MENTAL HEALTH REPORT 2001

A report on observations of mental health systems in the United States, the United Kingdom, and elsewhere.

Neville Barber
PRESIDENT
In May 2001, I attended and presented at the Second International Conference on Therapeutic Jurisprudence in Cincinatti, Ohio. This gave me the opportunity of observing first hand some aspects of the mental health systems in a number of US states, namely California, Arizona, Texas, New York and Ohio. In addition, I visited the Regional Chair of the Mental Health Review Tribunal in the United Kingdom and also attended the World Health Organisation office in Switzerland.

In particular, I gained knowledge of the system of civil commitment in the US and the UK. There are differences in the various states of the US, though all operate their commitment laws within a judicial system. That is, in the US, courts generally make the order for involuntary commitment, or are at least involved in the review of the decision to make a patient involuntary. In contrast, the UK, like each State and Territory of Australia, operates its civil commitment laws within a quasi-judicial system, with reviews of involuntary status, generally but not always made by a psychiatrist, conducted by a Board or Tribunal.

In two States of America, I observed civil commitment proceedings. The results of the Californian commitment proceedings observed were interesting in that one person had two separate hearings on the one day, using different personnel, different standards of proof, and different procedures. In these circumstances, perhaps it is not surprising that the results were different: a person found to satisfy the criteria for involuntary status in the morning was not found to satisfy the (stricter) criteria for involuntary treatment the same day. Accordingly, that person was discharged from the hospital against medical advice the same day. The reviews observed in Ohio were notable for their short duration (less than 7 minutes average) and lack of an adversarial approach inconsistent with the legislation under which they were conducted.

Overall, my observations were that the legal system in the US provides some level of legal safeguard – but that the level of safeguards in practice is very different to what it is at law. It is also my observation that, given the obvious deficits in the broader mental health system in the US, with some states acknowledging that they treat less than 20% of the demand, undue focus on the legal system to the detriment of the overall mental health system is unhelpful. There would appear not much point in having, for example, a ‘model’ mental health statute if its application is minimised or simply irrelevant to the vast majority of sufferers of mental illness and their families and carers due to funding constraints, other priorities, or political apathy.

Every system has its positive and less positive aspects. The US model has some good features as does the model in existence in the UK and Australia. Perhaps what is more important than the particular model of civil commitment utilised is the degree to which it is recognised as being part of the ‘composite whole’ of mental health service delivery in the jurisdiction. From the material and information I gained from the World Health Organisation, it is evident that in global terms, the US, UK and Australia rank highly in the degree of mental health infrastructure that is in place. Of course, it remains important to guard against complacency and to continue always to maximise the respect and dignity given to persons who have a mental illness, regardless of the system that is in place in the particular jurisdiction.
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Between 15 April and 15 May 2001, as a consequence of my attendance at a conference in the United States, I took the opportunity to visit a number of American States and also the United Kingdom and Switzerland, to gain first hand knowledge of other mental health systems.

Following some preliminary research, I chose to visit the following American states:
- California (being one of the largest and wealthiest states in the US, with a population of 34 million people and having one of the world’s largest economies);
- Arizona (a small, sparsely populated and poorer, mid-western State);
- Texas (a large widely diverse State, now with a large population of about 21 million);
- New York (a huge metropolitan area with a population of 8 million people, in a state of 19 million); and
- Ohio (another mid-western State with a diverse population (of 11 million) and a different approach to mental health services and service delivery).

In Ohio, I attended and presented at the Second International Conference on Therapeutic Jurisprudence.

This report summarises my observations of the mental health systems of the places visited. It commences with a summary of the world mental health environment, the details of which were obtained from the World Health Organisation in Geneva, Switzerland.

GLOBAL OVERVIEW

In April 2001, the World Health Organisation (WHO) published a fact sheet on mental health resources in the world. This fact sheet confirms that between October 2000 and March 2001, 181 countries covering 98.7% of the world’s population provided information in response to a questionnaire about their mental health services.

Of the 181 countries studied:
- 43% have no mental health policy;
- 23% have no legislation on mental health;
- 38% have no community care facilities; and
- 41% of countries have no treatment availability for severe mental disorders in primary health care.

In the last decade there has been some improvement in these figures. However, still about half of the African and Western Pacific region countries do not have a mental health policy.

Of the 160 countries that provided information on legislation, 23% have no mental health legislation. Of those countries that have legislation, about 17% date back to a period before 1960, before most current treatment methods became available and before the greater emphasis on human rights began. This early legislation is consequently much less likely to contain significant protection for human rights.
While it is agreed that most mental health disorders are best managed at primary care level, this has proven difficult to achieve in practice. Eight-five per cent of countries report that mental health services are available at primary care level, but actual treatment is reported to be available only in 59%. Forty three per cent of countries have no regular programme to train primary care personnel in mental health care.

Availability of essential drugs to treat mental and neurological disorders at primary care level is crucial for providing effective care. Although a national therapeutic drug policy or a list of essential drugs is now present in most countries, in many instances this has been put in place only in the last 5 years. Still, more than one quarter of the world’s countries do not have the most commonly prescribed antipsychotic, antidepressant, and anti-epileptic drugs considered essential for the treatment of common mental and neurological disorders at the primary health care level.

Community based care is better than institutional care for chronic mental illness. However, only 38% of countries have any community care facilities. Of those countries that have community care, the coverage is far from complete.

There are also significant contrasts in human resources around the world in the mental health sector. About 71% of the world’s population have access to less than 1 psychiatrist per 100,000 people. 46% of the world’s population have access to less than 1 mental health nurse per 100,000 people. Compare for example, the African region, which has a total population of about 840 million people, with Europe, which has a similar population. In the African region, there are only about 1,200 psychiatrists and 12,000 mental health nurses. In contrast, the Europe region has more than 86,000 psychiatrists and 280,000 nurses.

Monitoring and data collection system
More than 27% of countries have no system of reporting mental health data in their annual health report. Often, where there is a system, it is not sufficiently developed to provide useful information about changes in demand. Forty-five percent of countries have no facilities for collection of epidemiological or service data at national level.

Programmes for special populations
Only a small number of countries have programmes for special populations. Programmes for minorities and indigenous populations are not present in the majority of countries. Programmes for the elderly and for children are present in only 48% and 59% of countries respectively.

Conclusion
Overall, the mental health resources in countries present a dismal picture of severe shortage, neglect and apathy, which has only started to be improved in the last decade in many countries. The WHO considers that a concerted action by governments, professionals and the community is needed to improve the mental health resources availability for the world’s population.

It is important when considering the situation in Western Australia to have some regard to the global context of mental health issues, resources and resource allocation.
Whilst we may be legitimately concerned about whether mental health legislation should reasonably contain this word or that line, the majority of the world’s population have no access to mental health resources of any nature. This knowledge should not inhibit us in seeking always to improve the mental health system in Western Australia but it may provide a useful point of reflection for our deliberations – and should encourage greater compromise on the difficult issues that are inherent in the field of mental health. Bearing in mind the overall context, I now report in a more detailed way on the meetings and discussions that I had when overseas.

The focus of my overseas visit was the United States. This was for two reasons. First, the US has similar human rights protections to those required by the United Nations Principles for the Protection and Care of the Mentally Ill and for the improvement of mental health care (UN principles). This is not surprising, given the promotion by the US of the UN Principles during its extremely long gestation period. I therefore considered it very useful and relevant to learn more about the US mental health systems and how they worked both legislatively and practically. Secondly, the conference at which I presented was in Ohio, thus providing me with the opportunity of being in the US. Attached to this report and marked with the letter A is a list of places attended and persons that I visited. Attached to this report and marked with the letter B is a list of resource material obtained when overseas and retained at the Board’s offices.
THE UNITED STATES

Overview
I visited five States of the United States of America, being California, Arizona, Texas, New York and Ohio in that order. Because the population of American States is significantly larger than Australian States and probably for other historical reasons, all States visited had a separate department responsible for mental health. In some instances, for example, California, these Departments were limited to mental health; in other instances, for example, Texas, the Departments include intellectual disability or other areas, such as alcohol and drug abuse, within their ambit. However, even though there were separate departments, I was advised that the importance of mental health had been downgraded in recent years by, for example, there no longer being a departmental head in Cabinet in some States.

This report details my visits in chronological order.

CALIFORNIA

Introduction
In California, I met with a number of people, including Dr Mayberg CEO of the Department of Mental Health in California, Mr Carl Elder, Ms Angela Lazarow, and Dr Norman Black. I was provided a tour of a (city based) county psychiatric facility. At that facility, I was also privileged to observe a number of mental health reviews, the details of which are provided later in this report.

Admission and review process – legislative provisions in California
The relevant statute in California is the Lanterman-Petris-Short Act (LPS Act). The LPS Act was passed in 1967 and implemented two years later. It was a pioneering piece of legislation in the United States and it became a ‘template’ for many American states. The LPS Act rested the state’s power to commit on a mentally ill person’s dangerousness, although it includes an additional provision for those who are so gravely disabled as to be unable to meet their physical needs.

The LPS Act limited commitment for danger to self to a duration of only 31 days. Persons deemed to be still dangerous to self after 31 days can be held against their will only if they were also gravely disabled and thus qualified for conservatorship (guardianship). Commitments for danger to others were renewable after the first 14 days but a full re-hearing was required every 90 days. The essential requirement was that of ‘imminent danger’.

Involuntary status
Attached to this report and marked with the letter C is a flow chart of involuntary admissions in California.

In essence, in California, anyone may request a person’s admission to hospital. The hospital makes a decision as to whether criteria are satisfied by what is known as Pre-petition screening. If satisfied that the criteria are met, the health service files a petition for involuntary status. A Certification Review Officer may order an
evaluation and can make a treatment order for 14 days following a certification hearing. Alternatively, the patient may appeal to the District Court (habeus corpus) and such an appeal must be heard within 2 days of application.

A federal court case (*Lessard v. Schmidt*) in 1972 ruled that a preliminary hearing must be held within 48 hours of detention to determine whether ‘probable cause’ existed, with rights to notice, attendance, and counsel. A full hearing was required within 10 to 14 days where the standard of proof required was much higher. The rights procedures were borrowed from the criminal law. These reforms, which had as their basis a series of US cases, were widely followed in most American states in subsequent years. The reforms were based on the libertarian belief that the state is justified in infringing individual liberty only when one person’s actions endanger others, and perhaps in a limited set of circumstances when people act irrationally to endanger themselves.

In California, the LPS Act (or at least the procedural safeguards that attach to civil commitment in that State) were taken further as a consequence of the decision of *Reise v. St Mary’s Hospital* 209 Call.App.3d 1301 (December 1987)

This decision was in relation to the capacity of a treating team to administer antipsychotic medication to a patient in the absence of that patient’s consent. The Court of Appeal held that, in the absence of a judicial determination of incompetence, antipsychotic medications may not be administered to involuntarily committed mental patients in non-emergency situations without their informed consent. It held that, although the LPS Act does not explicitly grant such patients the right to refuse antipsychotic medication, throughout the statutory scheme the Legislature admonishes that the failure of the Act to explicitly confer a particular right upon mentally ill persons cannot provide a basis upon which to deny it. The court thus held that patients had statutory rights to exercise informed consent to the use of antipsychotic drugs under such circumstances. The decision included a ‘test’ derived from an academic textbook. This test is that judicial determination of the specific competency to consent to drug treatment should focus primarily upon three factors:

(a) whether the patient is aware of his or her situation (eg if the court is satisfied of the existence of psychosis, does the individual acknowledge that condition);
(b) whether the patient is able to understand the benefits and the risks of, as well as the alternatives to, the proposed intervention;
(c) whether the patient is able to understand and to knowingly and intelligently evaluate the information required to be given to patients whose informed consent is sought and otherwise participate in the treatment decision by means of rational thought processes.

In relation to the last consideration, the appropriate test was urged to be a negative one: in the absence of a clear link between an individual’s delusional or hallucinatory perceptions and his ultimate decision it should be assumed that he is utilising rational modes of thought.

**Electroconvulsive therapy**

The administration of Electroconvulsive therapy requires authorisation by two doctors and the informed consent of the patient or a superior court to determine (in)capacity, with the patient present and represented by counsel. If the patient is able to give informed consent to ECT and refuses, then ECT cannot be given.
Discussions in California
My first meeting in California was with Dr Stephen Mayberg. Dr Mayberg is the Director of the California Department of Mental Health and is based in Sacramento, the capital of that State.

Dr Mayberg noted that there had been 14 Directors of Mental Health Services in California in the last 20 years. He stated that, due to the difficulties inherent in the area of mental health, the average length of tenure of a director of mental health in the United States is two years. In contrast, he has been in his current position for 8 years. Dr Mayberg gave me a comprehensive overview of mental health services in California.

I also met with John Rodriguez, Deputy Director, Long Term Care Services and Ms Angela Lazarow, Chief of the Office of Human Rights.

Mr Rodriguez has responsibility for State (as opposed to county) mental health hospitals. There remain 4 stand-alone State mental health hospitals in California with a total patient population of about 850 people. Perhaps ironically, about 80% of patients within the hospitals are there due to the criminal system, having been found not guilty by reason of insanity or unfit to stand trial. The remaining 20% are mentally ill persons who are treatment resistant. All wards at State hospitals are secure wards. It costs approximately $107,000 a year to maintain a patient in a State hospital.

Ms Lazerow provided me with a copy of the Patients’ Rights Manual, a publication developed by Protection and Advocacy, Inc. (a federally funded agency) with the California Department of Mental Health. Ms Lazerow’s role is to act on behalf of patients with respect to issues and complaints. Such complaints are referred to her from county facilities. Her office may refer them to the Department when appropriate.

Later, I met with Mr Carl Elder, Chief Counsel, Office of Legal Services, Mental Health, and Dr Norman Black, Senior Staff Counsel, Office of Legal Services and discussed with them the detail of the LPS Act and their review system. They confirmed that the number of occasions when an involuntary order was either not made or was discharged was very low (less than 5%) although, because of the county based system of management in California, there is no central data collection on the results of reviews. They also explained aspects of the LPS Act and accompanying legal decisions.

Reviews observed in the Sacramento county hospital:
(1) General comments
Reviews in California share the following features:
- Both the hospital and the patient are represented in all reviews;
- Depending on the type of review, there is a difference in hearing officer; and level of representation;
- ‘Probable cause’ hearings require a ‘balance of probabilities’ (51%) standard of proof and are conducted before a Hearing Officer (who may or may not be a lawyer);
‘Consent’ or Reise hearings require a ‘clear and convincing’ (75%) standard of proof and are heard before a judge;

Generally, advocates attend the hospital early on the day of the review, get access to the notes and see the client, and then represent the client at the review;

Up to 30 reviews can be scheduled and dealt with in a day;

The predominant reason for most applications for 14 day orders is the ‘gravely disabled’ criteria;

The Public Defenders Office, attorneys who represent patients, has, at the request of judges, agreed to ‘screen’ habeas corpus hearings. About 30-40 persons request such hearings each month; about one is conducted following merit screening by Public Defenders’ Office;

Each psychiatric facility has a full time hearings officer. For probable cause hearings, the State provides an advocate for the patient. For Consent hearings, a State Attorney represents the hospital and a lawyer from the Public Defenders Office represents the patient;

The minimum number of persons involved in a consent hearing is 7, being the patient, a doctor, a lawyer for the patient and the hospital, a judge, the judge’s sheriff and the judge’s bailiff. Consent hearings generally occur at the hospital but may occur in a separately located court. Apart from the patient, all persons involved in a consent hearing are funded by taxpayers.

(2) Specific observations – California reviews

First review. Probable cause hearing. Duration 40 minutes.

Material information: Patient’s diagnosis: paranoid schizophrenia. The hearing officer was told by the hospital’s representative that upon admission the patient believed that her co-workers were trying to poison her and that TV reports were continuing to talk about her. She was initially very isolated at the hospital.

The file (from which the hospital’s representative read) indicated that the patient had been brought to the hospital by her family members after she had lost her job, allowed her flat to deteriorate, and become very paranoid and isolatory, believing that people were out to poison her. Because of this belief, the patient had stopped eating and would only drink bottled water. The patient’s family members (father and two brothers) were present during the review but were not asked to provide comment upon the criteria.

The patient through her representative maintained that she did not have a mental illness and that there was no need for treatment. She said that the medication was poisonous to her.

It was common ground that the patient was a highly intelligent individual who had been enrolled in Berkeley University, California. A particular interest of the hearing officer was how the patient would, if discharged, provide for herself. The patient’s response was that she would get a job, rely upon her family and friends, and find a way.

Decision: The hearing officer held that, on balance, probable cause was shown and ordered that the patient continue to be an involuntary patient.
Second review: Probable cause hearing. Duration 15 minutes.
Patient’s diagnosis: undifferentiated schizophrenia, polysubstance abuse, antisocial personality disorder. This was the patient’s 18th admission to hospital. Previous admission (of one month’s duration) was 6 months previously. Patient denies mental illness or previous admissions and denies drug abuse.
Submission: patient wants release. He has his own apartment, cooks for himself and can use public transport. Patient is taking medication and is ready to leave hospital.

Decision: application was made under one section of the relevant but relied upon another section of the statute. Therefore, the application was technically incorrect and there was insufficient information for the application made. Patient discharged from involuntary status.

Third review: Probable cause hearing. Duration 10 minutes.
Patient’s diagnosis: undifferentiated schizophrenia. This was patient’s 16th admission to hospital. Patient was much better following reintroduction of medication. Discharge plan still unclear.

Decision: Patient did not contest the hearing and therefore the involuntary order was continued.

Fourth Review: Probable cause hearing. Duration 5 minutes.

Patient’s diagnosis: undifferentiated schizophrenia. Application under ‘gravely disabled’ provisions. Picked up by Police disoriented, no ID, no residence. 4th admission. Last admission in 1999. Patient was agreeing to stay so accommodation could be arranged. Decision: Order confirmed.

Fifth review: Reise or consent hearing. Duration: 30 minutes.
This hearing related to the same patient as the first hearing on the day. Although the two hearings for the same person were held on the same day, they involved different people. The consent hearing was heard before a judge, who attended the hospital with his sheriff and bailiff. The patient was represented by a lawyer from the Public Defender’s Office. The doctor was represented by a District Attorney. Although present at the hospital, the patient’s father and two brothers were not invited into the hearing.

Material information: The Police brought the patient to hospital as it had been reported that her unit was completely disorganised, strewn with rubbish, and that the patient was not caring for herself properly. She had resisted assistance from her family. At that time, the patient had noticeable auditory and visual hallucinations. Her diagnosis was schizophrenia. Her treatment was oral antipsychotic medication. The patient had taken the medication, but only erratically. She had last taken the medication two weeks prior to the review. At the time of the review, the patient was less preoccupied with paranoid behaviours but still was guarded. Her objections to the medication, as explained to the doctors, were a burning sensation in her chest and a complaint that her thoughts were going slower. The patient had been provided with
information about alternative medication but had refused the alternatives. The patient believed that the only treatment she required was family therapy. In the doctor’s opinion, her objections to the medication (that it was poisonous, that she did not have a mental illness and that she needed only psychotherapy) were not rational. The doctor also believed that the patient’s illness was interfering with her ability to process the risk and benefit of the medication.

The patient told the court that she had been given information about the medication and that she had read it. She said that she was sensitive to medications and to chemicals and that she could detect chemicals in water. She said that her thought processes had been messed up since she had been in hospital. She said that she was not convinced that she had schizophrenia and would take medications if necessary and if enough research into them had been carried out.

Held: The law required that the judge had to be satisfied to a ‘clear and convincing standard’ that the patient could not consent to treatment. There must be proof of a link to the patient’s delusional perceptions. Due to the negative test, the judge was not so satisfied and therefore the petition was denied.

Effect of decision: This patient, who only a few hours before had been held to satisfy the criteria for a continuation of her stay in hospital for a further 14 days under a different test and with a different standard of proof, could not be treated against her will during her continued stay. Therefore, immediately following the decision of the Court, the doctor discharged the patient from the hospital against medical advice.

Attached to this report and marked with the letter D are some of the relevant committal and court papers involving this patient provided to give an indication of the documentation required for Californian court processes.

Commentary on reviews
There are evident tensions in the review system in California. As a result of court decisions, the review system now requires two types of hearings for some patients. These hearings generally do not occur simultaneously as they involve different hearing officers, different representatives, and different standards of proof. The hearings require dedicated hospital resources (hearing officer) and representatives for the patient. In the vast majority of cases, the applications are affirmed. Where this is not so, such as in the matter I observed, the results may be contradictory. In the observed matter, the intervention of the legal system and its protections resulted in a patient with a serious mental illness being prematurely discharged from the hospital. It was particularly concerning that the legal system allowed no input from the patient’s primary care-givers and relatives. This highlights the generally highly individualistic nature of mental health laws in the US. It was also noteworthy that, due to the judicial (and adversarial) nature of the reviews, the hearing officer or judge did not review any files but relied upon what they were told by the hospital’s representative. In relation to the probable cause hearings, the only information that appeared to be of relevance was that occurring in the preceding two or three days – anything longer was considered ‘too old’. This narrow time frame and focus,
required by the legislation, is most likely a reflection of the age of the legislation, with more modern legislation now more likely to have greater regard to the patient’s social circumstances and the rights of carers and others.

Emerging issues in California

There are a number of important issues emerging in mental health care in California. A significant issue in California as well as other American States, is that of involuntary outpatient commitment. (IOC). Legislation is currently before the Californian parliament to expand commitment legislation to allow for IOC. Earlier similar moves led to the Californian Senate requesting research into the effectiveness of IOC. This research was conducted by Rand Health Communications and the published report (of which I have a copy) is known as the Rand Report. Essentially, the Rand Report draws the following conclusions:

• There is no evidence that a court order is necessary to achieve compliance and good outcomes or that a court order, of itself, has any independent effect on outcomes;

• Relevant professionals support IOC but feel that available services are inadequate for making IOC work.

Attached to this report and marked with the letter E is a copy of the Executive Summary of the Rand Report.

In November 2000, the Little Hoover Commission provided its report to the parliament. (I retain a copy of this report). This committee was scathing in its criticism of mental health services. In its accompanying letter to legislators, the Commission stated as follows:

‘The Commission also discovered that we spend billions of dollars dealing with the consequences of untreated mental illness – rather than spending that money wisely on adequate services. We pay for jail space and court costs that we incur because mental health clients do not receive care and treatment. We pay for redevelopment and struggle to revitalise our inner cities, but we pretend we cannot do anything to keep people with mental health needs from sleeping in the doorways of downtown homes and businesses.

We have, in effect, criminalised mental illness. State law instructs counties to turn away those in need because funding is limited. But law enforcement is expected to respond to every call, to keep every peace, and to ensure everyone’s safety. Absent adequate mental health services, the cop has become the clinician. The jail has become the crisis centre.’

In discussion with people that I met, concern was expressed about the reasons for the problems in the Californian system. The reasons given to me included:

• The civil liability issue, a very prevalent issue in the US which can have the consequence of people not being willing to make the best decisions;

• The domination in mental health services of high end services, with an adversarial system then becoming entrenched at a point where lesser options cannot be considered;

• The ‘churn’ effect: although the average length of hospitalisation is now just 6 days, there is a 40% re-hospitalisation within 6 months;
• The Director considered that the movement towards more prescriptive and court based orders result in more people being pushed into the criminal justice system;
• There is an 18% vacancy rate for psychiatrists in California.

From this list, as well as more generally, it is evident that the mental health system in California, like mental health systems everywhere, faces significant challenges in many areas. Like other jurisdictions in the US and elsewhere, there is constant pressure on resources in mental health in California with a diminution rather than increase in resources being considered or implemented. The legislative framework for involuntary status is just a small part of the issues faced in California and not necessarily by any means the most important issue. The LPS Act provides important legal safeguards for the small number of people now being made involuntary. However, the safeguards provided by the legislation and the limits of the legislation need to be considered in the context of their US background. In short, the legal system for mental health matters operating in the US should not and cannot be automatically considered for adoption in Australia as the context here is significantly different.
Introduction
I spent a day at the Arizona mental health services in Phoenix. I met first with Mr Jack Silver, the CEO of the Arizona Department of Health Services, and CEO of the Arizona State Hospital. This hospital is part of the Department of Health Services, Bureau for Persons with a Serious Mental Illness in Arizona. I was also able to participate in a meeting with various key mental health personnel and observed the opening session of a meeting between Federal review personnel and State based officials. Later that day, I was provided with a tour of the Arizona State Hospital.

Though my visit to Arizona was brief, I was able to maximise its utility. Persons at the meeting of key personnel included Mr Jack Silver, CEO, Dr Jerry Dennis, Chief Medical Officer Arizona (ADHS), Ms Vicki Staples Manager ADHS, Ms Judi Higginbotham, Human Rights Coordinator, ADHS, Judge Mundel Mental Health Justice Maricopa County Probate Court, Ms Josephine Jones Attorney Public Defender’s Office, Mr Joel Rudd, Assistant Attorney General and Ms Pat Razo, Director of Social Work, Arizona State Hospital.

Overview of mental health legal system in Arizona
Under the legal system in Arizona, it is more difficult than some other American States for a person to be made involuntary but thereafter treatment can proceed more readily. The relevant Act is the *Mental Health Services Act*. This Act came into force in 1974.

Any responsible individual may apply for a court-ordered evaluation of a person who is alleged to be, as a result of mental disorder, a danger to self or others, persistently or acutely disabled, or gravely disabled and who is unwilling or unable to undergo a voluntary evaluation.

In relation to the criteria for involuntary treatment, gravely disabled is defined as ‘a condition evidenced by behaviour in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because he is unable to provide for his basic physical needs.’ ‘Persistently and acutely disabled’ is defined as a severe mental disorder that meets all of the following criteria:
(a) If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behaviour or capacity to recognise reality.
(b) Substantially impairs the person’s capacity to make an informed decision regarding treatment and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages and alternatives are explained to that person.
(c) Has a reasonable prospect of being treatable by outpatient, inpatient or combined inpatient and outpatient treatment.
Once such an application is filed, the screening agency shall, prior to filing an application for court-ordered evaluation, conduct a pre-petition screening. Upon completion of the pre-petition evaluation, the court-ordered evaluation may proceed and a peace officer may apprehend the person for transportation to the evaluation agency. Once the evaluation has occurred, the person may by court order be admitted to hospital.

For involuntary status, the affidavits of two physicians are required. The time limits of orders are different to California. ‘Danger to self’ has a 90 day limit, ‘danger to others’ has a 180 day limit, ‘gravely disabled’ has a 365 day limit and ‘persistently or acutely disabled’ has a 180 day limit. Once an application is filed, the approval of the court is required to discharge from involuntary status or admit involuntarily. The criteria of gravely disabled and persistently or acutely disabled were added to the statute some years ago because of concern that those who required involuntary treatment for their mental illness did not satisfy the criteria.

Court orders may include orders for the following: apprehension, transportation, counsel, and an independent evaluator.

A person can be admitted to hospital on an emergency basis and the hospital has 24 hours to decide whether to petition for court ordered evaluation or not. A court may make its initial determination ‘on the papers’ – that is without taking evidence – and can order the admission of the person for a further 72 hours, during which time the person cannot be treated involuntarily. If continuous treatment is required but the person is not consenting, then another petition for court ordered treatment is filed and a hearing is held within 6 days. For court ordered treatment, the burden of proof is on the State and the standard of proof is ‘clear and convincing’ evidence. These hearings require specific treatment plans to be presented (as set out in the rules and regulations). Evidentiary material must also include the efforts taken to get the patient to take the medication and also require affidavits of two psychiatrists and approval by the Chief Medical Officer. Lay persons may include one family member and one member of the treating team who is not a doctor. Social workers are responsible for getting witnesses and may subpoena a witness if required. As a family member is required, there is some scope for that person being blamed for the admission of the patient. Parties to the proceedings may request a verbatim request of proceedings.

The court has the capacity to make an order for conditional outpatient treatment. There is also a requirement for mandatory local treatment: patients must be treated in a local facility before hospitalisation in the state hospital unless the court decides that the patient will not benefit from the local treatment programme. This system was implemented to prevent patients immediately being transferred to Phoenix. Where a person is admitted involuntarily on the criteria for danger to others and discharge is sought prior to the allowed treatment period, notice is required to be provided to relevant others.

The court has the power to order inpatient /outpatient treatment eg six months of both. If an outpatient on one of these orders, the person can, upon breach of the order, be apprehended without warning and taken for treatment. The outpatient treatment order can also be revoked and the patient returned to hospital.
An involuntary patient is entitled to request judicial review every 60 days. In such instances, the patient and psychiatrist file reports. An attorney is appointed to represent the client and that attorney makes the decision about whether or not to request the hearing, not the patient. If the attorney does not request the hearing, it does not occur. This policy was explained to me as being consistent with an attorney’s obligations as an officer of the court not to waste valuable court time with applications that did not have *prima facie* merit. What the policy demonstrates is that even though the law allows a regular judicial review, that law is not enforced except where persons not specified in the legislation, that is attorneys, decide that it should be enforced. In this way, attorneys clearly act as a ‘filter’ on a mentally ill person’s legal rights and in a way that is not recognised by the legislation. This provides an example of the difference between what legislation says and its utility in practice.

**Review of applications for involuntary status**

Like all US systems, the Arizona review system is a court-based system. Due process provisions include the appointment of counsel, who is obliged to do certain things by the law, including interviewing the patient within 24 hours, explaining to the patient his rights, reviewing the petitions, interview the petitioner, if available, and interview other witnesses, if known and available. If the attorney is appointed, he also is required to explain that the patient can obtain his own counsel at his own expense and that, if the person is not indigent, he or she will be responsible for the fees of the appointed attorney after the initial conference.

The Court may make a number of types of orders, including treatment in an outpatient or inpatient program or a combination of both.

**Time taken for hearings**

At a county level, the doctors’ reports and lay reports are required. Oral testimony is not usually required and I was advised that the hearings generally last for not more than 30 minutes.

For admission to the State hospital, at least one psychiatrist is required to testify as well as two lay members and hearings may take between 45 minutes to one hour. If a patient exercises his or her right to an independent evaluator, then the hearing may last longer.

**Acceptance of applications**

I was advised that in the preceding three months, only one application for involuntary status had been refused by the courts. This case was rejected because a technical deficiency (incorrect box being ticked) rather than because of a lack of evidence. Unfortunately, because of the county based system that operates in the US, I was unable to get State wide statistical information.

**Access to records**

Patients are entitled to access their records – with many exceptions, including a doctor’s belief that release of records may be harmful to the patient. In some instances, a guardian can be appointed to read the records and then report on them to the patient.
**Conservator (guardian)**
Under the law of Arizona, an appointed guardian can authorise a person’s admission to hospital (county or state), provided that the hospital agrees.

**Apprehensions**
Due to concerns about liability (that is, being sued) the Police as a matter of routine put all apprehended patients into handcuffs, something that is clearly not a desirable outcome from a health or human rights’ perspective.

**Criminalisation of the mentally ill**
As I heard in every state that I visited in the United States, concern was expressed in Arizona about the criminalisation of the mentally ill in the US. LA County jail was described as being the ‘largest mental hospital’ in the US. Concerns were expressed in Arizona about so-called ‘mercy arrests’ – arrests that occurred because it was easier to arrest someone than seek that they be made an involuntary patient.

**Arizona State Hospital**
This facility is the only psychiatric hospital in the State. It is licensed for 355 beds and currently has about 305 patients. In most rooms, there are 4 beds; in the past there used to be 5 or 6 beds in a room. Wards can include up to 45 persons and have three staff, a very low ratio, for that number. I toured the State Hospital. The wards were dangerous, crowded, and dingy. Also included as part of the hospital (merely a separate ward) was a 16 bed adolescent unit. Like all facilities that I saw in America, the hospital consisted entirely of secure wards.

The State Hospital was perhaps the most unsuitable hospital for mentally ill persons that I have ever seen. Fortunately, site works have just commenced for a new Arizona State Hospital that will be completed in about two years’ time.

Also on site was a new purpose-built sexual predators facility. This was built to house those persons convicted of an act of a sexual nature after they have completed their criminal sentence. Such facilities have been built in a number of American States and relevant persons can be kept in them indefinitely. (A number of State and National Supreme Court appeals have been lodged about this type of legislation). It was also noteworthy that the Arizona Correctional System has leased hospital lands and has built a medium security prison on that land.

The average length of stay at the State hospital is 9 months as the clientele of the hospital are the most severely unwell patients in Arizona.

Mental health service funding in Arizona is 49th lowest out of 50 states. In 1998, a private company took over management of at least one Arizona county’s mental health system. The system has meant that there has been a ‘lock down’ – with many patients having to go through many steps and satisfy so many levels of criteria that people are just not receiving the level of services that they need. Ironically, the legal system, in place to protect people’s rights, has contributed to patients not receiving services because it provides further steps that must be satisfied before some mentally ill persons can be treated. It has been reported that the number of people applying for adequate services and actually receiving those services has been as low as 9%.
Discussion
Many of the complexities of the system were discussed with me at a meeting involving the eight persons mentioned in the introduction. The consensus of those with whom I met was that the Arizona mental health system had inadequate resources. It was also evident from our discussions that there are significant tensions in the Arizona mental health system. There seems little doubt that the mental health system in Arizona, like many US systems including its legal system, is becoming increasingly polarised. Those that have health insurance, usually through employment, have access to one system. Those that do not have health insurance, have much more limited access to another and far less satisfactory system. The public health system, now privately operated in Arizona, is a system that requires several levels of assessment before a person can be assisted.

The Arizona Health Care Cost Containment System (AHCCS) is a state agency that oversees all federal Medicaid programs. AHCCS provides the funding to the Arizona Department of Health Services (DHS) which, through its Behavioural Health Services Division (BHS) provides the funding and monitoring of the private agency ValueOptions.

ValueOptions does an assessment of a person before providing services. If a person has private mental health insurance or sufficient income, they are rejected for services unless there are other relevant factors, for example, they have utilised the maximum claims on their personal insurance. If a person has no or limited income, no insurance, and a serious mental illness, they may be eligible to have their needs assessed and can then access services. If an apparently eligible person is rejected, they can appeal first to ValueOptions and then to BHS.

In these circumstances, and according to newspaper reports to which I had access, the primary problem in Arizona is not (legal) rights based, but getting access to mental health services in a system that has significant in-built impediments to getting that service.

The legislation in Arizona, like mental health legislation in most jurisdictions, is only utilised for a small cohort of the population. Many people with a mental illness seek treatment for their mental illness and access to the legislation is therefore required in only a limited way. (The Arizona legislation contains some provisions regarding voluntary admissions which includes, amongst other things, admission to hospital by authority of one’s guardian (for a person for whom a guardian has been appointed) or parent (for a minor).

In these circumstances, and bearing in mind even only the very limited information about the overall structure of the Arizona mental health system in this report, it seems evident that there is little point in considering the legislative framework without having regard to the rest of the mental health system in Arizona. Such a narrow focus does not, for example, allow any discussion of the merits or otherwise of having the involuntary admission system run by a private for profit company, nor the met and unmet needs for mental health services in the general Arizona society.
TEXAS
I met first with Ms Roshunda Farmer, Director of Government Affairs with the Texas Department of Mental Health and Mental Retardation. Ms Farmer had arranged a series of meetings with relevant persons in Texas. Summarised below are some of the discussions that I had in Texas.

I happened to be in Texas during its parliamentary session, a rare event as in Texas parliament sits for only 20 weeks every second year.

In general terms, it is evident that mental health funding is given very low profile (and low funding) in Texas. The relevant department has in the past two years been required to manage on a reduced budget to its preceding budget. A judge with whom I spoke said that in his opinion, only 15% of persons with a serious mental illness in Texas received adequate treatment for their illnesses. The hospital that I toured in Austin was very old and had been built more than 50 years ago. It was ‘prison like’ in structure with little natural light, high small windows, and crowded conditions. All wards at this hospital (a State hospital) were secure wards. Frequently in conversations in Texas, the issue turned to the issue of money and who, of the respective service providers, would pay for relevant services. For instance, in Texas there are significant court filing fees that have to be paid for an application for involuntary status. There seemed to be relentless discussion about whose responsibility it was to pay these filing fees, county or State, MHMR department, court services, or other.

I spoke with a mental health consumer in Texas. She had regularly been arrested on minor criminal charges (eg refusal to give her address). These charges are known as precinct charges and can result in significant fines that poorer people are not able to pay. Thus, the criminalisation of the mentally ill is something that can and does occur in Texas. This consumer expressed no faith in Public Advocacy Inc. the federally funded agency, and said that they were not interested in people but only in rights.

The government system in Texas
Texas, as the largest US State, consists of 254 counties, with each county having its own form of government. The state has 42 local authorities for mental health across these 254 counties as some of the counties are rural and small and have therefore amalgamated for service procurement and delivery.

Involuntary outpatient treatment
Although involuntary outpatient treatment is available in Texas, it is used in only about 300 instances a year. (It was not possible to obtain details of the total mental health population in Texas. However, Western Australia, with a population of less than 10% of that of Texas, has at any given time around 150 Community Treatment Orders in existence.) The reluctance to use involuntary outpatient treatment orders in Texas is driven by concern that the use of involuntary commitment would only mean that voluntary patients would go onto the waiting list and also by the concerns of psychiatrists about liability.
Commitment of children gives access to federal funds. In Illinois, people can only get public funding for children with mental health problems if they abandon their children. The only alternative is to send their children to private hospitals in Texas.

As a result of a federal law suit, seeking to force the State to provide adequate services for the mentally ill, there has been increased funding and a greater focus on the mentally ill. The federal law suit ran from 1973-1997.

Like mental health systems elsewhere in the US, there has been a significant reduction in public mental health beds. There has also been a decrease in private mental health beds.

In Texas in February 2001, there were 1289 patients in State hospitals – 82 voluntary and 1207 involuntary. The length of stay is quite low, with a 30 days average in one facility, and another facility having an average of 7-10 days.

**Inpatient order process**
1. 24 hours – sign forms
2. 14 days order of protective custody  2 doctors file
3. Hearing. Order can last 90 days, order can be extended up to one year.

Like other US systems, the Texas system has had a consent hearing ‘grafted on’ to the statutory requirements. If the person is psychotic but agrees to the treatment – his/her capacity to consent to treatment is not questioned. Also, if the psychiatrist believes the person is capable of consenting to treatment, then an application will not be made. However, where the psychiatrist believes that a patient is not capable of consenting to treatment and refuses treatment, then the psychiatrist can make application to the court for an order for treatment. An affidavit and application are required, together with payment of relevant fees, and another hearing is then held. Depending on the court, and judge, the consent hearings can be heard following the involuntary status hearing or may be heard at another time. The order for psychoactive medication includes classes of medication. There is therefore a need to put all medications on form or otherwise if new medications are introduced a further application to the court will be required.

Hearings are likely to proceed within 10 days of application. Unless there is an emergency, treatment cannot be enforced prior to the hearing. This can lead to injuries: the highest rate of injury or assault is in the first two weeks of admission.

Ms Any Mizeles Public Policy Director, NAMI Texas confirmed the generally held view in Texas that mental health is severely underfunded in that State. She also stated her concerns in relation to criminalisation of people with a mental illness. She noted that whereas California spends an annual amount of $25 million on new generation drugs (atypical antipsychotic medication), Texas spends $1 million on these medications. If Texas were to spend on a pro rata basis with California, it would have to spend $15 million on this medication. Ms Mizeles advised that relevant consumer organisations in Texas included: the Mental Health Association, Texas MH Consumers, Federation of Families (children); Public Advocacy Inc.) (Federal)
When I was in Texas, a new Guardianship Bill was before the Texas parliament. This Bill proposed to allow a guardian to commit his or her ‘client’ to a mental hospital for 45 days a year, 15 days maximum at a time. This proposal was vigorously opposed by Judge Herman who took the matter up directly with law-makers in a series of representations.

A further Bill being considered was a bill for transportation of mentally ill persons. This Bill if passed would require the Police to apprehend such persons and take them to gaol for up to 72 hours but perhaps as long as 7-8 days if there are public holidays. The Bill was in response to the costs of transporting mental ill persons, especially from remote areas in Texas and probably represented an attempt by counties (currently responsible for transportation) to cost-shift to the sheriffs attached to courts. Judge Herman was also vigorously opposing this measure.

**Conclusion**

The mental health system in Texas was indicative of other mental health systems in the US. Although mental health services had a large and separate budget, in the last two years their budgetary allocation had been cut. The hospital that I saw was old and unsuitable. The legal system provided a degree of protection to human rights for those few people who came within it. However, it seemed agreed that a very large number of people in Texas who suffer from mental illness do not have reasonable access to mental health resources or services.
NEW YORK
Following my visit to Texas, I travelled to New York, being the largest US city and one of the largest cities in the world.

Overview of mental health system in New York
The mental health system has changed dramatically in New York city in the last half century. In 1950, nearly 100,000 patients were secured in hospital in New York alone. Many of these patients were long term patients and the conditions were terrible. There was a lot of abuse with family members often putting relatives into hospital, sometimes inappropriately. As elsewhere in the US, the civil rights movement initially promoting the welfare of black Americans began to apply more to other groups, including women and minorities, such as the mentally ill.

New York city has a population of over 8 million people. There are about 120,000 admissions to mental hospitals each year. The New York State mental health budget is about $2 billion a year. The New York City budget is $1.2 billion. The relevant State Department is the Office of Mental Health. The New York City Department is the Department of Mental Health, Mental Retardation and Alcoholism Services.

During the 1950’s, inpatient numbers peaked at around 93,000 patients in New York, with 17,000 patients being held in a single facility. By 1977, the number of inpatients had dropped to 20,000 and in 2001 there are about 4,500 inpatient beds available.

As in other States, the patients remaining in State hospitals tend to be the most treatment resistant patients who are hardest to discharge.

The New York mental health legal system
Much of the information in the following section was provided from my meeting with Mr Marvin Stein, Director of the Mental Hygiene Legal Service, and Mr Stephen Harkavy, Deputy Director of the same service. Some information in the section was provided by Ms Joe Lazar, Director of the State Office of Mental Health.

The Mental Hygiene Legal Service is established and funded by the Supreme Court, First Judicial Department of the State of New York and was established to represent mental health patients in reviews of their involuntary status. The Mental Hygiene Legal Service operates in one of the four judicial districts of New York city and is appointed to provide legal counsel. Staff members of the Service have some concern about being part of the judiciary/court system when they are appointed to represent patients within that system. The Mental Hygiene Legal Service has 35 attorneys and participate in about 3000 contested reviews (and many more uncontested reviews) each year. Their policy is to act in accordance with their client’s instructions but they acknowledge pressure from the courts if the matter has no merit. In some instances, attorneys seek to counsel their clients out of proceeding with their review.

The representatives reiterated the by now familiar concern of the criminalisation of the mentally ill. Ironically, psychiatric patients now often end up in jail. Mentally ill persons are referred from jail to psychiatric services.
Admission to a mental hospital in New York requires the certificates from two physicians. For an emergency admission, the certificate of only one doctor is required. Following admission, although a patient may request a review of the admission to involuntary status, there is no mandatory review until 60 days, a period even longer than the maximum statutory period for initial review in Western Australian (56 days).

In relation to requested reviews, the legislation requires that these reviews occur within 5 days of request; in practice, such reviews occur within 10 days due to the high volume. This provides another example of the law not being met due to practical considerations.

The largest hospital in New York city is Bellevue Hospital. Reviews occur at this hospital on a weekly basis. Up to 30 reviews are listed and dealt with each day.

In 1985, the New York Court of Appeal heard the Rivers case. This case concluded that any psychiatric patient had the right to control treatment unless the court decides that the person is incapable of consenting to treatment. Hospitals continue to have the right to treat in an emergency. However, for treatment on an ongoing basis, the court has to be convinced that the patient does not have the ability to consent. The court steps in and is involved in balancing competing risk factors.

Typically, like mental health systems elsewhere, the New York system involves psychiatrists seeking to come to a suitable arrangement with patients for appropriate treatment. Thus, applications are only brought where there has been no agreement. Given this ‘filtering’ of applications, the courts overwhelmingly grant applications for involuntary status. Although the statutory requirement is ‘clear and convincing’ evidence, the reality is that in almost all applications the courts grant the requested order.

It was explained to me that in New York the laws and their application are affected by the local political climate. In New York, there is a tremendous concern about violent people. As a consequence of a previous murder by a mentally ill person, for example, the mental health hospital system was in ‘total chaos’ for two years as ‘anyone who showed up was admitted’.

Kendra’s law
This law arose following pressure from the parents of a person (Ms Kendra) who was killed when pushed in front of a train by a person suffering a mental illness. It is a type of involuntary outpatient treatment order. The ironies relating to the law are at least two-fold. First, this particular patient was known to mental health services and in fact seeking assistance at the time. He had been evicted from the hostel in which he lived and was seeking treatment (and housing) when the incident occurred. Secondly, there is already a provision in the legislation for patients to be discharged on leave from hospital by psychiatrists. However, this provision is rarely used due to concerns by psychiatrists about liability issues in the event that a patient is discharged under this provision and then commits an offence.
COLUMBUS, OHIO
My first meeting in Columbus was with Dr Michael Hogan, the Chief Executive of the Ohio Department of Mental Health.

Dr Hogan painted a picture of mental health service delivery within a societal framework. He noted that the mental health system can render rights moot or can cancel rights that exist on paper if services are bad. He saw the delivery of mental health services as being within the context of health care more broadly – and constituted by good housing policy etc. All health care delivery is within social values of the society. The prevailing values of the society will determine the level of social responsibility for the poor and disabled (regardless of the wealth of the country).

I was advised that in the US, health care is financed largely through insurance procured through work. For those not in work, there are two large federally funded programmes – medicare, for the elderly or disabled workers, and medicaid, a joint federal/state partnership programme for the seriously disabled or very poor or elderly.

Employed people with a mental illness may be covered for mental health care as part of their health insurance, though there is tremendous variability regarding the extent to which cover is offered. However, if the job is lost, then whatever cover was held is also lost. Given that medicaid is only available for the very poor and seriously disabled, a person with a mental illness may not be disabled or poor enough to receive assistance. Therefore, at least in Ohio, there are safety net programs designed to assist this group of people. The contents of such programmes varies considerably.

In terms of legal standards, the Ohio legislation is similar to other US states. It allows for short term commitment (between 3 and 10 days) on the affidavit of 1 or 2 doctors, and a review by a medical officer. The criteria include having a mental illness and behaviour caused by the mental illness that is a danger to self, danger to others, or gravely disabled.

At the end of the short term order, the patient may leave or continued confinement can be ordered by a probate court.

Current trends shaping mental health law include:
1. The push for community treatment. Family members/doctors, and those seeking to get mentally ill people off the streets are all promoting enforced community care. The mechanisms across states vary. In some states, community care orders follow in-patient orders. In other States, like Ohio, an order may be made for a county Board to place a patient in hospital or in the community. The criteria are the same and the court processes are the same in both instances.
2. The issue of sexually violent offenders. Statistics indicate that of such persons, about 25% will reoffend. The problem is that it is not possible to accurately predict which 25%. Some research on the efficacy of treatment for such offenders indicates that the risk of offending can be reduced by 30-40%. Some states have legislated for a period of commitment following criminal commitment for sexually violent offenders, with the offender having to prove that he is no longer a risk before being released.
3. Advance directives. Advance directives to guide decision making in a crisis have become more prevalent and have been implemented by some states at a small level. The suggestion is that, for mentally ill persons, they sit down after hospitalisation and debrief on what was learned, develop a memorandum and give their preferences for care to be given and care not to be given if there is another emergency.

There are acknowledged problems with advance directives. For example, a person may make an advance directive when well and deny its contents when unwell. However, they can be of assistance. Ohio is developing a durable power of attorney for health care purposes. Coupled with this is a small card which states:

‘I ………….. have an Advance Directive for Health Care. It’s a legal document in which I have named an agent to speak for me in the event that I am unable to speak for myself.’

Ohio
Ohio is a large diverse state. It has 11 million people living in 88 counties, with 50 local mental health systems. It has a larger number of cities with populations about 200,000 than any State except California yet there is no dominant city. Most of the State is rural and 1/3 of the State is mountainous, thus not having very good transportation. There is considerable ethnic diversity and poverty in many rural areas.

In 1967-68, legislation was passed that allowed community mental health Boards to govern local mental health centres. Between 1968 to 1988, the community boards expanded but county hospitals consumed most of the money.

In 1991, Pam Hyde, who used to work as an advocate for the Protection and Advocacy Agency Inc. was appointed by Dick Celest, the Governor (whose wife had had a bad experience of services when depressed) to head the Department of Mental Health. Pam was given the mandate to make changes and to promote the interests of consumers and their families.

The changes implemented over time included the following:
1. Place consumers at top not bottom – consumers began to sit on mental health boards;
2. Establish local mental health boards that would be wholly responsible for the people in their care;
3. Civil commitments were changed to be to the local board, not the hospital, with the local board to determine whether the patient would go to hospital;
4. Over time, the budgets of hospitals were allocated to mental health boards, for allocation to beds or community services.

Like other American States, Ohio had a high mental health inpatient population some decades ago. In 1960, about 25,000 lived in institutions. In 1965, the federal medicaid was established. This provided funds for nursing home care, but not for psychiatric care. Thus, most elderly people in mental institutions were transferred to nursing homes to attract medicaid funding. This of course led to a decrease in the number of people in mental hospitals. In 1980, there were about 4,500 beds in mental health services in Ohio. By 1988, this had reduced to 2,800 and it is now about 1,100.
Of the 1,100, 55% are placed in hospital by the criminal courts, with 50% being not guilty by reason of insanity. Most of the rest have been charged with a crime but are ill and not competent to stand trial.

State hospitals in Ohio provide short term care. Because medicaid will not pay for care in a psychiatric hospital but will pay for psychiatric care in a general hospital, there is an incentive for the use of general hospitals for psychiatric patients. A local Board may have nothing to pay for an admission to a general hospital (due to medicaid) but may have to pay $329 a day for a State hospital admission. For this reason, State hospital admissions, which constitute about 6000 per year, are mostly short term admissions.

Treatment resistant people are housed in normal housing both as a matter of ideology (not wanted to establish structured institutional community care) and strategic (less expensive). Case management is funded by medicaid and the rules, training, and promotion can be produced efficiently. Community based clinics have case managers who see patients about once a month and provide support to enable the patients to reside with family or friends. The advantage of this approach is that patients who like freedom will do okay. The disadvantage is that there are more possibilities for neglect and the possibility of criminalisation of the mentally ill. In that regard, it is estimated of the 46,000 people in prison, 10-12% have a serious mental illness. It is also the case that the number of people incarcerated who suffer from a mental illness has dramatically increased in the last 15 years.

Unintended consequences of mental health reforms across the US, with their shift to local responsibility for the care of the mentally ill, has been the diminished State investment in the problem of mental health care. Funding at a State level has been steadily decreasing. Generally, in the US, there has been less investment in the mentally ill. Politically, there has been a decrease in the significance attached to mental illness. For example, separate mental health agencies have been merged with health departments. Also, now, in only 12 States is the Director of Mental Health a member of the Governor’s cabinet.

Most consumers like the clinic system in preference to the hospital system. Primary leadership amongst consumers has not been around rights but empowerment and access. In Ohio, there are about 100,000 people with a serious mental illness. 250,000 services a year are provided to the mentally ill, with 5000 admissions to hospital. Court processes are therefore a rare event that do not affect most people at all. Only about 3-4% of people with a serious mental illness go to hospital. A local mental health service, serving a population of 160,000 might have only 100 episodes of hospital admissions a year.

Within this structure of mental health service delivery, the Department’s role is that of funding and monitoring services provided by others. It provides funding to county mental health boards, who then distribute that funding for mental health services in the relevant catchment area.

Franklin county – Alcohol, Drug and Mental Health Board
I met with David Royer, CEO of the Alcohol, Drug and Mental Health Board of Franklin County, Ohio and other members of that Board.
Franklin county is a county of about 1 million people. It is the second largest county in Ohio in terms of population yet has the smallest physical size as it is constituted in Columbus.

The Board administers an annual budget of $100 million. It has a staff of 61 people and spends $5.2 million on administration. The Board sees its tasks as follows:
1. Assess, evaluate needs, prevention and treatment;
2. Make plans to address the needs assessed;
3. Contract with non-government agencies to provide services;
4. Monitor and evaluate services contracted.

Thus, Ohio has a two level contract and monitor programme – State to county, and county to non government organisation.

Legal system
Michael Evans and Dr Charlie Chesanow provided me with information about the court system. The system is similar to other jurisdictions mentioned in this report and will not be repeated here, except where there are differences.

A notable area of difference is the appointment in each instance of an independent psychiatrist to review the patient prior to the review. This psychiatrist is appointed by the court, examines the records and sees the patient, and reports to the court.

Until the late 1980’s, the court used to hear from the treating psychiatrist, and an independent psychiatrist appointed for the patient. Now, generally the court relies upon the psychiatrist it appoints. For general matters, the only psychiatrist to give evidence is the appointed psychiatrist, though the patient has the right to request independent evidence. However, given that the independent expert usually agrees with the court psychiatrist, there is no need for that person to testify.

Most applications for involuntary status are agreed. If a patient agrees to treatment, his or her court records can be expunged and the patient can still say that they are voluntary patients. If a patient signs in voluntarily, but refuses to cooperate with treatment, then an application can be made to the court. If it can be shown that the patient was refusing to cooperate, then the patient loses the right to re-sign voluntary admission forms.

In relation to consent, if a patient agrees to the treatment plan, there is a presumption that they have the capacity to consent to treatment.

Where a patient disputes treatment, there has to be a hearing about the need for treatment. That hearing may or may not occur simultaneously with the hearing about involuntary status.

I was advised that most counsel adopt a ‘best interest’ model of representation.

Netcare
Netcare is a ‘front door’ service. It provides services to the mentally ill on the basis of a contract with Franklin county.
Netcare runs two 24 hour crisis centres and 17 assessment centres across the county. It seems about 16000-18000 clients a year and makes about 490-500 assessments each month. It has admitting privileges to the State hospital, on either a voluntary or involuntary basis.

Twin Peaks hospital
I toured this psychiatric facility and met relevant people. By US standards, it was a fairly modern and better facility. It has only secure beds. Wards hold 24 beds. In the late 1980’s, the hospital housed between 800 and 900 patients. It now has about 150 patients, half of whom are forensic. The hospital offers acute care and the average length of stay is between 10 and 12 days. Many patients change from involuntary status to voluntary status during their stay.
CINCINATTI, OHIO

Mental Health system

I first met with Ms Alice Gray, the Director of Support Services at Summit Behavioural Centre, the largest State hospital in Cincinatti. The average daily population of this hospital is 210 patients, of whom 60% are forensic patients. I later toured this facility. Like many such facilities, it reflects its past role as custodian to thousands. More recently, some of the facility has been redeveloped to better reflect modern treatment and therapeutic values.

On 2 May 2001, I was able to observe a number of reviews conducted at the Summit Behavioural Centre. A description of those reviews is now provided:

All reviews observed occurred at the Centre.

First review. Duration: 2 minutes. The patient did not attend this review.

Decision: On the basis of the doctor’s and the case manager’s reports, the order was continued and a full hearing scheduled for October 16 (5 months).

Second review. Duration 10 minutes.
Patient did not attend the review (still in bed). His appearance was waived by his counsel.
Evidence (from treating psychiatrist): Patient has paranoid schizophrenia. Patient reports no mental illness, hardly sleeping or eating. Condition deteriorated since being in hospital. Refusing medication. Worst I have seen him. Last time, in hospital for 30 days. Stopped medication on discharge. At this point, the patient has no capacity to give informed consent. His condition is already worsening due to no medication.
Second doctor: Agrees medications appropriate. Patient avoids medicine and food to be pure. Defence: no questions asked.

Decision: satisfied to relevant standard (clear and convincing) that patient does not have the capacity to give informed consent. Treatment in patient’s best interests. No less restrictive option. Request for treatment granted. Full hearing July 17 (11 weeks).

Third review. Duration: 2 minutes
Patient did not attend review – said that she did not want to come. Defence lawyer advised that patient had told him the previous day that she did not want to come. Evidence: Part A satisfied (substantial disorder of thought). Part B (danger). Meets B passively. Urinates on self, won’t go outside etc. Psychiatrist agreed with treating doctor’s diagnosis of schizoaffective disorder. Defence: no questions asked.

Decision: Patient has a mental illness, in need of treatment, no less restrictive alternative. Order granted. Full hearing July 25 (12 weeks).
Fourth review. Duration: 10 minutes.
Patient did not attend review. Told lawyer that he would not be coming and that he expected to be kept for a few more days. Presence waived.

Independent psychiatrist: met with him. He suffers from schizophrenia, and the disturbance to his thought, mood and perceptions are substantial. There is a grossly adverse impact on his behaviour. Patient denies his illness. When patient stopped his medication, his support system fell apart. Risk of harm: actively or passively to himself. Paraplegic. Jumped off bridge. Said he was thrown off by God. Suggested that prospects with medication good and could say that with a reasonable degree of psychiatric certainty. Defence: No questions asked.
Decision: Order granted. Full hearing July 25 (12 weeks).

Fifth review. Duration 6 minutes. Patient attended review.
Independent psychiatrist: Patient does not satisfy Part A or B. (Private meeting between magistrate and two attorneys.) Met with patient previous day. Dominant impression, angry man. Significant disturbance of thought, but not substantial. Defence lawyer: Moved to dismiss.
Decision: Application dismissed. (Patient had been in prison for 20 years. His family were afraid of him and wanted him kept in custody. Though the patient had a history of mental illness, the psychiatrist was not satisfied that he satisfied the criteria at the time).

Sixth review. Duration 7 minutes. Patient attended review.
Evidence: Opinion patient has organic personality disorder secondary to motor vehicle accident. He has major depression with psychotic features. His thought/mood disorder are substantial. Risk to self: passive. Prognosis: fair with treatment. He should stay in hospital. He does not have capacity to consent to treatment. Defence: no questions asked.
Decision: Order granted. Full hearing October 17 (5 months).

Seventh review. Duration 4 minutes.
Application for referral to mental retardation services. Not opposed.
Eighth review. Duration: 18 minutes. Patient present.
First witness: cousin of patient. Last 30 days contact: seen patient in group home, twice a week. Then received a phone call from Mercy Connection. Patient injured badly, broken bones from fall. Doesn’t feed himself. Lost 30 pounds. Personal hygiene poor. They were concerned with his well-being and suggested he be brought to hospital. However, patient left home. Witness found his cousin in an abandoned trailer. Witness explained that he had cared for his cousin for 11 years and that a grant of probate made it a lot easier for him to care for his cousin. Without probate, the patient gets worse and it is harder for him to recover.

Second witness: Case Manager community programme. Has seen patient in last 30 days. His personal hygiene is way down. Dirty, shaking badly, extremely anxious, fixed delusions. Patient not complying with treatment plan. Not attending appointments as stipulated.

Third witness (independent psychiatrist): Opinion that patient has long term illness (schizophrenia) complicated by alcohol abuse that exacerbates his mental illness. Substantial disorder? Disorder still there but reduced, not quite substantial. Outside hospital setting, prone to regress when off medication and on alcohol. Needs hospitalisation until stable. On admission, was substantial disorder of thought, perception, mood. Very vulnerable to continued relapse.
Defence: No questions asked.

Decision: Order granted. Full hearing 25 July (12 weeks).

Ninth review. Duration: 9 minutes. Patient present.
Decision: Adjournment application granted.

Summary: nine reviews were conducted in ninety minutes, utilising sixty minutes of hearing time. In five instances, patients were present. The results were: one patient discharged, one referral to mental retardation services, one adjournment and six orders continued. Average hearing time: under seven minutes.

Therapeutic jurisprudence conference
The second International conference on therapeutic jurisprudence was held at Cincinatti between 3 and 5 May 2001.

There were two main themes to the conference. The first theme was the development of therapeutic jurisprudence as a consequence of the excesses of the law. Whereas in early times, the legal man in the village was seen as the bringer of peace and the determiner of disputes, this image has now been subsumed by the image of ambulance chasing attorneys. Therapeutic jurisprudence seeks to redress the balance and bring the law back into better repute by looking at law in its context. Secondly, time was given at the conference to the concept of restorative justice to improve society and provide a better way forward than mere punishment orientated justice. There were a number of notable speakers at the conference, including Bruce Winick and David Wexler, who founded and have promoted therapeutic jurisprudence, John Braithwaite,
Professor of Law at Australian National University, Professor Michael Perlin, who has written extensively on mental health law and Professor Robert Schopp, also a significant writer on mental health law and issues. My own paper presented at the conference was a comparative piece on mental health review systems in Australia and overseas and was based on my observations of reviews in many jurisdictions.
UNITED KINGDOM

Overview
In London, I met with Ms Mary Kane, the Regional Chair of the Mental Health Review Tribunal. I had extensive discussions with Ms Kane, and also attended a review day though, as it transpired, I was unable to observe a review because the one patient being reviewed that day had been discharged from involuntary status the morning of the review. In the context of attending a hospital for the purposes of observing a review, I also had the opportunity for a brief tour of that facility.

The system of reviews in Australia is based upon the 1959 Mental Health Act in England. This in turn was based upon the Percy Commission, established to review mental health legislation in England and operative between 1954 and 1957. Consistent with the Percy Commission, the 1959 Act established the Mental Health Review Tribunal. In particular, the Commission recommended that the decision to make a person an involuntary patient be reviewed by an independent tribunal, at the patient’s request. The Commission recommended that the Tribunal include non-medical members who should be people with experience of judicial or administrative purposes and knowledge of the social services.

Although in many ways the solutions that it proffered would not be generally accepted today, at least in Australia, the Percy report indicates a willingness to grapple with some fundamental issues that has often been sadly lacking since.

An interesting aspect of the Percy Commission recommendations was that in response to the issue of independence, the Commission recommended that the Tribunal medical members personally examine the patient before the review. In this way, the Commission considered that the members would not have to rely upon possibly biased information. This pre-examination continues in Great Britain today, though it is now recognised that it has the potential to compromise the Tribunal, with a member being both a witness and part of the decision-making group.

Relevant legislation
The British legislation has been amended over the years and, in recent times, has been extensively reviewed on several occasions. The current relevant legislation is the Mental Health Act 1983, as amended.

The Mental Health Act 1983 (the UK Act) provides a definition of mental disorder as follows:
‘mental illness, arrested or incomplete development of the mind, psychopathic disorder and any other disorder or disability of mind.

A person who suffers from ‘mental disorder’ generally may be detained for assessment for up to 28 days provided that it is established that the patient is a risk to his or her own health or safety or for the protection of others. (Broadly, these are the same criteria that apply in Western Australia). Unlike the Western Australian legislation (the Mental Health Act 1996), the UK Act goes on to distinguish between four classes of mental disorder: mental illness, psychopathic disorder, severe mental impairment, and mental impairment. The vast majority (over 98%) of persons
admitted involuntarily for treatment are classified as suffering from a mental illness. This is not defined in the legislation but includes bipolar disorder and schizophrenia.

An application for hospital assessment may be made by an approved social worker, or the person’s nearest relative, upon medical evidence. If continued assessment is required, then a further application can be made, for two periods of six months, and then annually if still required. Once a patient is committed to hospital, the patient may apply for a review by the Mental Health Review Tribunal. The Tribunal must discharge from involuntary status unless satisfied that the relevant criteria are met, either forthwith or at a specific future date (in contrast, the Western Australian legislation only allows for immediate discharge). An appeal lies from decisions of the Mental Health Review Tribunal to the High Court.

The UK Act carries provisions about the appointment of counsel and legal representation is now generally the norm in the UK. Legal practitioners are appointed to represent the patient from a panel that is non-exclusive and is open to all admitted solicitors, trainee solicitors and others. Service providers are not legally represented in the UK.

The UK Act allows for detention for assessment for 28 days in the normal course of events. Therefore, the Act provides that the tribunal shall hear any application made by or in respect of a patient within seven days of its receipt. In Western Australia, currently requested reviews are heard within 12 days of receipt of the application on average.

In 2000, a ‘white paper’ was published considering some aspects of mental health law in England. This document, which was the product of the Working Party on Psychiatry and Human Rights, a subordinate body of the steering committee on bioethics, was produced by the Parliamentary assembly of the Council of Europe. The working party’s criteria for involuntary placement in a psychiatric establishment and for involuntary treatment are generally consistent with the current provisions in Western Australia. In fact, the criteria for involuntary placement or treatment are virtually identical and are:

(a) the existence of a mental disorder must be recognised or assessment required to determine whether a mental disorder is present;

(b) The mental disorder must represent:

(i) a serious danger to the person concerned (including his/her health); and/or

(ii) a serious danger to others (provided that the placement or treatment or both are likely to be beneficial to the person concerned)

(c) the person in question is capable of consent and does not consent to the placement or treatment or the person is incapable of consenting to treatment and refuses placement or treatment;

(d) Means of giving the patient the appropriate care which is less restrictive than involuntary placement are not available.

The paper proposes that admission be by examination by a psychiatrist or medical doctor with the decision to be confirmed by a ‘relevant independent body’. The Committee made no recommendations about this body save that it be independent from the one that proposed involuntary treatment and that the body should ensure that
social care aspects are duly taken into consideration. The committee did not recommend compulsory legal assistance.

Commentary on UK review process
The UK Act is based on the Mental Health Act 1959. This latter Act was the first that required review of the decision to admit a person by an independent body. The UK Act remains relevant to current standards, but the Tribunal established under the Act is compromised by the fact that its psychiatrist member is required to assess the patient before the review and is then required to be part of the decision-making panel. It is expected that this situation will be challenged now that the UK Human Rights Act has commenced operation and it seems evident that the UK Act will require amendment in this area, at least.

At a practical level, the Tribunal in the UK seems to operate in a very inefficient manner. This is partly due to the closure of large facilities and the establishment of much smaller regional facilities within a city as large as London. The new facilities are widely spread and travel time between them is high. It is also partly due to the requirement of a review within 7 days of request. For example, this requirement can have the effect of requiring the Tribunal to attend the same place on successive days to conduct just one review at that place each day. The consequence of these factors is that the Tribunal only lists two or at most three reviews a day and sometimes, like the day I observed, only one. I was advised that the Tribunal has up to 12 panels working simultaneously. If the panels are only reviewing two patients a day, at a cost of over 2000 pounds a day per panel, then the mechanism of review in the UK is very expensive indeed.
WORLD HEALTH ORGANISATION: GENEVA

In Geneva, I met with Dr Benedetto Saraceno, Director of the Department of Mental Health and Substance Dependence in the World Health Organisation (WHO). I also met Dr Jos Bertolote, a WHO psychiatrist who used to head the Division now headed by Dr Saraceno, Dr Michelle Funk, Department of Mental Health (currently writing a ‘primer’ for less developed nations with Ms Natalie Drew) and Dr Alexandra Janca, Consultant psychiatrist, WHO. At the WHO, I was provided with a copy of the world mental health fact sheet, reference to which was made at the commencement of this report. I was also invited to be a consultant to provide comment upon the draft report that will be made available later this year.

The World Health Organisation last year considered whether to seek amendments to the UN Principles document, as it has long been recognised that the document has some internal inconsistencies and pays less attention to the rights of other persons besides the person suffering a mental illness (for example, carers) than is now considered desirable. However, the WHO concluded that it would not be feasible to consider amendments to this document. It is likely that the time taken to get the UN Principles established (approaching twenty years) was a significant factor in resisting the possibility of amending the principles.

I made enquiries about the mental health system in Switzerland. However, I was not able to either meet with local mental health staff members or see a local mental health facility. I was advised that as Switzerland was a conservative country its laws in relation to mental health matters were probably neither new nor protective of human rights.
SINGAPORE

I had intended to meet with Professor Kua Ee Heok, Chief Executive Officer of Singapore’s only hospital established under the Singapore’s Mental Disorders and Treatment Act but it was not possible to do. However, I obtained a copy of the Singaporean legislation.

The Singaporean legislation was first passed in 1952 and reflects that era. Admission to hospital is based upon an examination by a medical officer who may admit the patient for 72 hours. The patient can then be admitted for a further period of one month and thereafter indefinitely (by annual orders) following examination by two medical officers, one of whom shall be a psychiatrist, who shall examine the patient separately. The Singapore legislation provides no external review mechanism except that an application can be made to a court for an inquiry into the patient’s unsoundness of mind if it is shown to the court that the patient’s unsoundness of mind has ceased. It is not clear who is to initiate such an application and on what basis the court would consider it. Although no statistics are available, it would seem inevitable that recourse to that section, in a piece of legislation without acknowledgment of the rights of involuntary patients, is very rare indeed.
COMPARISON: WESTERN AUSTRALIAN MENTAL HEALTH ACT 1996

The admission process under the Mental Health Act 1996 (the Act) is closest to the UK system and different from the US system. The Act requires a referral by medical practitioners or authorised mental health practitioners for assessment by a psychiatrist and allows a psychiatrist to make an order for involuntary status, either in the community (Community Treatment Order) or in an authorised hospital.

Upon admission to involuntary status, an involuntary patient has access to the Mental Health Review Board, a board consisting of psychiatrists, legal practitioners and those who are neither psychiatrists nor legal practitioners. The Board was established under the Act to review involuntary patients on a periodic (mandatory) basis or upon request. Mandatory reviews are required to occur as soon as practicable and before 8 weeks have elapsed since an involuntary order was made. However, a review may be requested at any time and can occur within a short time after request.

The procedure of review is more flexible here than in the US, as the Act requires the Board to act according to equity, good conscience and the substantial merits of the case without regard to technicalities and legal forms. (In general terms, Boards or Tribunals are created precisely because they provide quicker and more informal and less ‘legalistic’ proceedings.) In WA, the Board is required to consider matters beyond the legislative requirements for involuntary status. It is to have regard primarily to the psychiatric condition of the person concerned and is to consider the medical and psychiatric history and the social circumstances of the person.

In WA, there is no mandated legal representation, though as a matter of practice, all patients are advised of their right to legal representation and of the agency (the Mental Health Law Centre) that has been established by government to provide that representation. It is concerning that even with full notification to patients of the availability of legal advice/representation, the percentage of involuntary patients reviewed without representation remains above 80%.

The majority of involuntary patients (approximately 65%) are taken off that status by their psychiatrist within the first 28 days of the order. Of the patients reviewed by the Board, the rate of discharge of involuntary orders in Western Australia has declined since the Act commenced. In the first months following the introduction of the Act, the rate of discharge was 10%. It has since steadily decreased and is now about 3-4%. For the reasons provided earlier in this report, this is not a surprising result and does not reflect on the Board’s decision-making capabilities. The number of scheduled reviews that are cancelled in WA because the patient is discharged from involuntary status after the review was scheduled but before it was completed has slightly decreased since the Board commenced operations. Whereas in the first two or so years since the Act started, the rate of cancellation prior to review was approximately 40%, it is now approximately 35%. Thus, 5% more reviews are actually proceeding.

The standards of hospitals in WA exceeded all that I saw overseas. Even some of the wards of some of Perth’s older facilities, for example, Graylands, are, though in need
of replacement, of better standard than what I observed. As earlier indicated, the hospitals I observed consisted entirely of secure facilities whereas each facility in WA has both secure and open wards, providing a graduated pathway for return to the community for those recovering from acute episodes of mental illness.

The focus arising from the National Mental Health Plans and the State based services is that of community based care being the primary source of provision of mental health services in WA. Various models of community based mental health care were observed overseas. Each would appear to have positive and negative elements.

In terms of medication, cost was a significant factor in decision-making overseas. In contrast, I have not heard that the cost of medication is a relevant factor in determining what medication to use in WA. Rather, the focus in WA has, to my knowledge, been on what medication appears to have been most effective for the patient, taking into account all relevant factors, including the patient’s willingness to take it. (A theme that arises in WA is that of psychiatrists resorting to the use of older injection medications because the patient is unable or unwilling to continue to take newer oral medications).
CONCLUSION

When overseas, I was able to observe, either directly or indirectly, a number of mental health systems and, within them, systems of review. A wide variety of review systems were noted, ranging from formal court based legal proceedings in US jurisdictions, to the quasi-judicial proceedings in the United Kingdom (sharing some characteristics with the model in use in Western Australia) to the system in Singapore that provides for no legal review of the decision to make a person an involuntary patient.

The WHO report referred to at the commencement of this report reflects the diversity of mental health systems in the world, and the paucity of resources allocated to mental health in many areas in the world. Where there are models of review, there are significant differences in those models, though not in outcomes, given the fact that in most jurisdictions the number of persons discharged from involuntary status by court or tribunal is very low.

The fact that review systems result generally result in a very low rate of discharge of involuntary orders is not surprising, given the degree to which any system is likely to be ‘self-levelling’. That is, where there is legislative criteria for involuntary status, that criteria will become known to those that use the legislation who will then be able to make an informed decision about what is likely to be granted and what is not. Thus it should logically follow that the rate of discharges from involuntary status by courts or review boards is quite low. If this were not so, it would be very alarming, because it would suggest that the legislative criteria were being ignored. It seems therefore to be a false ‘test’ to assess the performance of a court or board making decisions about involuntary status by the number of discharges that it makes. This is akin to suggesting that a criminal court should be criticised for only finding guilty a low percentage of those that come before it and does not reflect an adequate understanding of the role played by review bodies in the area of mental health. Rather, it is important to always bear in mind the principle underpinning independent review as a symbol of the regard held by society for the importance placed upon state based intervention and interference with a person’s liberty.

Types of due process safeguard vary, depending upon the jurisdiction. US states visited seem to place, at least at face value, a high regard on due process safeguards. However, it is important to bear in mind the contextual issues that led to the development of these safeguards. For instance, the criminal system in the US, upon which their due process safeguards are based, is very different from the criminal system here and was developed in very different circumstances. Therefore, considerable caution is required in the promotion of the US civil commitment system to other jurisdictions with a different history. It is also worth noting that the examples of the US civil commitment system observed clearly demonstrate that there is often a wide gulf between law and practice. What for example is the benefit of a due process entitlement to an attorney if the attorney asks no questions in a review? Although this could be explained by the suggestion that each patient still had the benefit of advice about his or her commitment, some would reasonably question the value adding that occurs in a process where an advocate is silent.
The UK mental health review system is closer to the system operational in Western Australia. The UK Tribunal is distinguished by its unusual constitution with the tribunal medical member both assessing a patient and then participating in a decision about that patient’s status. In contrast, in Western Australia, the medical member, like all members, receives information from both the treating team and the patient and then makes a decision on that information without conducting an assessment of the patient during the course of the review.

Time frames for mandatory reviews varied between jurisdictions. For example, California requires its first review within a few days of admission but other States such as New York, require a mandatory review of involuntary status only before 60 days have elapsed. Because in all jurisdictions in the US and UK patients can appeal against admission, the practical effect of the differing times for mandatory review is probably quite negligible. As was noted as long ago as the 1950s in the Percy report, even an early review cannot satisfactorily review the decision to admit because even in a short time the patient’s mental condition may have improved or deteriorated. Therefore the purpose of a review, whenever it occurs, is to consider the patient’s mental condition at the time of review, and to decide whether the involuntary status order should be continued.

Assuming that patients are admitted because of an acute episode of illness, it follows that reviews that occur within two or three days of admission are even less likely than reviews that occur subsequently to be ‘successful’, that is to result in the discharge of the patient from involuntary status. This is because a person’s condition is likely to improve over time. The argument in favour of early mandatory review is therefore not the likelihood of discharge but rather that the decision to place limitations upon a person’s autonomy is such that society requires an early external review of the decision. This is a very important consideration but one which should be considered in the context of the overall legislative scheme. In Western Australia, for instance, although the period of mandatory review is extended, patients may immediately upon being made involuntary request a review.

More broadly, it is evident from my observations overseas that protections for patients cannot be appropriately considered in terms of legal protections alone. For example, there appears to be little point in having due process provisions in place if the services ultimately offered are provided in grossly inappropriate facilities using inappropriate medications and poor treatment methods. If mentally ill persons are not receiving the treatment they require due to issues of personal liability (there being no statutory indemnification in the US), that would appear to be a matter of grave concern. Although such concerns seem not to be at the forefront of the minds of human rights’ advocates, it could be argued that a denial of any opportunity for appropriate treatment for a person’s mental illness is as much a breach of human rights – or more - as an arguably inappropriate infringement of a person’s liberty.

In these circumstances, a more global view of protections is required so that legal issues can be considered in the context of the overall health of the mental health sector. Clearly, a focus solely on legal protections to the exclusion of considerations of other relevant factors, notably including the capacity of the mental health sector to deliver services required by clients in a culturally appropriate and context relevant way, is a misleading focus. It would appear much more prudent and useful to
concentrate on improving all aspects of mental health service and delivery, including legal protections that, though vital, remain just one important part of the whole mental health system.
APPENDIX A: PLACES AND PERSONS VISITED

Sacramento, California
Dr Stephen Mayberg, Director California Department of Mental Health
Ms Angela Lazarow, Chief, Office of Human Rights, California DMH
Mr Carl Elder, Chief Counsel, Office of Legal Services, CDMH
Dr Norman Black, Senior Staff Counsel, Office of Legal Services, CDMH
Ms Susan Andreani, Federal Legislative Liaison, CDMH
Mr John Rodriguez, Deputy Director, Long Term Care Services, CDMH

Sacramento Community Mental Health Facility: given tour of this mental health facility and also given opportunity to observe reviews conducted

Phoenix, Arizona
Mr Jack Silver, Chief Executive Officer Arizona Department of Health Services (ADHS)
Dr Jerry Dennis, Chief Medical Officer Arizona (ADHS)
Ms Vicki Staples Manager ADHS
Ms Judi Higginbotham, Human Rights Coordinator, ADHS
Lunch time meeting also included:
Judge Mundel Mental Health Justice Maricopa County Probate Court
Ms Josephine Jones Attorney Public Defender’s Office
Mr Joel Rudd, Assistant Attorney General (representing hospital)
Ms Pat Razo, Director of Social Work, Arizona State Hospital

Austin, Texas
Ms Karen Hale, Commissioner Texas Department of Mental Health and Mental Retardation (MHMR)
Mr Mark Blockus, Assistant Director Community Systems Management MHMR
Mr Michael Maples, Behavioural Health Services MHMR
Mr Ken Dudley, Director Mental Health Services MHMR
Ms Roshunda Farmer, Director Government Affairs MHMR
Dr Clifford Moy, Clinical Director MHMR
Mr Frank Genco, Public Policy Officer Texas Council for Developmental Disabilities
Ms Amy Mizcles, Public Policy Director NAMI Texas
Judge Guy Herman, Probate Court, Texas

New York City, New York
Mr Joe Lazar, Director, New York State Office of Mental Health
Mr Marvin Bernstein, Director Mental Hygiene Legal Service
Mr Stephen Harkavy, Deputy Director Mental Hygiene Legal Service
Dr John Lesser, Director New York City Dept of Mental Health Mental Retardation and Alcoholism Services
Mr Isaac Monserrate, Assistant Commissioner, Department of Mental Health,
Columbus Ohio
Dr Mike Hogan, Director Department of Mental Health
Dr Dale Svendsen Medical Director Department of Mental Health
Mr Mathew Rucker Executive Director, Community Support Network
Mr Lon Herman Program Director, Residency, Training and Learning Initiatives
Mr David Royer, CEO of Alcohol, Drug and Mental Health Board
Dr Charles Chesanow Psychiatrist, ADAMH
Ms Sandy Applegate Network Services Manager, ADAMH
Mr Michael Evans Counsel for mentally ill persons
Ms Bobby Fulton, President, Netcare ‘front door’ to services in Franklin County
Mr Jim Ignelzi, CEO Twin Peaks Psychiatric Systems
Mr Lon Herman, Program Director Residency, Training and Learning Initiatives Ohio Department of Mental Health (ODMH)
Dr Dale Svendsen, Medical Director ODMH

Cincinnati, Ohio
Ms Beth Erdman, CEO, Summit Behavioural Care, Cincinatti
Summit Behavioural Care: given tour of this facility and observed reviews
Ms Pat Wamsley, Legal Assurance Administrator
Mr Eric Sis, Quality Control Administrator
Mr Mark Combs Chief Trial Magistrate Hamilton County Probate Court
Ms Valerie Barber Forensic Monitor
Ms Susan Rivers Payne Clinical Nurse Practitioner/Consumer Wellness Project

Therapeutic Jurisprudence Conference, Cincinatti
Professor Bruce Winick
Professor David Wexler
Professor Michael Perlin
Professor Paul Stavis
Professor Robert Schopp
Dr Alan Tomlinson
Professor John Braithwaite

London United Kingdom
Ms Mary Kent, Regional Chair Mental Health Review Tribunal

Geneva Switzerland
Dr Benedetto Saraceno, Director Department of Mental Health and Substance Dependence World Health Organisation (WHO)
Dr Bertolote, WHO
Dr Michelle Funk, Department of Mental Health WHO
Ms Natalie Drew, Department of Mental Health WHO
Dr Alexandra Janca, Consultant Department of Mental Health WHO
APPENDIX B: RESOURCE MATERIALS RETAINED AT THE BOARD’S OFFICES

California:  California Department of Mental Health (1999) A compendium of Long Term Care Services  
California Judges Benchguide portion relating to mental health  
Joint Committee on Mental Health Reform (2000) Report of the public hearings (mental health)  
Joint Committee on Mental Health Reform (2000) Report of the public hearings on mental health reform and findings and recommendations as adopted by the Senate Select Committee on Developmental Disabilities and Mental Health  
Little Hoover Commission (2000) Being there; Making a commitment to Mental Health  
Patients’ Rights Advocacy Manual  
Superior Court Cases: John Doe v. Gallinot 486 F.Supp 983 (1979)  
Reise v. St Mary’s Hospital and Medical Centre (1987) 209 Cal.app.3d 1303  
Superior Court (2001) copy actual application for involuntary status  
Welfare and Institutions Code select portions relating to Mental health

Arizona  
Arizona Laws relating to mental health, including criminal matters and sexually violent offenders  
Series of newspaper articles on the mental health system in Arizona January 2001

Texas  
Texas Laws relating to Mental Health and Mental Retardation (12th Edition)  
An analysis of the Texas Mental Health Code Churgin MJ  
Information regarding the services provided by the Austin State Hospital  
Mental Health Speech Judge Guy Herman, Travis County Probate Judge

New York  
Kingsboro Psychiatric Centre (2000) Patient orientation booklet  
Mental Hygiene Law Admissions process spreadsheet  
Supreme Court (2001) Copy actual papers filed in court for an application for Assisted outpatient Treatment (‘Kendra’s law’)  
Office of Mental Health (1996) Rights of Inpatients in New York State OMH psychiatric centres  
Police Mental Health Training Program (1999) Officer’s Guide
Ohio
Carhahan W A (2001) *Lessons from the Japanese: collective choice in public policy decisions to care for and treat the mentally ill in Japan*
Ohio Department of Mental Health (1999) *Clients rights* information booklet
Ohio Department of Mental Health (1999) *Towards best practices: Top ten findings from the longitudinal consumer outcomes study 1999*

United Kingdom
Statistics and Graphs relating to operation of the MHRT
‘White Paper’ (2000) *Paper on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric system*

Geneva

Singapore
*Mental Disorders and Treatment Act*
APPENDIX C: Flowchart of involuntary admission in California
Certification Flowchart

72 hours

5150

(danger to self; gravely disabled, danger to others)

Certification hearing

14 day

5250

Danger to self  Gravely disabled  Danger to others

no judicial review
14 day

5260

suicide certificate

(then must be discharged)

Certification hearing

30 day hearing

5270

Court ordered
180 day hearing

5300

Conservatorship
(1 year; Supreme Court judge)

(can repeat)

180 day hearing

(can repeat)
APPENDIX D: Committal papers, California
APPENDIX E: Executive Summary of the RAND Report, California