MENTAL HEALTH LAW PROFILES

Mental health law profiles

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Australia and the USA, two high-income countries within the increasingly divergent Anglo-Saxon tradition, provide the focus of this issue's thoughtful and stylistically diverse mental health law profiles. An emerging question in this series is whether law primarily aimed at protecting the civil liberties of people with a mental disorder may have reached its high point. With the economic crisis, the continuing influence of neo-liberal economics, the global retreat of the welfare state and the rise in the numbers of older people, neglect rather than coercion may be the more pressing issue. Kirkby and Henderson suggest that, in Australia, more emphasis should be put on ensuring access to good-quality, evidence-based treatment, and this position seems to be echoed to some extent in the USA, according to Vitacco and Degroot. The latter authors write in favour of community treatment orders, while the former refer to evidence seriously questioning their effectiveness or superiority in terms of service use, social functioning and quality of life. An interesting issue raised in the Kirkby and Henderson review is the increasing contribution of private/independent practitioners in the provision of compulsory mental healthcare and this, in Australia at least, appears to be related to the greater use of community treatment orders.

MENTAL HEALTH LAW PROFILE

Australia's mental health legislation

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Australia has a generally progressive approach to mental health law, reflective of international trends in human rights. Responsibility for most legislation is vested in the six States and two Territories, a total of eight jurisdictions, such that at any given time several new mental health acts are in preparation. In addition there is a model mental health act that promotes common standards. Transfer of orders between jurisdictions relies on Memoranda of Understanding between them, and is patchy. State and Territory legislation is generally cognisant of international treaty obligations, which are themselves the preserve of the Federal Parliament and legislature. UK legislation has had a key influence in Australia, the 1959 Mental Health Act in particular, with its strong emphasis on voluntary hospitalisation, prefacing deinstitutionalisation.

Since 1959 the key developments in Australian mental health legislation have concerned the review processes by tribunals, with some jurisdictions taking a more legalistic approach, such as legal representation at all tribunal hearings, while others make this optional, at the discretion and expense of the patient. With the shift to community care, community treatment orders have been introduced, reflecting the most common and preferred locus of long-term care. Guardianship acts are commonly invoked, for example for the management of financial affairs and typically run in parallel with mental health acts (MHAs). Dementia-related aged care is also supported by guardianship acts. Criminal justice and mental impairment acts typically provide for insanity defences and admissions to forensic secure mental health units.

A development of particular interest in Australia is the shift of an increasing proportion of care and treatment under MHAs to private practice. Under the universal coverage of the federally funded Medicare rebate scheme, private general practitioners, private psychiatrists and, on a limited basis, private psychologists, combined, outweigh the public mental heath system. Historically these groups played a minor role in the care of 'involuntary' patients but they are moving to centre stage as the emphasis on community treatment increases.

Personality disorder is rarely mentioned in Australian mental health legislation, except where solely antisocial behaviour or antisocial personality is exempted from the definition of mental illness. In principle, individuals with personality disorder(s) are judged against the same criteria for mental illness and risk of harm as others are.

Some legislation sets out standards of care, although more commonly services seek to warrant these by accreditation processes. Advance directives, decision-making capacity (including capacity to consent to treatment) and access to advocacy are three topical issues exercising the minds of policymakers and drafting committees. These are areas