DEVELOPING NATIONAL CIVIL COMMITMENT LAWS FOR THE MENTALLY ILL

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I INTRODUCTION

This paper argues that Australia should develop national civil commitment laws[1] for the mentally ill, or, as a second preference, develop a model Australian legal approach that could be adopted by individual Australian jurisdictions. The main reasons for that view are as follows: the fundamental importance of such laws to the Australian community both from a human rights perspective and the perspective of community protection; the interrelatedness of the Australian mental health system including its legal, policy and service areas; the importance of international principles and treaties; greater accessibility of the legislation; improved data collection and monitoring; a more cost effective option on a systemic level; reducing cross border issues where two sets of State and/or Territory laws interrelate; and the significant problems with the present State and Territory approaches.

Currently there are no national mental health laws or national standards for such laws. Instead, the states and territories have their own laws, processes and institutions that deal with civil commitment. State and territory jurisdictions provide broadly similar legal approaches to civil commitment.[2] Each has a form of civil commitment on the basis of a mental illness that involves risks to the community and/or to the individual. Each jurisdiction has broadly similar legislation and decision-making systems for mental health and civil

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1 For the purposes of this paper, civil commitment means the use of the legal system to detain a person with a mental illness against their will for non-criminal behaviour in a hospital, psychiatric ward or other medical institution.

2 *Mental Health Act 1986* (Vic); *Mental Health Act 2007* (NSW); *Mental Health Act 2000* (Qld); *Mental Health Act 1996* (WA); *Mental Health Act 1996* (Tas); *Mental Health Act 2009* (SA); *Mental Health (Treatment & Care Act) 1994* (ACT); *Mental Health & Related Services Act 1998* (NT).

commitment including the use of specialist mental health review tribunals. Each contains objectives that attempt to identify and balance the protection of the individual consumer's rights and autonomy with the need for appropriate care and treatment, if necessary on an involuntary basis, and the right to protect the community from risk.

However, as discussed below, there are also significant differences between jurisdictions in the content and process of these laws, significant gaps in service provision, and there is a lack of a coordinated and consistent approach to the civil commitment of the mentally ill across Australia. A properly planned and resourced national set of laws with accompanying policy support would significantly reduce these problems.

The paper then argues that the best way to develop national laws would be through the establishment of a national, public inquiry into Australia's civil commitment laws for the mentally ill. The paper discusses the reasons for the need for such a national, public inquiry which include: the importance of the topic; the controversies that surround it; the number of complex issues and possible reforms involved; the need for broad consultation for major law reform; and the specific defects and concerns with current approaches by state and territory jurisdictions. Thus far, such an inquiry has not occurred and there has never been in Australia a national, State or Territory inquiry that has focused on civil commitment.

The paper then assesses the institution which would best carry out this inquiry. Finally, the paper explores the feasibility of achieving national laws.

II WHY THERE IS A NEED FOR NATIONAL LAWS

A *Civil Commitment is of Significant National Importance*

This part of the paper refutes perhaps a general argument against national laws that they are not justified because civil commitment is not important enough to warrant the effort of introducing such laws. Instead this part demonstrates the national importance of the issue.

The mental health of all Australians should be of paramount importance. Large numbers of Australians, apparently at an increasing rate, are directly affected by mental illness. For example, about one in

five Australians experience a mental illness episode during their lives while about one in ten report a long–term mental illness or behavioural issues at any point in time.[3] Estimates from the second National Survey of Psychosis conducted in March 2010 suggest almost 64,000 people have a psychotic illness and are in contact with public specialised mental health services each year.[4] Thus, civil commitment has a direct and dramatic impact on thousands of Australians each year together with their families, carers and friends, and an indirect impact on us all.

In 2006, the Senate Select Committee on Mental Health classified mental illness as the number one health problem in Australia causing years lost to disability and referred to mental illness as the 'disease burden' and 'the significant unmet need' for treatment and action.[5] The National Action Plan on Mental Health 2006-2011 estimated that the annual cost of mental illness in Australia is approximately $20 billion, including the costs from loss of productivity and participation in the workforce.[6] In addition, mental illness as a political and community issue is gaining greater prominence. Political parties are spending more time and more money on mental health as an issue. The Government introduced a $2.2 billion mental health reform package in the 2011-12 Budget.[7]

It follows that policy and laws relating to mental health issues should apply fairly and consistently to all Australians regardless of their origins, ethnicity, social class, education or place of residence. It is clearly a national issue involving the fundamental rights of individuals and the protection of the community.

Laws relating to mental illness occupy a very important position. As Unsworth argues, the legal system is a major force in the provision and effectiveness of mental health system: '[l]aw actually constitutes the mental health system, in the sense that it authoritatively constructs,

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3 Australian Bureau of Statistics, 'National Survey of Mental Health and Wellbeing: Summary of Results' (2007) <http://www.abs.gov.au>.

4 Australian Government, Australian Institute of Health and Welfare, *Mental Health Services in Australia* <http://mhsa.aihw.gov.au/home/>.

5 Parliament of Australia, Senate Select Committee on Mental Health, *A National Approach to Mental Health - From Crisis to Community*, Final Report (April, 2006), rec 2.2.

6 Council of Australian Governments (COAG), *National Action Plan on Mental Health 2006-2011* (14 July 2006) 1.

7 Australian Government Department of Health and Ageing <http://www.health.gov.au>.

empowers, and regulates the relationship between the agents who perform mental health functions.'[8]

Civil commitment laws can play a vital if not determinative role in addressing the rights of the mentally ill and ensuring that people who need treatment and care may receive it.

Civil commitment is the sharp end of the mental health system. It involves serious and often drastic consequences for individual consumers, their families, carers, friends and the community. It may abrogate, or at least significantly curtail, fundamental human rights such as freedom of movement, control of one's mind and body, freedom of choice of treatment or no treatment, and rights to dignity and respect. In broad terms of consequences it equates to penal powers with respect to criminal offences and it stands at odds with other types of illness which are categorised as bodily or non-psychiatric, where compulsory detention or treatment is rarely permitted, even if such treatment may be clearly in the interests of the patient from a medical viewpoint. There has perhaps been a tendency to gloss over the exceptional nature of civil commitment for mental illness because it has been used for so long and because it is widespread around the world. In addition, discrimination, stigmatisation and ignorance have led communities to undervalue the human rights of those with a mental illness. Therefore, it is important in any review of civil commitment laws to bear in mind that the powers of the state and its organs in this area are extraordinary and therefore need to be considered with the greatest of care.

Moreover, the mentally ill tend be one of the most marginalised groups in the community whose rights as to liberty, employment, education and decent housing can be ignored or minimised. A national set of laws would help to ensure that proper attention is paid Australia-wide to issues of their liberty. There are significant general barriers to access to justice for mentally ill people including those who wish to dispute or review civil commitment decisions and processes.[9] There are individual barriers such as lack of awareness of legal rights, being disorganised and exhibiting difficult behaviour and there are also

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[8] Clive Unsworth, *The Politics of Mental Health Legislation* (Clarendon Press, 1987) 5; see also, Bernadette McSherry, 'Rethinking Mental Health Laws: Developing Model Frameworks' (Paper presented at Criminal Justice Research Consortium Seminar, Monash Law Chambers, Melbourne, 19 February 2008).

[9] See, eg, NSW Law Foundation, *On the Edge of Justice: the Legal Needs of People with a Mental Illness in NSW* (Sydney, 2006) 96.

systemic barriers such as insufficient availability of affordable legal services, time constraints, being in remote or regional areas, lack of credibility from the perspective of practitioners, stigmatisation and discrimination. It is suggested that these factors also indicate that civil commitment is worthy of national legislation.

There has been a growing realisation that civil commitment involves serious human rights issues. Over the past 30 years an international trend has developed for an increasing interest in protecting the rights of the mentally ill. This trend is clearly observable in many Western countries.[10] For example, human rights jurisprudence particularly concerning involuntary detention, conditions of confinement, civil rights and access to mental health services has been growing in Europe and the Americas.[11] One aspect of that increased interest has been the development of international standards for patients' rights. While overall the jurisprudence of human rights in health care has developed slowly and in piecemeal fashion it is in the area of mental illness that jurisprudential growth has been more marked.[12]

The main objectives of civil commitment laws are clearly of fundamental national importance as they involve the rights of individuals and of the Australian community. These objectives must be carefully considered and balanced.[13] The two basic objectives are usually described as follows. First, commitment may be necessary to protect the community by stopping mentally ill people from harming others. A major concern with this rationale is the problematic nature of predictions of risk or dangerousness.[14]

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10 Hedy d'Ancona, 'Patients' Rights: Our Common Concern' in World Health Organisation (ed), *Promotion of the Rights of Patients in Europe* (Kluwer Law International, 1995) 2; Bernadette McSherry, 'Human Rights and Mental Illness: The Legal Framework' (1994) 1 *Journal of Law and Medicine* 205.

11 Laurence Gostin and Lance Gable, 'The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health' (2004) 63 *Modern Law Review* 20, 20-21.

12 Ian Freckelton and B Loff, 'Health Law and Human Rights' in D Kinley (ed), *Human Rights in Australian Law* (Federation Press, 1998) 267.

13 Ian Kerridge, Peter Saul and John McPhee 'Moral Frameworks in Health Care: An Introduction to Ethics' in Ian Freckelton and Kerry Petersen (eds), *Controversies in Health Law* (Federation Press, 1999) 276; David Kentsmith, Pamela Miya and Susan Salladay 'Decision –Making in Mental Health Practice' in David Kentsmith, Pamela Miya and Susan Salladay (eds) *Ethics In Mental Health Practice* (Grune & Stratton, 1986) 6; JK Mason and RA McCall Smith, *Law and Medical Ethics* (Butterworths, 4th ed, 1994) 6.

14 See, eg, C Lidz, E Mulvey and W Gardner, 'The Accuracy of Predictions of Violence to Others' (1993) 269 *Journal of the American Medical Association* 1007; JK Mason, 'The Legal

The second major rationale is that mentally ill people may themselves need protection in their own best interests through civil commitment, particularly because of severe mental illness. This justification is often regarded as a *parens patriae* protection. The rationale is controversial because it involves making decisions that infringe upon the autonomy and free choice of the individual and it is difficult to draw a clear line between when paternalism is justified and when it is not.[15]

The importance of achieving national standards for Australian mental health law including civil commitment has been recognised by a variety of experts from different disciplines. The five year project called *Rethinking Mental Health Laws: An Integrated Approach* was funded by the Australian Research Council and conducted by a number of academics, some other experts and some consumer representatives. The aim was to develop recommendations for developing model frameworks for mental health laws in both the civil and criminal law fields.

It is therefore crucial on the basis of the frequency of mental illness and its significant consequences, both for the basic rights and interests of individuals and the community, that an optimal approach to involuntary commitment is adopted across Australia. National laws after an appropriate national inquiry offer the best chance of these important issues being addressed and settled.

B *National Laws are the Best Response to International Principles and Obligations*

Modern mental health jurisprudence has a substantial foundation in international principles and treaties. In particular, the international principles and guidelines arising from the *United Nations Principles for the Protection of Persons with Mental Illness* (1991),[16] and the *Convention*

Aspects and Implications of Risk Assessment'(2000) *Medical Law Review* 69; DE McNeil, RL Binder and TK Greenfield, 'Predictor of Violence in Civilly Committed Acute Psychiatric Patients' (1988) 145 *American Journal of Psychiatry* 965.

15 See, eg, David Price, 'Civil Commitment of the Mentally Ill: Compelling Arguments for Reform' (1994) 2 *Medical Law Review* 321.

16 C Gendreau, 'The Rights of Psychiatric Patients in the Light of the Principles Announced by the UN' (1997) 20 *International Journal of Law and Psychiatry* 259; Neil Rees, 'Compliance with United Nations Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health Care'(2003) 10(1) *Psychiatry, Psychology and Law* 33.

on the Rights of Persons with Disabilities (2006)[17] have played a significant role in Australian law and commentary. Leaving the implementation of such international principles and obligations to the states and territories means the implementation is clearly subject to the vagaries of different legislatures which will often have divergent priorities and approaches. This can be seen by the fact that Victoria and the ACT have enacted human rights charters that have an impact on mental health issues whereas the other Australian jurisdictions have not done so.[18] The optimal approach that will guarantee consistency of approach and consistency of protection of human rights for all Australians is for national implementation of civil commitment laws including implementation of international principles and obligations. Moreover, it is preferable in terms of status and publicity of the principles and laws that it is the sovereign state which signed the treaties which legislates to make them part of domestic law. A national response will also make it far easier to monitor the administration and enforcement of such international obligations.

Moreover, in the course of formulating the national civil commitment laws consideration could be given to related national initiatives such as:

- the development of a national Mental Health Charter, as for example in the Netherlands, covering such matters as the rights of patients and the rights and responsibilities of medical practitioners and State institutions;[19]
- the development of human rights protections for the mentally ill under a general Australian Bill of Rights (on the basis that such a Bill is feasible in Australia);
- the roles of the Australian Human Rights Commission (AHRC),[20] the *Disability Discrimination Act 1992* (Cth), State and Territory anti-discrimination bodies, and ombudsman offices

Another significant benefit of Australia developing national, model civil commitment laws is that they could be adopted in other countries.

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17 Operative in Australia from 17 July 2008.

18 *Charter of Human Rights and Responsibilities Act 2006* (Vic); *Human Rights Act 2004* (ACT).

19 World Health Organization, *Promotion of the Rights of Patients in Europe* (Kluwer Law International, 1995) Chs 12-13.

20 The AHRC has power to inquire into certain alleged breaches of the ICCPR: see *Australian Human Rights Commission Act 1986* (Cth).

Australia could become a major leader and innovator on mental health law, thus helping to improve the quality of mental health law not just for Australians but for others.

C National Laws will be more Effective in Responding to the Interactive Nature of the Mental Health System Including Policy and Service Delivery

Another major reason for a national laws is that civil commitment laws need to be considered as a part of a system or number of systems or subsystems, for example, the health system, mental health system, and a subsystem of mental health law. The breadth of the topic and its context requires a national, broad based response. Mental health is an area where law, medicine, public policy and culture are inextricably linked. National policies, planning and service delivery will be better served by national laws than by a series of different State and Territory laws. This argument is borne out by a consideration of national mental health issues and the growing realisation that national policy and planning are vital.

There is already a considerable degree of consensus for adopting a national approach to mental health. There is a fourth national health plan which has set an agenda for collaborative government action in mental health for 2009-2014.[21] There is also an Australian Health Ministers Conference (AHMC) that meets regularly and a Mental Health Standing Committee that reports to the AHMC.[22] In addition, there has been a Council of Australian Governments (COAG) national action plan on mental health 2006-2011.[23] Moreover, Commonwealth, State and Territory governments are committed to implementing human rights principles as part of the National Mental Health Strategy.[24] As discussed below, there is now a national Mental Health Commission. A set of national laws for civil commitment fits in well with this developing national mental health strategy.

1 *General Concerns about Current Lack of Cohesion and Planning*

The current array of civil commitment laws reflects the fragmented framework for Australian health care. Under Australia's federal

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21 See Department of Health and Ageing <http://www.health.gov.au>.

22 Ibid.

23 Ibid.

24 Terry Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom and Treatment?* (Themis Press, 2011) 38.

political and legal system there is no one government with sole responsibility for health care. Instead, the Commonwealth and state governments have the capacity to have different and sometimes shared or conflicting responsibilities and powers. The Commonwealth has no power under the Australian Constitution in relation to health care generally. However, it can use various other powers to legislate in relation to health matters.

The states have residual powers, that is, those powers not exclusively those of the Commonwealth. Therefore it is the states who have direct power in relation to the delivery of health care, public health and the regulation of health professionals. The states have responsibility for hospitals and mental health law including civil commitment. This means that each state and territory jurisdiction has somewhat different legislative and policy approaches to civil commitment, although broadly speaking their legislation is similar. The Australian health care system is intrinsically differentiated because the Commonwealth provides funding for the health care system but the delivery and regulation of that system is essentially the responsibility of the states.[25]

Thus responsibility between the Commonwealth and the states is to some extent shared and this can present difficulties in developing one coherent and integrated mental health system for Australia. Moreover, on occasions the Commonwealth and states, and states with respect to each other, may differ over policy and funding priorities and this may make it even more difficult to develop a coherent, national policy. A further potential problem is that gaps develop in health care which may disadvantage certain groups within the community and there may also be cross border issues about patients who move between jurisdictions with differences in civil commitment laws.

There are general reservations about the lack of resourcing, planning, co-ordination, supervision, accountability, and access to services with respect to Australia's mental health system as demonstrated in the Burdekin report[26] and other reports from the Human Rights and Equal

[25] Peter JM MacFarlane, *Health Law in Australia & New Zealand Commentary and Materials* (Federation Press, 3rd ed, 2000) 29-31.

[26] Human Rights and Equal Opportunities Commission, Report of the National Inquiry into the Human Rights of People with Mental Illness ("the Burdekin Report") (1993), Select Committee on Mental Health, Parliament of Australia, A National Approach to Mental Health: From Crisis to Community, First Report, Canberra, 2006.

Opportunity Commission[27] and the Senate Select Committee on Mental Health.[28]

These difficulties together with a lack of consumer awareness mean that people 'muddle through' in terms of service delivery and their legal status which is often not based upon any rational pathway or patient choice.[29] For example, there is overlap and confusion about the roles of civil commitment, the criminal justice system and adult guardianship with the result that placement in the system may be haphazard and unprincipled.[30] This might require a clear and formal enunciation of principles and protocols that can be used for all service providers and decision makers.

While the focus must be on the legal responses to civil commitment, that topic needs to be put in its proper context. In reality, designing an ultimate model legal response to civil commitment would involve at least contemplating a best practice mental health legal system because of the interdependence of the components of that system. Civil commitment is but one component of the mental health legal system which consists of numerous parts including voluntary treatment and care and delivery of mental health services, inpatient civil commitment and mandated outpatient treatment. Each of these parts is closely interconnected. Civil commitment will be affected by, and in turn affect, the other components. For example, a move towards tougher, more legalistic rules may mean that more mentally ill people will be in the community with a consequent increased demand for community services and for involuntary community treatment, commonly known throughout Australia as Community Treatment Orders (CTOs). A trend towards looser rules that make it easier to use involuntary commitment is likely to result in the need for more in-house psychiatric hospital resources and beds.

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[27] See, eg, Sev Ozdowski 'The Human Rights of Mentally Ill People: the HREOC Inquiry and After' (Mental Health, Criminal Justice and Corrections Conference, Marrickville, 19 October 2001); Mental Health Council of Australia, *Not for Service, Experience of Injustice and Despair in Mental Health Care in Australia*, 2005.

[28] Select Committee on Mental Health, Parliament of Australia, *A National Approach to Mental Health: From Crisis to Community,* First Report, Canberra, 2006.

[29] Carney et al, above n 24, 7.

[30] John Dawson, 'Choosing Among Options for Compulsory Care' in Kate Diesfeld and Ian Freckelton (eds), *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment* (Ashgate, 2003) 133-134, 152-153.

High quality mental health services, particularly community ones including preventive and crisis intervention services, are likely to reduce the level of involuntary commitment. In contrast, inadequate services with gaps in delivery and effectiveness will likely lead to more civil commitment and moreover, likely lead to people who could have successfully used voluntary services deteriorating to the point where civil commitment appears to be the only option for them or instead they receive only very superficial assistance within the community.

2 *The Litigation System*

For litigation to be an effective tool for achieving objectives there needs to be effective access to justice for mentally ill people. Legal aid which is essentially funded and oversighted by the Commonwealth must be available as part of a wide range of advocacy services with respect to civil commitment. There should be a properly resourced legal system for dealing with civil commitment including: fostering partnerships and co-ordination between legal service providers such as legal aid commissions, community agencies and courts and tribunals to improve client access and the referral network; and providing an effective litigation system including legal assistance and representation allowing individuals to effectively pursue their rights and options to seek review and make complaints. These are broad national issues of planning and funding which can best be implemented and assessed when the same laws are used across jurisdictions.

3 *Adequate Resourcing for the Operation of the Laws and the Relevant Institutions*

A chronic and longstanding complaint about the Australian mental health system is the lack of adequate resourcing, particularly in relation to service delivery.[31] National laws will make it easier to identify funding and service delivery issues and make funding and planning more effective.

4 *Structural Issues and Reforms*

A major issue connected to civil commitment laws is the institutions that administer the law and monitor it. It is necessary to consider

31 The Burdekin Report, above n 26; Senate Select Committee on Mental Health, Parliament of Australia, *A National Approach to Mental Health - From Crisis to Community* (Final Report, April 2006); Mental Health Council of Australia, above n 26. Carney et al, above n 24.

which institution or institutions could undertake critical functions for developing a model, best practice system of civil commitment. The essential functions would include the following with respect to the laws and associated policy:

- planning, policy and co-ordination;
- supervision and monitoring;
- complaints handling;
- research and data collection;
- training and education;
- general advocacy for the mentally ill; and
- legal advice, research and policy.

Many countries around the world, including many common law countries, have developed mental health commissions, authorities or councils to carry out these sorts of functions, with typical functions being policy and supervision. There are such bodies, for example, in England,[32] Scotland,[33] Ireland,[34] New Zealand,[35] and Canada.[36] Discussion of establishing such bodies is not new in Australia.[37]

The Australian Government has recently established the National Mental Health Commission.[38] Its primary function is planning more effectively for the future mental health needs of the community, creating greater accountability and transparency in the mental health system and giving mental health prominence at a national level.

The NSW government has also established a Mental Health Commission with the key purpose to ensure that there is quarantined and accountable funding for mental health expenditure and that resources are focused on where they are most needed through the most appropriate models of care. Other priorities for the Mental Health Commission include:

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[32] *Health and Social Care Act 2012* (UK).

[33] Mental Welfare Commission for Scotland <http://www.mwscot.org.uk>.

[34] Mental Health Commission of Ireland <http://www.mhrcirl.ie>.

[35] New Zealand Mental Health Commission <http://www.mhc.govt.nz>.

[36] Mental Health Commission of Canada <http://mentalhealthcommission.ca>.

[37] See, eg, I Hickie et al, 'Australian Mental Health Reform: Time for Real Outcomes' (2005) 182(8) *Medical Journal of Australia* 401.

[38] National Mental Health Commission <http://www.mentalhealthcommission.gov.au>. It commenced operation on 1 January 2012.

- to better manage the experience of people with mental illness, their families and carers;
- divert people with mental illness away from the prison system; and
- help ensure a smooth operation of the Mental Health Review Tribunal.[39]

There is also a Western Australian Mental Health Commission, whose major functions include policy, evaluation, monitoring and ensuring accountability of the system.[40]

It is too early to judge the performance of the new Australian Commissions but their role is clearly significant in any development of national civil commitment laws. One issue is the extent to which such bodies will actively supervise the working of the law and the relevant institutions or investigate issues or complaints about mental health law decisions and operation including, for example, decisions by doctors, mental health facilities and officers, tribunals or courts. Their general objectives make no specific mention of the mental health legal system so there is at least the potential that the law will not be a focus. The other point is that there is a danger in our federal system of a multitude of federal and state bodies and strategies all operating at once with the real risk of consumer and stakeholder confusion about responsibilities, cases falling into the gaps, uncoordinated results, duplication and even competition between the different institutions.

A major example of the current uncoordinated approach is the potential complaints avenues about civil commitment or other aspects of mental health law. The bodies that could be involved in complaints investigation and referral could include:

- courts and tribunals;
- the Australian Human Rights Commission (AHRC);
- State and territory anti-discrimination agencies;
- Commonwealth, and state and territory ombudsmen;
- official visitors to mental health facilities;
- consumer groups;
- legal aid commissions and community legal centres;

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39 Mental Health Commission Bill 2011 (NSW) introduced 24 November 2011; see also http://www.parliament.nsw.gov.au/prod/parlment/hansart.nsf/V3Key/LA20111124008?open&refNavID=HA8_1>.

40 Western Australian Mental Health Commission <http://www.mentalhealth.wa.gov.au>.

- mental health facilities;
- health departments; and
- health complaints units.

The complaints could range from trivial to serious and could include human rights violations. Currently there is no body with any overall responsibility to oversee the handling of such complaints. It is clear that there could be gaps in complaints handling, needless duplication, wasting of resources and no proper understanding or monitoring of the performance of the mental health system including its legal processes.

What would be preferable would be a national Mental Health Commission to be given overall supervision and monitoring of complaints with respect to mental health nationally including complaints arising from laws and the legal process. The Commission could have protocols with all of the relevant agencies as to the recording and investigation of complaints. For example, the Commission could determine when it wished to itself investigate a complaint, when it wished to supervise the handling of a complaint by another body or when it determined that it did not need to have any direct input into the complaint.

It is likely that one overarching federal institution with national laws to administer and a national strategy will constitute the most desirable and effective outcome. This institution could have different divisions for research, planning, supervision and monitoring, complaints handling, training and education and advocacy. In the writer's view, national laws and policy would mean that there should preferably be one specialist Mental Health Commission which would have appropriate divisions dealing with the essential functions. It would then have regional offices in each state and serritory. This would provide a holistic response to mental health law but allow regional input. It would reduce the problems associated with diverse institutions and agencies all engaged in similar tasks but with differences in approach, improve coordination with national strategies and other services, enhance accountability and improve data collection including establishing national standards. The divisions could assist each other, for example, research and data could assist policy making as would the complaints process. The current National Mental Health Commission could be expanded to take up this greater involvement.

D *National Laws would Enhance Accessibility and be more Consumer Friendly*

A significant advantage of one piece of national legislation is that it would make the law more accessible to users. Currently any effort to consider Australia's civil commitment laws involves searching for and considering a multitude of Acts. This affects researchers, policy makers, lawyers and consumers and their advocates.

The differences in laws between Australian jurisdictions on civil commitment 'is a constant source of frustration and concern for organizations looking at issues from a consumer perspective'.[41]

National laws are more likely to assist in the system being more integrated, transparent and accountable. There are less likely to be gaps, ambiguities and inconsistencies between laws and between policies. In the writer's view, the national law should contain all the applicable human rights at issue together with the consequences of breaches of those rights including redress and reference to the investigation of alleged human rights abuses.

E *National Laws would Facilitate Data Collection and Monitoring*

A major concern is that there is a lack of empirical research and data about the nature, effectiveness and fairness of Australian civil commitment laws. The Law and Justice Foundation of NSW has produced a pioneering and valuable empirical report on some aspects of the functioning of three mental health tribunals being those of NSW, Victoria and the ACT.[42] However, there are in total, eight jurisdictions that need to be assessed for a more comprehensive picture.

A set of national laws would clearly encourage more comprehensive and accurate data collection about consumers, the law and its application right across Australia. It would enable more accurate analysis of policy impacts on the rate and dynamics of civil commitment and it could better inform policy making and service delivery. It would also facilitate monitoring on a national scale because there would be only one set of laws to deal with.

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41 Carney et al, above n 24, 74; See also Sophie Delaney, 'An Optimally Rights Recognising Mental Health Tribunal: What can be Learned from Australian Jurisdictions' (2003) 10(1) *Psychiatry, Psychology and Law* 71.

42 Carney et al, above n 24.

F *National Laws Would be Cost Effective on a Systemic Level*

One argument against national laws might be that introducing them would be costly and time consuming. While there is no doubt that introducing the laws, particularly after a national inquiry, would be relatively expensive, it is necessary to consider this issue in context. The introduction of national laws would in the longer term be cost effective for all Australians because it would remove the current multitude of state and territory inquiries and reviews of their own legislation. Moreover, in many cases, the states and territory reviews of legislation and policy are not comprehensive, do not engage with the entire community and to some extent each of them 'reinvents the wheel' when identifying relevant issues and in considering what the other jurisdictions are doing with respect to civil commitment.

G *National Laws Need not Stifle Innovation*

A national law and associated policy could take into account state or regional differences where appropriate. Moreover, as the paper has indicated there are significant inconsistencies, gaps, ambiguities and defects among the jurisdictions. A national review could identify and adopt the best parts of the various jurisdictions' approaches. In addition, where change is needed the national laws, once enacted, would be monitored and could be subject to periodic review. Therefore, national laws could be improved and refined and would not be set in stone.

H *National Laws would Reduce Cross Border Issues and Complexities*

Increasingly people are becoming more mobile and are more likely to move between jurisdictions. The absence of national laws means that there are complexities and issues arising from consumers moving between states and territories and hence becoming subject to different laws and processes. These issues may be very significant in areas or towns on state and territory borders.

There may be issues, for those not fully aware of the rules, about conflicting orders applying or which order takes precedence.[43] The interplay of different jurisdictions can be confusing not only to consumers and to their relatives and advocates but also to state and

[43] Eg for NSW agreements with other States, see NSW Government Health <http://www.health.nsw.gov.au/aboutus/legal/agreements.asp#para_3>.

territory medical authorities, tribunals, and police and emergency services. National laws would obviously remove most of these concerns.

III SPECIFIC PROBLEMS WITH THE CURRENT LEGAL APPROACHES

It could be argued that there would be no need for a national inquiry if it could be satisfactorily established that the laws and policies of the states and territories each appeared as at least adequate or acceptable and worked tolerably well in achieving their objectives. However, the writer considers that a more persuasive argument is that the standard of achievement should be more than adequate or acceptable and instead should be pitched at excellent or first class given the importance of the objectives, particularly the protection of important human rights of individuals and the protection of the community. In any event, there are sufficient concerns and doubts about the content and operation of these laws to justify a national inquiry. The current state and territory approaches need to be assessed both in terms of legislative and policy including improvements to legislative definitions, court and tribunal review, the litigation system and government policy regarding supervision, co-ordination and resourcing.

While it might be hoped that each state and territory legislature might eventually reach some sort of legislative consensus on civil commitment this is highly unlikely. A history of their legislation indicates, on the contrary, that they continue to take different approaches and use different terms, different language and have different priorities.[44]

In any event, there are also specific problems with the current Australian jurisdictions' approaches. The following discussion draws heavily upon the findings of the Law and Justice Foundation of NSW report which, as noted above, is the first major examination of the operation of involuntary civil commitment laws in Australia.[45] The problems and concerns about the current civil commitment laws and policy in Australia include the following matters.

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44 See Carney et al, above n 24.

45 Ibid.

A *Divergent and Inadequate Approaches*

There are significant differences across jurisdictions on matters such as definitions of mental illness and disorders, and justifications and criteria for civil commitment, methods and frequency of review, the availability of legal representation, and practice and procedure.[46] Moreover, there are jurisdictional differences in mental health service delivery and policy initiatives on mental health which will affect laws and policies and the use of civil commitment.[47] There is also the experience of overseas jurisdictions to consider.[48]

There are some major differences in focus between jurisdictions. For example, the Law and Justice Foundation of NSW report found that the NSW laws and approach are geared towards due process and tribunal control of civil commitment, that is a legal model, while Victoria and South Australia are much more within the clinical control model.[49]

This diversity produces a fragmented, often limited and inconsistent approach to civil commitment within Australia which can frustrate and confuse consumers, advocates and institutions.[50]

The Law and Justice Foundation of NSW report concluded that Australian mental health tribunals are 'unduly constrained by underfunding of their operations, and by the absence or scant provision of adjuncts such as routine second medical opinions or the advocacy and legal representation schemes which are becoming the gold standard internationally'.[51] The report also concluded that tribunals have become the 'poorest cousin in an already under-resourced mental health service system'.[52]

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46 Ibid 12-14.

47 See, eg, ibid 118-147 on some of the differences between NSW, the ACT and Victoria.

48 Eg, Jill Peay, *Tribunals on Trial: A Study of Decision-Making under the Mental Health Act 1983* (Clarendon Press, 1989); Elizabeth Perkins, *Decision-Making in Mental Health Review Tribunals* (London Central Books, 2002); Elizabeth Perkins, S Arthur and J Nazroo, *Decision-Making in Mental Health Review Tribunals* (University of Liverpool Health and Community Care Research Unit, 2000).

49 Carney et al, above n 24, 74.

50 Ibid 12; see also S Delaney, 'An Optimally Rights Recognising Mental Health Tribunal: What can be Learned from Australian Jurisdictions' (2003) 10(1) *Psychiatry, Psychology and Law* 71-84.

51 Carney et al, above n 24, 21.

52 Ibid 315.

B *Failure to Properly Protect Human Rights*

State and territory legislation fail to include a positive and cohesive list of human rights and a means by which a person can make complaints, seek personal redress or take action against institutions in relation to civil commitment.[53] Diverse civil commitment laws in mental health Acts do not optimally balance the civil rights of the mentally ill including a right to treatment or to refuse treatment[54] and the needs of the community.

The Mental Health Council in the 2005 report *Not for Service* stated that 'the stories related by consumers and practitioners … suggest that either the legislation is not yet consistent with the [Mental Illness principles] or that the legislation has not been effective in protecting consumers and carers against abuses'.[55]

C *Inappropriate and Inconsistent Legislative Criteria for Commitment*

Again, there is a diversity of approaches that do not always satisfactorily deal with significant issues such as definitions of mental illness, criteria for commitment, and the role of lack of insight or lack of capacity.[56] There are different approaches as to whether mental illness should be defined and if so how.[57] There are variations on what level or type of harm is necessary to engage commitment; for example, Tasmania uses 'significant' harm,[58] NSW 'serious harm'[59] while in Western Australia there is explicit provision that harm includes serious financial harm, lasting or irreparable harm to personal relationships

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53 See, eg, M Donnelly, 'Community–Based Care and Compulsion: What Role for Human Rights?' (2008) 15(5) *Journal of Law and Medicine* 782; Ian Freckelton and B Loff, 'Health Law and Human Rights' in D Kinley (ed), *Human Rights in Australian Law* (Federation Press, 1998) Ch 14; S Delaney, 'The United Nations Principles for the Protection of People with Mental Illness'(1992) 18 *Melbourne University Law Review* 565; Carney et al, above n 24, 23-46.

54 RL Binder and DE McNeil, 'Involuntary Patients' Right to Refuse Medication: Impact of the Riese Decision on a California Inpatient Unit' (1991) 19 *Bulletin of the American Academy of Psychiatry and the Law* 351; D Hermann, 'Autonomy, Self Determination, and the Right of Involuntarily Committed Persons to Refuse Treatment' (1990) 13 *International Journal of Law and Psychiatry* 361.

55 Carney et al, above n 24, 38; Mental Health Council of Australia, above n 31.

56 I Markova and G Berrios, 'The Meaning of Insight in Clinical Psychiatry' (1992) 160 *British Journal of Psychiatry* 850.

57 Carney et al, above n 24, 53.

58 *Mental Health Act 1996* (Tas) s 24.

59 *Mental Health Act 2000* (NSW) s 14(1)(b).

due to damage to the person's reputation, and serious damage to the reputation of the person.[60] Harm can be a difficult concept to encapsulate and may involve different interpretations.[61]

D *Reliance upon Non-legislative Criteria*

Research and critiques have suggested that tribunals may use factors and criteria that are not expressly referred to in their governing legislation.[62] Key concepts that may not be used in legislation but nevertheless seem to be of great significance in decision making are insight, consent and capacity. One of the reasons for this may be that review tribunals find that the legislative criteria are too ambiguous, too complex or inadequate.[63] The fact that using extra legal criteria has continued may be due to the relative lack of appellate review of decision making.

Queensland, Victoria, Western Australia and the Northern Territory have an additional consent criterion that the person has refused, or is unable to consent to, the proposed treatment.[64] The Law and Justice Foundation of NSW study reported that there were 'numerous murky and unresolved issues' about the definition and operation of 'consent and capacity and [tribunals] may resort to broad therapeutic considerations'.[65] The use of extra-legislative criteria is a significant problem because it impugns the integrity and authority of the legal system, thereby affecting the predictability, accountability and transparency of the review process. It leaves much to the potentially unfettered discretion of tribunal decision makers. If the legislative criteria are problematic then they must be reconsidered and if necessary amended.

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60 *Mental Health Act 1998* (WA) s 26(2).

61 Carney et al, above n 24, 202.

62 Kate Diesefeld, 'Insights on "Insight": the Impact of Extra-Legislative Factors on Decisions to Discharge Detained Patients' in Ian Freckleton and Kate Diesfeld (eds), *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment* (Ashgate, 2003) 359; Elizabeth Perkins, 'Mental Health Review Tribunals' in Ian Freckleton and Kate Diesfeld (eds), *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment* (Ashgate, 2003) 221.

63 Elizabeth Perkins, above n 62, 221, 228; See also Jill Peay, *Decisions and Dilemmas: Working with Mental Health Law* (Hart Publishing, 2003) 160.

64 Carney et al, above n 24, 56; *Mental Health Act 2000* (Qld) s 14(1)(f).

65 Carney et al, above n 24, 305.

E *Concerns about Consumer Confidence in Involuntary Processes*

Empirical studies note numerous expressions of consumer dissatisfaction with the law and tribunal operation and decision making. Australian empirical studies suggest the following expressions of consumer dissatisfaction:

- Consumers believing that they are forced into a passive role, unable to effectively voice their concerns;[66]
- Lack of effective communication between tribunal and consumers;
- Tribunal systems that are confusing to navigate;[67]
- Concerns about consumers not being able to understand what options they had or who they could talk to about their experiences and whether an independent person or body could assist in this task;[68]
- Lack of access to information for consumers including treatment plans and clinical reports;[69]
- Concerns about bias with an inadequate system of review from tribunals and courts that tends to 'rubber stamp' the views of hospitals and decision makers with resulting concerns about the lack of time, effort and resources expended to properly review cases.[70] A number of consumers and their legal advocates think that tribunals place too much weight on the evidence of the treating team and not enough on their case.[71] The treating team's opinion was treated as the authority for whether there was a mental illness and its severity;[72] and

66 Ibid 272.

67 Ibid 280.

68 Ibid 240.

69 Ibid 13, 189.

70 The rates that review tribunals tend to set aside decisions is generally be well below 15% - see Ian Freckelton, 'Involuntary Detention Decision–Making, Criteria and Hearing Procedures' in Ian Freckleton and Kate Diesfeld (eds), *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment* (Ashgate, 2003) 296; T O'Brien et al, 'A One Year Analysis of Appeals Made to Mental Health Review Tribunals' (1995) 29 *Australian and New Zealand Journal of Psychiatry* 661; Perkins, above n 62, 228.

71 Carney et al, above n 24, 227.

72 Ibid 232.

- A lack of proper discussion of treatment including medication levels, types or forms.[73]

F *Problems with Participation*

There appear to be problems with sufficient participation which varies according to jurisdiction. For example, clinicians may not attend many hearings instead sending junior staff to review clinical notes.[74] There may be a relatively low rate of attendance by consumers; for example, about 60% in Victoria.[75]

In addition, there is a great variety as to the mode of participation with different uses being made of personal hearings, videolink and telephone hearings.[76] These different modes raise issues about the nature and impact of hearings, particularly on consumers.

G *Legal Representation and Advocacy*

There are significant differences among jurisdictions on the level, source and quality of legal representation which often does not extend beyond inpatient admissions.[77] Overall, legal representation is not the norm and can be very low (for example, 5-10% in Victoria).[78] In addition, there is a need for consumers to see legal representatives prior to hearing (which does not always happen), so that the representative can properly obtain instructions and prepare a case.[79] There is also a divergence of views about the approach by lawyers as to whether they may be too adversarial or, on the other hand, they may not sufficiently test evidence.[80]

H *Tribunal Membership*

There are general concerns about budgetary constraints threatening interdisciplinary, multidisciplinary tribunals, which overall are

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[73] Ibid.

[74] Ibid 96.

[75] Ibid.

[76] Ibid 140-143.

[77] Ibid 44.

[78] Ibid 96.

[79] Ibid 166.

[80] Ibid 241, 252.

considered to be a preferable option than a single member constituted tribunal, particularly in terms of providing a holistic review of orders.[81]

I *Inconsistent Procedural Standards*

There appear to be inadequate and inconsistent procedural standards across jurisdictions.[82] For example, not all jurisdictions expressly refer to the requirements of natural justice or to the rights of access to information for consumers or some may have narrow versions of such rights.[83]

Some consumers and their advocates have complained about:

- statement of reasons not being asked for by consumers and when they are given they vary in quality;[84]
- the timeliness and adequacy of notification about hearings and assistance to parties including access to clinical reports and treatment plans;[85]
- a divergent approach to the timeframes for Tribunal review of commitment decisions and then differences in the frequency of tribunal monitoring of consumers; and
- the lack of treatment plans being reviewed.[86]

J *Time Constraints*

A striking concern from the Law and Justice Foundation report is that of the limited time and resources available to hear individual matters. The median time for hearings is around 20 minutes, which seems comparatively short when compared to other tribunal jurisdictions in Australia such as social security matters and also seems much less than comparable mental health jurisdictions overseas (for example, Britain).[87] The authors of the report conclude that the average time spent 'appears unreasonably short'.[88] Time constraints can clearly

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81 Ibid 96-115.

82 Ibid 45.

83 Ibid. See also, B McKenna, A Simpson and J Coverdale, 'What is the Role of Procedural Justice in Civil Commitment?' (2000) 34 *Australia and New Zealand Journal of Psychiatry* 671.

84 Carney et al, above n 24, 235.

85 Ibid 189.

86 Ibid 73.

87 Ibid 309.

88 Ibid.

damage the quality of decision making, the credibility of the process and consumer confidence.

K *Limited Role of Appellate Courts*

There are very few civil commitment orders taken on appeal and this seems to be the case across common law countries.[89] This means that there is comparatively little court supervision of the approach of tribunals to civil commitment and their interpretation of the legal requirements. This is a matter that warrants further attention including why there is such a low rate and the extent to which the status and personal difficulties of the clients and perhaps the reluctance of legal services to run such matters, impacts on the rate of appeal.

IV THE NEED FOR A PUBLIC, NATIONAL INQUIRY TO HELP DEVELOP NATIONAL LAWS

The main reasons for the need for a public, national inquiry are as follows. First as discussed above, achieving best practice civil commitment laws for all Australians should be regarded as a significant national priority and a comprehensive national and public inquiry would best achieve that result. Secondly, civil commitment laws are controversial and therefore the laws and policy need to be considered and debated widely within the community. There are a wide variety of views about civil commitment within the community. .[90] A diversity of views is inevitable given the complexities of the issues, for example, the problematic nature of defining and explaining mental illness and its treatment, the interaction between medicine and law, the need to justify detention and to balance the potentially competing interests of the individual against the community represented by the state.

Perspectives on civil commitment include rights based approaches as discussed above, philosophical,[91] sociological,[92] ethical,[93] critical,[94]

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[89] TA O'Brien et al, above n 70, 661-665; Perkins, above n 62, 228.

[90] See, eg, Clive Bridge 'Civil commitment: A Multi-Disciplinary Analysis' (1984) 14 *Victoria University of Wellington Law Review* 145.

[91] JK Mason and R McCall Smith, *Law and Medical Ethics* (Butterworths, 4th ed, 1994).

[92] Joan Busfield, *Rethinking the Sociology of Mental Health* (Blackwell Publisher, 2001).

[93] Ian Kerridge, Peter Saul and John McPhee, 'Moral Frameworks in Health Care: An Introduction to Ethics' in Ian Freckelton and Kerry Petersen (eds), *Controversies in Health Law* (Federation Press 1999) 276; Paul Chodoff, 'Involuntary Hospitalization of the Mentally Ill as a Moral Issue' (1984) 141 *American Journal of Psychiatry* 384.

feminist,[95] theoretical, personal/consumer and therapeutic jurisprudence.[96] There is also a variety of interest groups including a range of consumer groups and advocates with different agendas, carers, the legal profession, legal aid, community legal services, the medical profession, hospitals, health departments, official visitors, the police, tribunals, courts and governments. Each may well have different perspectives and views. There is also the real potential for turf wars between medical and legal models.

Some medical practitioners and elements of organised psychiatry may complain and react against what they see as the over legalisation of civil commitment with too much focus on legal criteria and procedural safeguards which may lead to patients 'dying with their rights on'.[97] On the other hand, lawyers with a particular concern for protection of the civil rights of patients, may be skeptical of allowing the medical profession to have too much power in relation to civil commitment or to overemphasise the need for preserving the therapeutic alliance between patients and doctors.[98]

A third reason for a national public inquiry is the need for a very broad, comparative and interdisciplinary approach. The inquiry would have to take such an approach if it were to consider the range of issues, information and reform options, conduct the necessary research and consultations, and devise a model response. This would best be achieved by a properly funded national inquiry.

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[94] Martin Forst, *Civil Commitment and Social Control* (Lexington Books, 1978); Ronald D Laing, *The Divided Self: An Existential Study in Sanity and Madness* (Penguin, 1960); Ronald D Laing, *Self and Others* (Routledge, 1961); Ronald D Laing and Aaron Esterson, *Sanity, Madness and the Family* (Penguin, 1964).

[95] Katherine Bartlett and Rosanne Kennedy (eds), *Feminist Legal Theory: Critical Readings in Law and Gender* (Westview Press, 1991).

[96] See, eg, Michael L Perlin, 'Preface' in Ian Freckleton and Kate Diesfeld (eds), *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment*, (Ashgate, 2003) xxxiii; Michael L Perlin, *Mental Disability Law: Civil and Criminal* (Lexis Law Publication, 2nd ed, 1989) Ch 1; David Wexler and Bruce Winick, *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence* (Carolina Academic Press, 1996).

[97] Paul S Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change* (Oxford University Press, 1994); Darold Treffert, 'Dying with their Rights On' (1973) 130 *American Journal of Psychiatry* 1041, 1042.

[98] Ibid.

Civil commitment is an area particularly suitable for comparative analysis because it is used in the majority of countries and it involves issues that are common to most countries.[99]

The fourth reason for a broad based national, inquiry is the multitude of complex issues and options for reform. The main questions that the review needs to answer are the following:

- When, if at all, is the civil commitment of mentally ill people justified?
- What should be the objectives of civil commitment laws?
- What principles and standards should be used to form the foundation of civil commitment laws?
- what are the problems with the current legal responses including legislation, review of decision-making by tribunals and courts, and the litigation system associated with civil commitment in particular, by applying the identified principles and standards and assessing to what extent the laws achieve the desired objectives?
- How can these legal responses to civil commitment be improved taking into account domestic and international legislation and developments so that the new law and policy optimally meet the standards of assessment?
- What should the role be of specialist mental health review tribunals including their rationale, their organisation, membership[100] and decision making processes?[101]
- What should be the general roles of representatives in civil commitment process,[102] particularly lawyers and should deal,

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[99] Perlin, above n 96; Paul S Appelbaum, 'Almost a Revolution: An International Perspective on the Law of Involuntary Commitment' (1997) 25 *Journal of the American Academy of Psychiatry and Law* 135; Constantijn Kelk and Johannes Legemaate, 'Legal Protection on Psychiatry: A Comparative Perspective' (Netherlands Association for Comparative Law, 1990).

[100] Phillip A Swain, 'Admitted and Detained - Community Members and Mental Health Review Boards' (2000) 7 *Psychiatry, Psychology and Law* 79.

[101] J Mulvaney, 'The Review of the Compulsory Detention of the Mentally Ill: Who Should Decide?' (1993) 28(3) *Australian Journal of Social Issues* 211; A Eldergill, *Mental Health Review Tribunals: Law and Practice* (Sweet and Maxwell, 1997); Ian Freckelton, 'Decision-Making about Involuntary Psychiatric Treatment: An Analysis of the Principles Behind Victorian Practice' (1998) 5(2) *Psychiatry, Psychology and Law* 249; J Higgenbottam et al, 'Variables Affecting the Decision-Making of a Review Panel' (1985) 30 *Canadian Journal of Psychiatry* 577.

[102] Bruce Winick, 'Therapeutic Jurisprudence and the Role of Counsel in Litigation' (2000) 37 *California Western Law Review* 105; Bruce Winick, 'The Civil Commitment

for example, with issues as to taking instructions, acting on them and to what extent the role should be adversarial or otherwise.

- what should be the interaction with criminal laws, guardianship laws and also forensic mental health laws? [103]

Each of the above is complex and contains many sub-issues.

The final and perhaps most important reason for such an approach is that a review of civil commitment law, as a major piece of law reform, requires a broad and inclusive consultation process. This is borne out by the experience of various law reform bodies. Justice Kirby has noted the great value of broad consultation for successful law reform.[104] It is important because it improves the democratic process, enhances the public's perceptions of law reform, gives the report and process legitimacy, and provides practical benefits of learning how the law operates thus producing a better report.[105]

V THE MOST APPROPRIATE INSTITUTIONAL RESPONSE

In the writer's view the most appropriate approach to the review of commitment laws would be for the following process to occur. The Standing Council on Law and Justice (SCLJ), which has replaced the Standing Committee of Attorney's-General (SCAG),[106] should formally request the AHRC to investigate and report on the current Australian civil commitment laws for the mentally ill and the policy that underpins them and draft at least the major provisions of model laws. The AHRC should be specifically funded for this project. The Commission's report would then be considered by the SCLJ with a view to enacting national laws.

The SCLJ (and SCAG before it), is intended to achieve the Council of Australian Governments' (COAG) strategic themes by pursuing and monitoring priority issues of national significance which require

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Hearing: Applying the Law Therapeutically' in Lynda E Frost and Richard J Bonnie (eds), *The Evolution of Mental Health Law* (American Psychological Association, 2001).

[103] S Riordan et al, 'Diversion at the Point of Arrest: Mentally Disordered People and Contact with the Police' (2000) II *Journal of Forensic Psychiatry* 683.

[104] Michael Kirby, *Reform the Law: Essays on the Renewal of the Australian Legal System* (Oxford University Press, 1983) 65-67.

[105] Ibid.

[106] The SCLJ started operation from 17 September 2011 <http://www.scag.com.au>.

sustained, collaborative effort and addressing key areas of shared Commonwealth, State and Territory responsibility and funding. Civil commitment would appear to satisfy both of those criteria. Furthermore, a consideration of the successful transitions to national laws indicates that national laws for civil commitment for mental illness would not be out of place. Past projects have included national laws for defamation, evidence, foreign judgments, arbitration, apprehended violence orders, and the corporations power. The process can readily encompass diverse, complex and controversial topics.

The current projects also suggest that civil commitment is not out of place. The current projects include victims of crime, surrogacy, suppression orders, and the national legal profession. Again, this is a diverse set of topics each with a degree of complexity and variations between jurisdictions.

The Commonwealth can have powers referred to it under s 51(xxxvii) of the Constitution.[107] Another alternative is mirror legislation which occurs when state parliaments enact identical legislation to achieve consistency across the states.

The AHRC has functions that would encompass such an inquiry including conducting public inquiries into human rights issues and making recommendations for reform; and giving advice and making submissions to parliament and government on the development of laws, policies and programs consistent with human rights. The Commission not only has the investigatory experience and the law and policy functions to carry out the inquiry but also has the necessary human rights focus which must be an important part of the process.

The AHRC, formerly known as the Human Rights and Equal Opportunity Commission (HREOC), also has the institutional background and history as it produced the first, and so far only, major public report on the rights of the mentally ill in Australia, known widely as the Burdekin Report.[108] It also coproduced the *Not for Service* Report in association with the Mental Health Council of Australia and

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[107] Section 51 (xxxvii) provides: 'Matters referred to the Parliament of the Commonwealth by the Parliament or Parliaments of any State or States, but so that the law shall extend only to States by whose Parliaments the matter is referred, or which afterwards adopt the law.'

[108] Mental Health Council of Australia, above n 49.

the Brain and Mind Research Institute.[109] As noted, the writer considers that broad and public, national consultation with government and other stakeholders may be crucial in the development of best practice national laws and approaches.

VI CAN NATIONAL LAWS BE ACHIEVED?

While there is no doubt that achieving national laws would be a difficult task there are reasons for some optimism and for a concerted effort to be made for such an outcome. The first is that when the arguments for national laws are examined as above the case becomes strong and the suggested problems of time and cost and apparent lack of importance are minimised. Moreover, there are other reasons to feel greater optimism.

The broad similarity of the current Australian jurisdictions and the fact that each faces essentially the same issues and challenges means that this is a suitable topic for a national law with already at least a reasonable amount of consensus on the basic approach both in terms of legislative form and content, forms of review and major issues. Moreover, the topic is sufficiently important in terms of its drastic consequences to individuals and to the community to justify the effort to make national laws.

There seems no compelling justification politically, economically or culturally for the continuation of diverse State and Territory laws with doubts and concerns about so much of the content and practical operation of those laws. Australia has in world terms a relatively small population, a relatively successful multicultural society, a stable liberal democracy and modern communication and transport systems. Issues of State rights or concerns about the invasive or creeping influence of federal government do not seem relevant in this area. There appear to be no major sectional interests such as competing economic interests.

There is sufficient international and national discussion about approaches and laws to enable national laws to be drafted after an effective inquiry that included research and widespread consultation. The other necessary ingredient for arriving at national laws is that stakeholders, experts and interest groups and those in government and its bureaucracies should advocate the cause of national laws and desirably form a lobby group for that purpose.

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[109] Ibid.

VII CONCLUSION

This paper has assessed the arguments for national laws and in the course of so doing examined the arguments against such a course of action. The fundamental argument is that there is no unified Australian system of civil commitment laws which therefore creates a situation for major differences in treatment and operation between jurisdictions. This is difficult to support when what is at stake are fundamental human rights, and access to treatment for those who are seriously ill and the protection of the community. The criteria and elements of a national best practice response need to be identified, developed and applied. The system will constitute the best overall balance between the rights of mentally ill people and the rights of the community in relation to civil commitment. The inquiry and the formulation of national laws should bring together all of the major elements to develop a model approach for Australia. It would be a comprehensive analysis that presents a vision for a much improved response and system.

The desired outcome is to develop an integrated legal response to civil commitment which covers all of the main elements of such a system, namely objectives, principles and standards, legislation, review processes and the role of legal institutions such as courts and tribunals, and the litigation system, training and education, research, coordination, supervision and investigation of complaints. This proposed system would remedy as much as possible the identified defects of the current Australian systems and meet the desired objectives and standards which have been discussed in this paper. When the issue is considered carefully and rationally there is no reason to believe that national laws are unrealistic.

It is possible that a national inquiry could be expanded to specifically make recommendations and draft laws about other elements of mental health law, such as the legal status of voluntary patients, CTOs, invasive treatment, guardianship and the forensic patient system. It is beyond the scope of this paper to canvass all of those issues. The terms and scope of the inquiry would depend upon the resources, timeframe and impetus for the inquiry.

The time is ripe for action.