



## Obligatory dangerousness criteria in the involuntary commitment and treatment provisions of Australian mental health legislation

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### ABSTRACT

**Objective:** Involuntary commitment and treatment (IC&T) of people affected by mental illness may have reference to considerations of dangerousness and/or need for care. While attempts have been made to classify mental health legislation according to whether IC&T has obligatory dangerousness criteria, there is no standardised procedure for making classification decisions. The aim of this study was to develop and trial a classification procedure and apply it to Australia's mental health legislation.

**Method:** We developed benchmarks for 'need for care' and 'dangerousness' and applied these benchmarks to classify the mental health legislation of Australia's 8 states and territories. Our focus was on civil commitment legislation rather than criminal commitment legislation.

**Results:** One state changed its legislation during the course of the study resulting in two classificatory exercises. In our initial classification, we were able to classify IC&T provisions in legislation from 6 of the 8 jurisdictions as being based on either 'need for care' or 'dangerousness'. Two jurisdictions used a terminology that was outside the established benchmarks. In our second classification, we were also able to successfully classify IC&T provisions in 6 of the 8 jurisdictions. Of the 6 Acts that could be classified, all based IC&T on 'need for care' and none contained mandatory 'dangerousness' criteria.

**Conclusions:** The classification system developed for this study provided a transparent and probably reliable means of classifying 75% of Australia's mental health legislation. The inherent ambiguity of the terminology used in two jurisdictions means that further development of classification may not be possible until the meaning of the terms used has been addressed in case law. With respect to the 6 jurisdictions for which classification was possible, the findings suggest that Australia's mental health legislation relies on 'need for care' and not on 'dangerousness' as the guiding principle for IC&T.

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### 1. Introduction

Involuntary commitment and treatment (IC&T) has a well-established but problematic history in medicine. It is problematic because it violates core ethical principles such as patient autonomy and self-determination and because it grants power to one section of the community over another section, which is potentially open to abuse. However, it is also recognised that there are circumstances in

which a person is unable to give consent and the benefits of treatment outweigh the violation of autonomy and self-determination. These benefits may be to the patient alone or to the patient and third parties.

In the field of mental health, the use of IC&T has been widely criticised as historically leading to abuse, most notably in relation to political dissidents in the former Soviet Union (Fulford, Smirnov, & Snow, 1993) but also in relation to lengthy, sometimes lifelong, incarceration of people affected by mental illness in institutions in many western countries (Grob, 1980, Burti, 2001). As a result most countries have specific laws that set out specific criteria for the use of IC&T in relation to people with a diagnosis of mental illness and establish processes that protect them from abuses. These laws recognise the need for IC&T but specify the conditions under which IC&T can be lawful and impose requirements for review that limit duration and protect the rights of people in receipt of IC&T.

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The legal basis for IC&T derives from two recognised principles, *police powers* (the government authority to prevent harm to the community and individuals) and *parens patriae* (the state demonstrating beneficence by acting in place of the parent taking responsibility for those unable to care for themselves) (Johnson, 2003, *Wyatt v. Stickney*, 325 F. Supp. 781, 784–85, 1971)<sup>2</sup>. While the principles that inform IC&T are well understood and widely accepted, the greater challenge is establishing in legislation and practice the proper balance between protection of the autonomy of a person affected by mental illness and ensuring that such a person or third parties are not exposed to unacceptable risk if treatment is not provided.

Varying views about the proper balance are reflected in differences in mental health legislation between countries and, in the case of federations such as Australia, between states. Of particular importance is the specified set of requirements that must be met for a person affected by a mental illness to be subject to IC&T. Johnson points out that: “components in deciding civil commitment include mental illness, dangerousness, and treatability” (Johnson, 2003). These requirements may be relatively more or less stringent, with more stringent requirements making IC&T more difficult thereby protecting the rights of the individual but reducing likelihood of treatment. It has been noted that jurisdictions in the US tend towards more stringent requirements favouring the autonomy of the individual whereas the UK has less stringent requirements, favouring protection of the individual and the community (Appelbaum, 1997). Hatfield (2008) found that during the period of 1996–2004 the risk to a person’s own health and the risk to a person’s own safety were approximately equal as causes of involuntary mental health detention although most commonly both were identified as being present and only in a small proportion of cases was risk to health the sole cause of detention.

While most debates concerning IC&T of people affected by mental illness have been dominated by ethical issues, there have been recent attempts to introduce empirical considerations by investigating the consequences of variation in legislative provisions that set the balance between the protection of autonomy and ensuring provision of treatment when required. The concept of ‘dangerousness’ has provided a basis for this more empirical approach.

### 1.1. Dangerousness as a requirement for IC&T

Mental health legislation has been classified according to whether or not it specifies a ‘dangerousness’ test or a ‘need for treatment’ test as a requirement for IC&T (Appelbaum, 1997). Mental health legislation is said to have a dangerousness requirement when IC&T is only permitted in circumstances in which failure to provide treatment would result in danger to the person with the diagnosis of mental illness or to a third party. Danger is usually taken to mean physical harm that is imminent and life threatening (Hewitt, 2008). Typical examples include suicidality and physical aggression. However, Appelbaum (1997) includes in the test of dangerousness to self, circumstances where a person is ‘so impaired as to be able to meet their basic needs’. By contrast, legislation that employs a ‘need for treatment’ requirement permits IC&T where failure to provide treatment would have adverse effects on the general health or well being of the person or community.

Appelbaum (1994, 1997) argues that, during the period of 1964–1979, a combination of increasing concerns about individual rights and freedoms and the wish to better manage costs of mental health care caused states in the US to change their laws concerning IC&T, replacing a ‘need for treatment’ test with a ‘dangerousness’ test. He further suggests that these changes were less evident in European legislation, where ‘need for treatment’ remained the primary

requirement for involuntary admission. Librun (1998) warns that an excessive reliance on dangerousness narrowly construed as a restrictive requirement for civil commitment would distort the IC&T process by emphasizing the state’s ‘*police power*’ at the expense of its ‘*parens patriae*’ responsibility.

Aside from the classification of legislation, there has also been interest in the effects of different legislative approaches to IC&T. Early work focused on the extent to which a shift from ‘need for treatment’ to ‘dangerousness’ in the US changed rates of IC&T. In a review of 19 studies that examined patterns of admission before and after legislative change that made IC&T more difficult (the majority) or less difficult, Bagby and Atkinson (1988) found that legislative change had only a short term effect and that longer term, rates of IC&T were largely unchanged despite changes in legislation. Other work has investigated the characteristics of those admitted involuntarily, but again, without detecting clear evidence of legislatively driven change. (Appelbaum, 1997)

More recently, it has been proposed that the characteristics of legislation may have longer term population effects by impacting on the duration of untreated psychosis. Large, Nielssen, Ryan, and Hayes (2008) reported that people who lived in jurisdictions with dangerousness requirements for IC&T had a longer period of untreated psychosis than people who lived in jurisdictions without this requirement. They argued that, since the longer duration of untreated psychosis increases risk of poor long term outcome, such jurisdictions were putting the mental health and well-being of citizens at risk with inappropriately and excessively stringent IC&T requirements.

### 1.2. Mental health legislation in Australia

Mental health is a State rather than a Commonwealth jurisdiction in Australia and each State and Territory has legislation that regulates the IC&T of people affected by mental illness. This means that it is not possible to determine the extent to which the principle of dangerousness informs IC&T in Australia without consideration of legislation in each State and Territory. Large et al. (2008) identified NSW as a jurisdiction whose legislation was characterised by obligatory dangerousness criteria (ODC), meaning that a person with mental illness cannot be treated involuntarily unless dangerousness is established. However, it is unclear how this classification was made. Comparative population studies that rely on classification of legislation in force in different jurisdictions require systematic and transparent classification processes. So far as we have been able to determine, no previous work has set out to examine the legislation regulating IC&T of people with mental illness on a state and territory basis so as to establish the extent to which a dangerousness requirement or a need for treatment requirement operates throughout Australia.

### 1.3. Study aims and objectives

As discussed above, the relationship between the legislative provisions and involuntary treatment practices remains unclear. Longitudinal studies of involuntary treatment practices in the US and the UK suggest little impact of legislative change. On the other hand, cross-section comparisons of involuntary treatment practices in jurisdictions with differing legislative provisions suggest that the content of legislation can impact on provision of treatment. Because the specific wording of involuntary commitment provisions is quite variable, there is a need for systematic procedures that enable classification of disparate legislation according to whether it is governed by principles of dangerousness or need for care. Without such procedures, judgments are necessarily subjective and it is difficult to evaluate the conclusions of either longitudinal or cross

<sup>2</sup> *Wyatt v. Stickney*, 325 F. Supp. 781, 784–85 (M.D. Ala 1971) (Johnson, CJ).

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