(c).

46 Vic MHA ss 12AC, 30(1).

47 NSW MHA 2007, s 74; ACT MHA, s 50; Vic MHA, s 18–19.

48 Vic MHA s 30(1). In practice, the Board attempts to schedule reviews sooner than the eight-week maximum.

49 Vic MHA ss 12AC(3), 30(3).

50 Vic MHA s 30(3).

(ii) New South Wales

The NSW MHA 2007 privileges due process, placing a high premium on individual liberty. Relatively frequent intervention by a legal body is mandated in order to initiate and continue compulsory treatment for a prolonged period. Immediately following the assessment period, the person detained must be brought before a magistrate to conduct a 'mental health enquiry', which may lead to a variety of outcomes (such as discharge into the care of a relative or making of a community treatment order) along with the option of authorising detention for observation or treatment (or both) for up to three months.⁵¹ At the end of this period, mandatory review by the NSW Mental Health Review Tribunal must take place, firstly at three-month and subsequently six-month intervals.⁵²

(iii) The Australian Capital Territory

The ACT MHA establishes something of a 'hybrid model', in that the ACT Mental Health Tribunal has more control on a formal level, but psychiatrists then have considerable discretion once compulsory treatment has been authorised by the tribunal. The Tribunal must give prior approval to initiate a period of compulsory treatment lasting up to six months.⁵³ Yet, the clinical control bent of the ACT legal framework is evident in the fact that the supervising psychiatrist decides a person's place of residence once an involuntary treatment order has been made by the Tribunal;⁵⁴ such orders are not location specific and may involve treatment in either a hospital or community setting.

Once a person has become an involuntary patient, the next step is determining the specific medical treatments they should receive, a category of decision-making which may impinge on an individual's right to *refuse* treatment.

C. Treatment Decisions and the Right to Refuse Treatment

United States and Canadian courts have recognised a limited constitutional right to refuse treatment in the mental health context. In *Fleming v Reid*,⁵⁵ the Ontario Court of Appeal recognised such a right in relation to competent mental health patients. The case involved a man with schizophrenia who had been involuntarily admitted to a psychiatric facility but had stated, while competent, that he did not wish to be treated with anti-psychotic medication. The court held that the legislative provision that allowed an incompetent patient's prior competent wishes to be overruled in favour of the patient's present best interests breached section 7 of the *Charter*.⁵⁶ Similarly, the Supreme Court of Canada held more recently in 2003 that a university professor's right to refuse medication had been violated.⁵⁷

51 NSW MHA 2007 ss 34, 35.

52 NSW MHA 2007 ss 37(1), 38.

53 ACT MHA ss 28, 36.

54 ACT MHA s 32(2)–(3); *J v V* [1995] ACTSC 66 at [115]. The tribunal has the discretion to mandate residence by making a 'restriction order' lasting for up to three months, but such orders are not frequently made: ACT MHA s 36B.

55 (1991) 4 OR (3d) 74.

56 Gupta, above n36 at 163.

Although the professor did not agree with the diagnosis of mental illness, a majority of the court found that he had sufficient insight into his condition to have the ability to understand the relevant information.

Partly in response to such judicial determinations, most jurisdictions in the United States, and several Canadian provinces, now provide for separate decision-making and review procedures for civil commitment and the specific treatments a person receives once they have become an involuntary patient.⁵⁸ These legal frameworks may be contrasted to those in NSW, Victoria and the ACT, under which a person subject to an order authorising compulsory treatment may generally be provided with medication regardless of whether or not they object.⁵⁹ The justification for this approach appears to be that involuntary patients are understood to be incompetent to make treatment decisions for the duration of an order. However this justification is far from compelling, given that there is no express incompetence prerequisite for compulsory treatment. Although the Victorian MHA does incorporate a consent-related prerequisite at the admission stage, this entails either inability *or refusal* to consent, meaning technically that an involuntary patient may retain the capacity to consent (but competently refuse) for the duration of an order.⁶⁰

Although a right to refuse treatment for people subject to compulsory treatment has not been recognised in NSW, ACT or Victoria, additional requirements are prescribed in these jurisdictions before individuals can be provided with *specified* treatments without their informed consent, and MHTs do have certain functions to approve and review the provision of treatment.

(i) *Additional Requirements for Specified Treatment Decisions*

Victorian psychiatrists are largely given free rein to administer treatment to involuntary patients, although additional requirements must be met where patients do not give informed consent to the administration of specified treatments. To administer electroconvulsive therapy ('ECT'), for example, the authorised psychiatrist must be satisfied that certain prerequisites regarding the appropriateness of the treatment and the possible risks are satisfied, and make all reasonable efforts to notify the person's guardian or primary carer of the proposed procedure.⁶¹ The NSW and ACT frameworks mandate the extra protection of

57 *Starson v Swayze* [2003] 1 SCR 722.

58 Fischer, above n39 at 165–170; Simon Verdun-Jones, 'The Right to Refuse Treatment: Recent Developments in Canadian Jurisprudence' (1988) 11 *International Journal of Law and Psychiatry* 51.

59 In Tasmania, the Guardianship Tribunal or the 'person responsible' currently makes this decision to override patient objections: Tasmanian Department of Health and Human Services, *Review of the Mental Health Act 1996: Discussion Paper* (2007) at 14–18. Other Australian jurisdictions prescribe separate review processes for treatment decisions, including South Australia and Western Australia.

60 The Northern Territory's *consent criterion* is more consistent with a criterion based on incomplete incapacity. It involves the higher threshold requirement that the person 'is not capable of giving informed consent to the treatment or has *unreasonably refused* to consent to the treatment': *Mental Health and Related Services Act 1998* (NT) s 14(b)(iii).

MHT approval to administer ECT where patients refuse or are unable to consent.⁶² The NSW Tribunal is also responsible for consenting to the performance of surgical operations and ‘special medical treatment’, including sterilisation procedures in certain circumstances.⁶³

(ii) *Review of Treatment Plans*

The Victorian and NSW MHTs have functions to review or approve treatment plans.

Since 2003, the Victorian MHA has required psychiatrists to prepare an individualised treatment plan for each involuntary patient.⁶⁴ The Board must review a person’s statutory treatment plan on each review it conducts and order the revision of unsatisfactory plans.⁶⁵ The NSW Tribunal effectively has the function of approving treatment plans when making CTOs, as one prerequisite to the making of a CTO is that the supervising agency has prepared a treatment plan that is capable of implementation.⁶⁶

D. *Limited Recognition of a Right to Receive Mental Health Care*

Article 12(1) of the ICCPR recognises ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’. The right to appropriate mental health care, being a positive right requiring more proactive governmental intervention for its attainment, is by far the most controversial of mental health rights. The importance of such a right in the civil commitment context is intensified because of the deprivation of liberty involved. In the United States, a number of lower courts have recognised a qualified right to treatment on the basis that an individual’s constitutional right to due process is violated if they are deprived of liberty for the purpose of treatment without actually receiving it.⁶⁷ The Supreme Court, however, has so far failed to recognise such a right.⁶⁸

In the landmark United States decision *Wyatt v Stickney*,⁶⁹ a group of patients and discharged employees of a State hospital alleged that the conditions in Alabama’s institutions were unconstitutional. The court recognised a right of mental patients to a basic level of treatment and, following a slow and painful

61 Vic MHA ss 72–73.

62 NSW MHA 2007 ss 87–97; ACT MHA ss 55A–55B, 55L–55N.

63 NSW MHA 2007 ss 102–104.

64 Vic MHA s 19A.

65 Vic MHA s 35A.

66 NSW MHA 2007 s 53(2)(a), (3)(b). The Australian Capital Territory Tribunal is not required to approve or review treatment plans. Instead the supervising clinician must determine certain conditions of the person’s treatment *after* the tribunal has made a mental health order: ACT MHA ss 32, 36D.

67 Rhoden, above n29 at 385. Some commentators argue similarly that erosion of this fundamental right through compulsory treatment pursuant to mental health legislation calls for a corresponding duty on the relevant mental health service to provide quality care and services: Nigel Eastman, ‘Mental Health Law: Civil Liberties and the Principle of Reciprocity’ (1994) 308 *British Medical Journal* 43.

68 Winick, above n32 at 200.

69 325 F Supp 781 (1971).

series of hearings, the court eventually issued an order detailing minimum treatment and care standards in an attempt to achieve *implementation* of the right (as opposed to mere recognition).⁷⁰ *Wyatt v Stickney* is a paradigmatic example of institutional litigation which led to a marked improvement in treatment standards in line with the court order.⁷¹ Notably, the court invited the parties and *amici* 'to develop and submit proposed standards of adequate care', many of which were incorporated into the court's order. The order included a minimum staffing ratios provision suggested by the defendants themselves, who *agreed* that they had failed to provide constitutionally minimal standards of care.⁷²

Institutional litigation may thus involve orders requiring affirmative action by institutions and public administrators based on consent, or negotiation and compromise. However, the outcomes of such litigation can be patchy. Thus judges making decisions about involuntary treatment in New Jersey responded in a unique and creative manner to the increase in the 1970s in the number of people who did not meet the criteria for 'civil commitment' (the preferred United States terminology), but were considered too unwell to manage independently and lacking appropriate support in the community.⁷³ Aviram and Smoyak write:

Judges were ... faced with a cruel dilemma: To discharge all those who did not meet the dangerousness criteria without considering whether or not those patients could survive on their own in the community, or continue the commitment of those for whom no appropriate placements were available.⁷⁴

Trial judges began to enter orders discharging patients 'pending placement' in suitable accommodation in the community, and in a 1983 decision, the New Jersey Supreme Court approved the intermediate legal status of Conditional Extension Pending Placement (CEPP).⁷⁵ While this approach may be criticised on a number of grounds,⁷⁶ it was an attempt to ensure that people did not go without needed care and to expedite the process of arranging suitable community placements for patients.⁷⁷ But it was misused to retain people well past their need for hospitalisation, and in April 2005, a challenge was brought: *New Jersey Protection*

70 Eisenberg & Yeazell, above n20 at 468–469.

71 Id at 468. Case Comment, 'Wyatt v Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment' (1973) 86 *Harvard Law Review* 1282.

72 Id at 1298.

73 Uri Aviram & Shirley A Smoyak, 'Discharged Pending Placement: How Courts Created a New Intermediate Legal Status for Confining Mentally Ill Persons' (1994) 17 *International Journal of Law and Psychiatry* 139 at 148–149. This situation was caused in part by the shift from a 'need for treatment' to a 'dangerousness' prerequisite for civil commitment to bring it in line with the ideology heralded by the civil rights movement of the 1970s and 1980s.

74 Id at 143.

75 *In re S L* 94 NJ 128 (1983).

76 Aviram and Smoyak note that the 'DPP' legal status may be viewed as an arrangement of convenience for judicial decision-makers and health service providers alike, which diminishes the imperative to develop effective community support for people with mental illnesses: Aviram & Smoyak, above n73. Its practical effect was that many people were detained well beyond the period of time contemplated by the interim nature of their legal status.

77 Aviram & Smoyak, above n73 at 148.

and *Advocacy Inc v Davy*, a case which is still wending its way through the discovery and negotiation phase a quarter of a century after the original CEPP rulings in 1983.⁷⁸

Australia's brief experiment with *Wyatt v Stickney* reasoning in the 1990s fell on equally stony ground. In 1989 the Victorian Mental Health Review Board canvassed such lines of reasoning in a test case hearing in respect of two forensic patients detained in 'J Ward' for the criminally insane at Ararat,⁷⁹ ruling that one patient (DWP) should be transferred back to prison, since treatment for his paranoid schizophrenia in J-Ward fell short of the *Bolam* standard for negligence, while the other (RJO) was reconfirmed in J Ward.⁸⁰ The Victorian Government did not take kindly to the Board straying into what was seen as the responsibilities of the executive, setting back any real prospects for North American jurisprudence to take root in Australia.⁸¹

E. Australian Mental Health Legislation: Rights-oriented Objectives and Barriers to their Achievement

Australian mental health statutes go further than listing a set of objectives regarding the provision of care and treatment. They contain a (weak) direction to decision-makers to implement those objectives. For example, section 4(2) of the NSW MHA 1990 stated the principle of the 'least restrictive alternative' (now captured in s 12(1)(b) of the 2007 Act), as follows:

It is the intention of Parliament that the provisions of this Act are to be interpreted and that every function, discretion and jurisdiction conferred or imposed by this Act is, as far as practicable, to be performed or exercised so that:

(a) persons who are mentally ill or who are mentally disordered receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given.

The objectives of mental health legislation, coupled with these broad statutory guidelines on its implementation, are the closest Australian laws come to assuring a right to mental health care. Decision-makers are thus expected to be working to achieve such a right for individuals in *practice*, even though such a right is unlikely to be legally enforceable at present.

78 The case is at the discovery and negotiation phase (personal communications, Director and Deputy Directors, New Jersey Protection and Advocacy, Inc, 6 April 2007). See New Jersey Protection and Advocacy, Inc, *Litigation Activities Page* (2007) NJP&A <<http://www.njpanda.org/litigation.htm>> accessed 5 April 2007; Human Services Research Institute, *Status Report: Litigation Concerning Home and Community Services for People with Disabilities* (2007).

79 'J Ward' of the then Ararat Lunacy Asylum was proclaimed as a 'temporary' facility for the criminally insane in 1886 in what had been the old gaol. It operated as part of Ararat Mental Hospital, providing care in horrific conditions until May 1988 when the Government announced its proposed closure, which finally took place in 1991.

The lack of clear powers for MHTs to make orders regarding the provision of treatment where the proposed treatment will be inadequate is a potential stumbling block in this respect, as evidenced by a recent decision of the ACT Supreme Court, *J v V*.⁸² Justice Higgins held in that case that the ACT MHT cannot make an order unless health services are willing to implement it, effectively reading into the ACT MHA a prerequisite of consent on the part of the relevant mental health facility or agency. The case involved an appellant with a history of drug and alcohol use and suicide attempts. A suicide attempt had resulted in brain damage, which exacerbated her problems. The presenting psychiatrist at the Tribunal hearing was of the view that the appellant's condition was not responsive to psychiatric treatment, identifying drug and alcohol abuse as the main problem. The panel ordered that the appellant be detained for one month in the custody of the Director of Mental Health Services at Woden Valley Hospital and authorised him to administer psychiatric treatment as necessary.

The ACT Supreme Court is empowered to conduct a *de novo* merits review of a decision of the Tribunal on appeal.⁸³ Justice Higgins, however, found that the Tribunal had no power to make an order directing the director to detain the appellant. This was because the director objected to the custodial role the order demanded of him, owing to the lack of available beds in the hospital: the ACT MHA highlighted 'the need for agreement with relevant mental health professionals in relation to the disposition of' an affected person.⁸⁴ Justice Higgins

80 The Board, comprising Neil Rees, President, Professor Richard Ball, psychiatrist and Ms Jennifer Lee, community member, took extensive evidence over a period of two months at a joint hearing of what were effectively two 'test' cases, the legal reasoning for which is republished in both decisions—DWP (1989) 1 *Decisions of the Mental Health Review Board of Victoria*, 208 (hereafter 'MHRB Casebook 1'] and *RJO* (Unreported, Mental Health Review Board of Victoria, 10 May 1989). In the course of construing the meaning of the need for, and provision of, 'treatment' in the exercise of its s 44 power to determine whether security patient status was warranted, the Board construed 'treatment' as implying a clinical standard of care. It invoked the negligence test in *Bolam v Friern Hospital Management Committee* ([1957] 1 WLR 582 at 587) ('*Bolam*') as denoting the minimum 'standard' of such care (DWP official CD rom version of reasons at 223; *RJO* at [42], noting that this was in line with the 'essential elements' of the (comparatively minimal) levels of treatment such as humane care, adequate professional staff and an individual treatment plan as insisted on in US 'right to treatment' cases such as *Rouse v Cameron* 373 F 2d 451 (1966) and particularly *Eckerhart v Hensley* 475 F Supp 908 (1979) (DWP at 224–25; *RJO* at [44]). For a summary of 'right to treatment' cases see: 56 *Corpus Juris Secundum* 'Mental Health' § 105. On the facts at hand, the Board determined that 'DWP' was seriously mentally ill and not in receipt of the required minimum level of treatment, so it exercised its power to transfer him back to prison, where a much superior (if still inadequate) level of treatment and care might at least be available, writing that:

We accept that the treatment available to him in prison may be no better or even worse than that available to him at J-Ward but the Act does not require us to contrast the treatment available in a psychiatric inpatient service with that available in a prison. We have no desire to cause harm to Mr DWP nor to cause him to become an unwilling victim in a test case. However we cannot sanction a state of affairs which has caused him to receive inadequate treatment by ignoring this matter or by pretending that the treatment afforded to him is better than it is (DWP at 226-27).

In *RJO* the Board concluded that, while less than ideal, the treatment at J Ward met the *Bolam* standard, so his continued detention in J Ward was confirmed (*RJO* at [53]).

also concluded that involuntary detention would in any case have placed an 'intolerable restriction upon the appellant's right to liberty' given that there was no short term cure for her condition, even though she was at serious risk of suicide.⁸⁵

This decision raises a host of questions, but perhaps the most important ones concern the boundaries between legal and clinical decision-making. Namely, what options are open to a MHT when confronted with a situation where a person meets the criteria for compulsory treatment but may not receive adequate and appropriate treatment as an involuntary patient? If the relevant mental health service is unwilling to implement an order in terms proposed by the MHT, should the person be discharged and left without any safety net at all? Is a negotiated *Wyatt v Stickney* style solution a possibility? In extreme cases, should the MHT be able to order the provision of treatment according to certain standards?

These questions are explored in the fieldwork observations reported in the next section.

5. *MHT Processes in Action: 4 Case Studies*

The following case studies provide a glimpse into the way MHTs in the three Australian jurisdictions can craft creative solutions to the human dilemmas they face. The examples are not representative; they were selected to illustrate cases which push the boundaries of the tribunals' jurisdiction, and force the tribunals to work out how to balance the broad principles of protection and minimal intrusion in their legislative charter with the narrow powers they have to implement those principles. If these are examples of judicial activism, they reveal the tribunals as fairly timid and restrained innovators, respectful of medical authority and careful not to overstep their own powers. Unlike the North American examples cited above, there is no evidence of a crusading zeal to challenge institutions, reform practices in a systemic way or discharge people without a safety net. The case reviewed above that came to the ACT Supreme Court was perhaps an exception in terms of the boldness of the Tribunal's decision, but even this veered in the direction of protection rather than liberty.

The strategies used in the following cases were all customised to address the needs of one individual and include: using the hearing to explore treatment options; declining to make an order; and postponing or deferring decisions. In one

81 One consequence was a 1990 amendment to s 8(1)(b) of the Vic MFHA which included *care* as an alternative to treatment. Subsequently the Board dealt with a ten-year resident of 'Ward 4' at the then 'Mont Park' facility, another to provide poor facilities and restrictive environments. In the case of *In the appeal of KMP an involuntary patient at North Eastern Metropolitan Psychiatric Services (Mont Park) KMP* [1992] VMHRB 4 (MHRB Casebook II) (O'Shea, Nettleton & Taylor), the Board maintained its view that a patient might be discharged due to inadequate levels of treatment, but found that although the accommodation was inadequate, the treatment and care was 'adequate' in the circumstances.

82 [1995] ACTSC 66.

83 *J v V* [1995] ACTSC 66 at [29].

84 *J v V* [1995] ACTSC 66 at [78].

85 *J v V* [1995] ACTSC 66 at [11].

case adult guardianship was raised explicitly as a less restrictive way of balancing autonomy and protection objectives. But in the other cases, it might be argued that the more flexible principles specified in guardianship legislation were being used to interpret the 'least restrictive option' for mental health tribunal matters. These include restricting the duration and extent of orders, and paying greater attention to the person's social and cultural context.

The cases all involve conciliation and gentle persuasion rather than conflict, with informal contracts being developed between the Tribunal and medical professionals. All four of them also involve an effort to ensure that treatment provision was effective. In one case an order was finally made, but the hearing provided a forum to discuss alternative treatments, the patient's preferences, and a procedure for early review if the patient was not satisfied. In another, an order was not made (despite a need) because there was no evidence it would help the situation, indeed there was contrary evidence it might undermine the patient-doctor relationship. In three of the cases, the matter was deferred, one of them to ensure a treatment plan was made, in one to allow alternative placement options to be explored, and in the third to see if treatment without an order would work.

However, improving some aspects of treatment was explored. In two of the cases, location of treatment was an issue, with the tribunals acting to encourage treatment sites that were convenient for patients and their families.

A. *Community Treatment Order Review 1: Victorian Mental Health Review Board*

'A',⁸⁶ the subject of the hearing by the Victorian Mental Health Review Board, was a middle-aged man who had been diagnosed with bipolar disorder. The Board's function was to review an extension of his community treatment order. The client was legally represented and his treating psychiatrist and case manager appeared for the health service. His advocate raised a number of concerns about the treatment he was receiving, and submitted that his treatment plan should be changed to incorporate alternative treatments and to allow for treatment to be provided closer to the client's home rather than at the health care agency, which required considerable travel.

The Board members were active in asking questions about the possibility of the client receiving regular injections of medication from his local GP rather than at the health care agency, as suggested by his advocate. The case manager expressed reservations due to security concerns. He said that the location of treatment had been shifted to the health care agency to ensure that security arrangements could be in place during treatment because their client had apparently threatened staff members. The treating psychiatrist appeared to be more open to the suggestion, however, saying that a gradual change to local treatment would be considered after a further month under the existing arrangements.

⁸⁶ Victorian MHRB, May 2006.

Although the Board affirmed the order, they sought to bring to bear some 'leverage', recommending that the treating team review the treatment plan, and suggesting that they try to arrange for the provision of care closer to the client's home. To facilitate further the likelihood of the desired change toward localised treatment, the Board also suggested the incorporation of recommendations made by the community forensic mental health team.⁸⁷ But the influence able to be exercised over treatment matters was indirect and subtle, unlike traditional court orders with their specific conditions and timelines. In the present case, when the advocate asked if there was any timeline for the changes after the decision was handed down, the legal member responded: 'No it just needs to be reviewed. If this is not done then there is the option of appealing to the Board.'

In this case, the Board used its authority to engage in a discussion of treatment issues of concern, effectively fashioning a non-binding informal 'contract', about the process for and direction of change. By answering the advocate's question in the way quoted above, the Board was both affirming the professional status of the clinicians, and subtly reminding the treating team that the patient had the option of re-opening the matter in the future. The intervention of the tribunal into treatment plans and practices was confined to the hearing, it was not reflected in the content of the order.

As shown in the next case, MHTs can craft orders to provide ongoing oversight into the treatment process, in this case by making a short-term order.

B. Community Treatment Order Review 2: NSW Mental Health Review Tribunal

The case of 'B'⁸⁸ was a review of the circumstances of a young woman who was detained in hospital as a 'temporary patient'. The hospital sought a 'continued treatment patient order' to continue her involuntary treatment as an inpatient. Continued treatment patient orders in NSW must be reviewed *at least* every six months by the tribunal.

The woman had a dual diagnosis of bipolar disorder and bulimia. Present at the hearing in addition to this client were the treating registrar, a registered nurse and a legal representative. The client was very vocal during this hearing, complaining about numerous aspects of her treatment, including her placement in the acute ward and in seclusion. After she had raised this issue several times, the psychiatrist member responded: 'We can't make decisions about your treatment and where you are in the hospital.'

The tribunal decided to make a continued treatment patient order, but mandated an early review after two months instead of the default period of six months. The decision to require an early review was prompted by the fact no treatment plan or behavioural management plan had been prepared. Handing down the decision, the

87 The Community Forensic Mental Health Service of Forensicare provides statewide assessment and multidisciplinary treatment services to high risk clients referred from many public or private sources: Forensicare <<http://www.forensicare.vic.gov.au/WebSite.nsf/web/main.html>> accessed 7 May 2007.

88 NSW MHT, February 2006.

legal member said: 'We're going to make the continued treatment order but only for two months and we'd like to see a treatment plan please.' A nod from the medical registrar was the only sign of recognition in response.

This case illustrates the way in which the Tribunals may effectively forge a formal 'contract' about the way the future development of treatment is to be monitored. By setting a short review period, and drawing attention to the lack of treatment plans, the Tribunal was telegraphing that it was unlikely to look favourably on further continuation of the order should such plans not be adequately developed by the time of that review. The following case illustrates another variant of the use of extended oversight over medical decisions, in this case to provide some supervision over the discharge process.

C. Review of Temporary Patient Order: NSW Mental Health Review Tribunal

An inpatient at a Sydney psychiatric facility, 'C'⁸⁹ was about to be discharged, and an application was sought for her to be placed under a community treatment order. The treating team was represented by a medical resident, a registered nurse and a social worker. C was accompanied by her mother and a legal aid solicitor. In a context of scarce accommodation options, the hospital had been successful in finding a place for her and was proposing to move her there on discharge. While the facility lacked the overnight supervision required, reportedly to monitor her gambling, it was the best that could be found.

The lawyer representing C objected on her behalf saying the proposed facility was too far away from the family, and such a placement would result in reduced family support. 'This is a crucial time', he added, 'for her to have the support of her Mum.' The psychiatric member of the tribunal, who had a good knowledge of service options in the region, named another facility that was not only closer but had overnight supervision. He noted that 'where she goes is up to the treating team, of course, we are just throwing some ideas in.' The nurse on the treating team would not confirm that if C was discharged the hospital would check any other options, observing that 'to me it's not an issue of location.'

The tribunal asked C for her views about the discharge plan and the proposed three-month community treatment order. She acknowledged the need for an order, but objected to being sent so far from her family. After some further discussion, the lawyer requested an adjournment for two weeks to allow the treating team to consider the other option and report back to the tribunal. In the end, the hospital did not object to this, and the caseworker assured the tribunal that the option they had raised would be investigated. So the tribunal, after noting that it was not their 'jurisdiction or function' to decide on the location of any placement, adjourned the hearing for up to two weeks.

This was a case of quiet diplomacy. The original placement proposed did not appear to be the 'least restrictive alternative', both because it would have cut C off from her support networks, and also because it would have been done in the face

89 NSW MHT, February 2006.

of her explicit resistance. On the other hand the Tribunal lacked the jurisdiction to direct the treating team where to place C. The solution to the dilemma was provided by C's lawyer asking for an adjournment. Such a procedure allowed the Tribunal to extend its surveillance over the case long enough to ensure that a placement could be found that protected her existing social networks.

There was a further twist to this case that relates to another authority the NSW Tribunal exercises, in relation to the financial affairs of persons detained under the NSW MHA. Gambling was an issue because C had received a large lump sum as a redundancy payment, and was in danger of losing it through gambling. The Tribunal had the power under the *Protected Estates Act* 1983 (NSW) to appoint a government official, the Protective Commissioner, to protect her financial assets, but they were wary of doing this, both because an enduring order could only be revoked if she regained capacity, and also because they doubted their mandate to constrain the operations of the Protective Commissioner just to the lump sum. 'I don't think we can make that sort of direction to the Protective Commissioner', the legal member commented. So the Tribunal made a temporary order for 12 months under the *Protected Estates Act*, with a possibility of renewal, even though they thought she needed a continuing order to protect her assets. In this case the Tribunal was parsimonious in its exercise of authority to provide the 'least restrictive option', something they were not formally required to consider under the *Protected Estates Act*.

As illustrated in the following case, the Tribunals can use their *processes* in a highly strategic fashion, as has been found in the management of cognate issues such as anorexia cases.⁹⁰ Rather than following strict guidelines about the order of proceedings the way tribunals in other states tend to do, the ACT uses a more flexible procedure, which can involve preliminary consideration of the issues. This case also illustrates an outcome focus, with the primary consideration being the likely effect of an order.

D. Mental Health Order Application: ACT Mental Health Tribunal

The subject of this matter, 'D',⁹¹ was a young man diagnosed with obsessive compulsive disorder. He attended this hearing, along with one of his friends (his brother's girlfriend), a representative of the statutory office of Community/Public Advocate, and two mental health tribunal officers acting as hearing clerks.

The tribunal appeared to reach a consensus about the preferable 'outcome' *prior to the hearing*, during preparation time. There was concern that making a further six-month mental health order sought by the treatment team would aggravate the situation, making the client less likely to engage with his treating team. They were hopeful that the alternative of an adjournment of proceedings would encourage him to keep on seeing his doctor, an approach described as 'creative use of the Act' by the presidential member.

90 Terry Carney *et al*, *Managing Anorexia Nervosa: Clinical, Legal and Social Perspectives on Involuntary Treatment* (2006) at 94–95.

91 ACT MHT, November 2005.

At the outset of the hearing, the tribunal proposed the option of an adjournment, but did in fact invite comment. The client was silent throughout the hearing. His friend spoke eloquently about the problems with his current living arrangements and treatment as she perceived them. The following is an edited version of the ensuing discussion, beginning with the presidential member's response to his friend's initial comments about his 'nightmare situation':

President: Well what do you think is the solution?

Friend: He needs care, someone to cook and clean for him ... He needs to be looked after. He needs a carer.

President: That is not the Tribunal's role.

Community Advocate: It is the role of the Chief Psychiatrist to provide treatment care *and support*.

Friend: The problem is that the therapy needs to be more aggressive. Just turning up to a doctor every now and again is not enough.

Psychiatrist member: The kind of services he needs just aren't available.

Friend: How does he get help?

The President suggested a guardianship order.

Friend: What's guardianship?

The community member suggested that one of the tribunal officers give the friend a pamphlet on guardianship. His friend was worried that he would not book and turn up for the next clinical review with his psychiatrist. One of the tribunal officers gave a pamphlet on guardianship to the friend and used the phone in the hearing room to make an appointment for the client with his psychiatrist as the discussion continued.

President: I don't think that a treatment order is the right way to go at this stage. It will not be effective as long as D is not engaging with his doctor. A psychiatric treatment order hasn't worked in the past. He has been having a better relationship with his doctor and we don't want to threaten that.

There was some further brainstorming about alternatives. The friend was concerned that D would soon be without community support because she and his mother would be moving away in a few months time. The hearing was adjourned for 3 months. The Community Advocate answered some of the friend's questions about guardianship and said that she could discuss other options with her at another time. After the hearing, the panel members and the Community Advocate continued to discuss D's situation. The Community Advocate said she might raise the matter with the Chief Psychiatrist because it was so complex.

This case shows the role of the Community Advocate (later renamed Public Advocate) in pushing the tribunal in the direction of considering the wider social context of the patient's life. This was a role taken by a lawyer representing the client in the NSW case. In this case the Community Advocate was arguing that the treating team had a responsibility to provide 'care and support' as well as 'treatment'. As with two of the other cases, it also illustrates a strategy for deferring decisions, although by not granting an order, they were not prolonging their own supervision over the process.

This kind of 'creative' strategic utilisation of the processes of adjournment has previously been found to be capable of bringing considerable leverage on parties to the hearing, depending on the way it is deployed. In jurisdictions where the Guardianship Tribunals are prepared to entertain a role in assisting to ensure compliance with treatment regimes, there is occasional acknowledgement that clinicians (and other parties) have a degree of 'choice' between using mental health and guardianship.⁹²

In the present case the adjournment served to 'buy time' and avoid imposing an order which risked exacerbating the situation. As such it was the 'least worst' of the limited range of options available to the tribunal, in that it allowed the parties to contemplate other avenues (such as turning to adult guardianship). This was a worthwhile if pragmatic outcome, similar to those experienced in the management of anorexia nervosa in some jurisdictions.⁹³ But it falls short of more closely honouring any statutory expectations of providing patients with efficacious 'treatment' under the ACT MHA, or the creative exercise of jurisdiction to provide a 'ticket to services' as has been found to occur in some adult guardianship hearings.⁹⁴ Given the ACT Supreme Court's criticism of the Tribunal for using an order to try to extract services for a patient from a reluctant provider, this is perhaps not surprising.

6. Conclusion

MHT processes may provide an opportunity to protect and extend rights for a relatively small restricted group of persons with a mental illness those who are potential candidates for compulsory treatment. These rights include not only the

92 Terry Carney *et al*, 'Institutional Options in Management of Coercion in Anorexia Treatment: The Antipodean experiment?' (2003) 26 *International Journal Law and Psychiatry* 647.

93 Terry Carney, Miriam Ingvarson & David Tait, 'Experiences of "Control" in Anorexia Nervosa Treatment: Delayed coercion, shadow of law, or disseminated power & control?' in Pamela Swain (ed), *Anorexia Nervosa and Bulimia Nervosa: New Research* (2006) 41.

94 Reliance on the law (or legal institutions) to broker access to government largesse is controversial on several grounds. Governments see it as a trespass on executive functions, while social policy commentators criticise the distortion of social equity entailed in providing a winning litigant/applicant with a 'ticket to service' which effectively enables them to queue-jump other applicants with equal or stronger claims to the service. See further Terry Carney & David Tait, *The Adult Guardianship Experiment: Tribunals and popular justice* (1997) at 146, 178–79; David Tait, Terry Carney & Kirsten Deane, *A Ticket to Services or a Transfer of Rights?: Young People and Guardianship* (1995); David Tait & Terry Carney, 'Caught Between Two Systems?: Guardianship and young people with a disability' (1997) 20 *International Journal of Law and Psychiatry* 141 at 153, 158.

negative rights to freedom *from* arbitrary detention, and to refuse treatment (where it appears that treatment proposed under an order will be inadequate or inappropriate) but also the positive right *to* be provided with quality care.

Do the tribunals actually play this role? The case studies presented above suggest there are two main ways this may be achieved, through providing some scrutiny of treatment during the hearing, and by adjourning the hearing.

Tribunal hearings may on occasion offer a meeting ground or ‘forum’ for dialogue between stakeholders. They may provide one of the few opportunities for a crossing of paths or ‘meeting of minds’ between mental health clients (and their families and carers) and the service providers and clinicians who provide care and serve as brokers to treatment access. Hearings may provide a valuable opportunity to discuss difficult issues surrounding treatment planning, including medication regimes, accommodation and lifestyle choices, whether during, or in the times before and after, the formal hearing encounter.⁹⁵ Where there is conflict between clients and their treating team, the legally enacted conflicts occasioned by a hearing may contain rich therapeutic material and can be an opportunity for dialogue,⁹⁶ as revealed by the comments of a lawyer who represents clients before the NSW Tribunal:

So we sidestep the legal criteria to some degree and look at the real issue that is holding things up and ask: can we do something about this? Sometimes the hospitals haven’t thought about those issues. There’s a default position and not always enough time to get to know the person. We can sometimes help to bridge that gap.⁹⁷

However there are divided views. Brophy’s research indicates that Victorian medical staff have quite conflicting views about the Board’s role, although some medical staff did agree that

Board hearings offer an opportunity for a thorough review of their patients’ situation. The senior psychiatrist present on the Board may offer suggestions regarding treatment issues, and furthermore, the Board may also help in deciding the patient’s future management. This support may be lacking within the doctor’s own facility, leading them to appreciate the opportunity of a Board hearing.⁹⁸

Erica Grundell also explored the relationship between clinical psychiatrists and the Victorian Board, following its acquisition of its current review role in 1987,

95 Of course the *opportunity* for such encounters to be productive depends in part on the information available, and the study site jurisdictions differ on this score. In NSW tribunals only have the full file for hearings which take place *in hospitals*, those conducted *by* videoconference, teleconference or over the telephone from the tribunal’s premises generally only have access to professional reports provided specifically for the hearing. However in NSW, the tribunal is more likely to have a separate *social work report* detailing information about a person’s social circumstances, whereas this is less common in Victoria and the ACT.

96 Sameer Sarkar & Gwen Adshead, ‘Treatment over Objection: Minds, Bodies and Beneficence’ (2002) (July) *Journal of Mental Health Law* 105.

97 Interview with legal representative, 2006.

98 Lisa Brophy, *The Impact of the Mental Health Review Board on Psychiatric Service in Victoria* (1995) at 144.

relying on interviews with experienced psychiatrists undertaken in 1995 and repeated in 2004.⁹⁹ Clinicians reported that the Board and its procedures and decisions had impacted on their clinical practice, but remained very dubious about any 'therapeutic' impact of the Board or its ability to raise standards of treatment and care.¹⁰⁰ Grundell therefore concluded that 'the positive therapeutic potential of administrative review is under-realised in the Victorian service system'.¹⁰¹ Some of the case studies reported here suggest the contrary is possible: that experienced tribunal members can initiate a useful dialogue that may lead to the development of less restrictive treatment environments.

Mental health legislation does not *preclude* efforts on the part of hearing participants to work towards better real life outcomes. Indeed to the extent that these outcomes are foreshadowed (or overlooked) in the treatment plan, the Victorian tribunal has a responsibility to consider the issues, while the NSW tribunal must consider whether a treatment plan is 'capable of implementation'. One might expect a somewhat negative response to an active treatment oversight role for tribunals from service providers. Many Victorian psychiatrists surveyed by Brophy certainly considered the Board's approach an 'affront to their clinical judgement'.¹⁰² On the other hand, it is notable that in other jurisdictions, such as in many European countries, the division between legal and clinical decision-making is not assumed to be a given, and courts tend to have more control over resource allocation in the delivery of services.

Whether tribunals are in fact well-equipped to embark on this scrutiny of care and treatment is sometimes an issue for those whose quality of service comes into question. Approved social workers exercising their mental health 'gate-keeping' role in England and Wales consider their mental health tribunal to be 'over-medical in its scope and over-bureaucratic in its operation'.¹⁰³ Eastman commented that tribunal hearings may often be 'little more than legalised case conferences'.¹⁰⁴ Partly the answer to this question is a subjective 'judgement call' the answer to which may depend on whether to characterise what is going on as deliberate or inadvertent 'overstepping' (or remaining impervious to) legal norms and boundaries.¹⁰⁵ Or instead to characterise it as a 'clash of values'¹⁰⁶ driven

99 Erica Grundell, 'Burden to Benefit? Psychiatric perspectives on the impact of administrative review in Victoria, Australia' (Paper presented at the 30th Congress of the International Academy of Law and Mental Health, Padua, Italy, June 2007); Erica Grundell, 'Psychiatrists' Perceptions of Administrative Review: A Victorian Empirical Study' (2005) 12 *Psychiatry, Psychology and Law* 68.

100 Grundell, 'Psychiatrists' Perceptions ...', above n99 at 79.

101 Ibid.

102 Brophy, above n98 at 91.

103 Patricia Walton, 'Reforming the Mental Health Act 1983: An approved social worker perspective' (2000) 22 *Journal of Social Welfare and Family Law* 401 at 408.

104 Eastman, above n67 at 44.

105 Genevra Richardson & David Machin, 'Judicial Review and Tribunal Decision Making: A Study of the Mental Health Review Tribunal' [2000] *Public Law* 494.

106 Genevra Richardson & David Machin, 'A Clash of Values? Mental Health Review Tribunals and Judicial Review' (1999) 1 *Journal of Mental Health Law* 3.

more by the imperative of finding ways to realise the health (or 'best interests') objectives.¹⁰⁷

The argument raised here is that the tribunals do face a tension between the narrow 'legal' tasks they are given to perform for the most part authorising or reviewing detention or coercive treatment in the community and the broader rights principles contained both in their own legislation and in other human rights documents to which Australia is a signatory to. In seeking to balance the specific review duties with the wider human rights framework, they may 'push the boundaries' a little by granting adjournments that some participants feel are unnecessary, or by examining closely whether patients are indeed receiving the 'best possible care and treatment'. The exploration of adult guardianship in one case provided discussion of a model in which decisions about medical care and consent could be provided by someone independent of the agency providing treatment. The ACT Supreme Court decision discussed above did deal with an issue of consent but it was the consent of medical staff that was of concern, not the consent of patients.

The case studies reviewed in this article were selected to represent the most proactive interventions by tribunals into quality of service issues. What they demonstrate is that, far from trying to challenge institutions (like American courts faced with prison overcrowding) or detaining people in psychiatric facilities 'pending placement', they show remarkably little attempt to remake the law or develop new standards of care. The relatively modest innovations tribunals made were to restrict the length of orders to permit speedy review by the tribunal, or adjourn hearings to allow treatment plans to be developed that were more likely to be effective. Hearings were used to examine whether proposed orders were the least restrictive options, not to excoriate institutions or develop new jurisprudence. The areas of controversy in North American debates distinguishing detention and treatment decisions, or treatment and consent issues, hardly rated a mention.

So do the Australian mental health tribunals develop and assert positive rights to quality services as well as providing protection for liberty? If they do it is by forging alliances with treating teams or placing pressure on them to undertake additional clinical assessments rather than engaging in outright confrontation, operating within the narrow constraints of their legislation to encourage clinicians to address concerns about treatment plans. They 'nudge' rather than push the boundaries.

In short, if major change is to come in achieving positive rights for people with mental illnesses in Australia it is more likely to be driven by consumer groups, advocates and parliaments than review tribunals.

107 Mandy Dixon, Femi Oyeboode & Chris Brannigan, 'Formal Justifications for Compulsory Psychiatric Detention' (2000) 40 *Medicine, Science and the Law* 319; Richardson & Machin 'Doctors on Tribunals...', above n14; Ruth Vine, 'Decision-Making by Psychiatrists about Involuntary Detention' in Kate Diesfeld & Ian Freckelton (eds), *Involuntary Detention and Therapeutic Jurisprudence* (2003) 113.