28th INTERNATIONAL CONGRESS

on LAW and MENTAL HEALTH

Programme & Abstracts

Sydney, Australia  September 28 – October 3, 2003

Under the auspices of the
International Academy of Law and Mental Health

New South Wales Department of Health
Commonwealth Department of Health and Ageing
New South Wales Attorney-General’s Department
Commonwealth Attorney-General’s Department
Commonwealth Office for an Ageing Australia
New South Wales Police
National Health & Medical Research Council
Centre for Applied Philosophy and Public Ethics, Charles Sturt University
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Dear Colleagues,

We are delighted to welcome you to Sydney for the 28th International Congress on Law and Mental Health.

The 28th Congress in Sydney is the first meeting of its kind to be held in the Southern Hemisphere. Over 350 experts from twenty countries will contribute to a dynamic programme that spans across six days. This represents a unique opportunity for Australian and international scholars, health and legal professionals, legal officers and government planners to share their experiences on a challenging area of social policy. We anticipate that, in addition to serving as a valuable educational forum on a range of issues, the 28th Congress will lead to many fruitful exchanges and long-term collaborations across disciplines and borders. The International Academy of Law and Mental Health (IALMH) remains the leading international multidisciplinary organisation in its field. Through its Annual Congresses and official publication – the International Journal of Law and Psychiatry – the IALMH has made an important contribution towards the evolution of scholarship and policy formulation in the multidisciplinary field of law and mental health in many jurisdictions throughout the world. It is our hope that the 28th Congress in Sydney 2003 will continue this fine tradition.

We are privileged this year to honour two internationally renowned colleagues. The Hon. Lady Justice Brenda Hale of the Royal Courts of Justice, United Kingdom, will receive the Prix Philippe Pinel during the Congress Plenary. Her passion for promoting social justice for vulnerable persons is reflected in the choice of her topic for the Philippe Pinel Address: ‘Justice and equality in mental health law’ – a fitting homage to the ideal of humane care for persons with mental illness espoused by Philippe Pinel after whom this award was named. The Hon. Justice Michael D. Kirby of the High Court of Australia will open this year’s Pre-Conference with the Yves Pélicier Address. Through his life-long commitment to the highest standards of legal scholarship and his ongoing contributions to human rights discourse, Justice Kirby, as the recipient of the Prix Yves Pélicier for 2003, graces the memory of our late colleague at the Université de Paris in whose name this award was established in 1998.

The programme for the 28th Congress evolved over a two-year period and is the result of the energies of many dedicated individuals with the support of institutions that recognise the importance of promoting dialogue in this area. We are particularly grateful to our Commonwealth and New South Wales State Government partners who not only provided financial support to make this event possible, but have been actively involved in the development of the scientific programme, thereby ensuring its engagement with issues of current relevance.

In addition, we would be remiss not to thank the members of our Scientific Committee and the Academy’s Executive Director, George Tomossy, without whom this undertaking would not have been possible. We are especially thankful to Prof. Beverly Raphael of the Centre for Mental Health in New South Wales for her encouragement since this project’s inception.

We hope that the upcoming days will be enjoyable, productive, and above all lead to outcomes that will improve the lives of persons who suffer from mental illness or intellectual disability.

Sincerely,

Terry Carney
Chair, 28th Congress.

David N. Weisstub
Co-Chair ex officio, 28th Congress.
Acknowledgments

The IALMH gratefully acknowledges the support of our government and institutional partners:

New South Wales Department of Health
New South Wales Attorney-General’s Department
Commonwealth Department of Health and Ageing
Commonwealth Attorney-General’s Department
Commonwealth Office for an Ageing Australia
New South Wales Police
National Health and Medical Research Council
Centre for Applied Philosophy and Public Ethics, Charles Sturt University

We are likewise indebted to the following institutions and organisations for their collegial assistance with organising and promoting this Congress:

Faculty of Law, University of Sydney
Royal Australian and New Zealand College of Psychiatrists
Australian Guardianship and Administration Committee and Mental Health Tribunals of Australia
Alzheimer’s Australia
Australian Association of Gerontology
Australian Institute of Health, Law and Ethics
Centre for Law and Genetics, University of Tasmania and Melbourne University
Monash University Centre for Human Bioethics
Medicines Australia

The Academy also wishes to thank the members of the Scientific Committee:

Terry Carney (Chair, 28th Congress),
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David Greenberg, Director, Community and Court Liaison Services, Corrections Health New South Wales

David N. Weisstub (Co-Chair ex officio, 28th Congress),
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Anna Howe, Consultant Gerontologist, Vic.
Alan Jager, Forensic Psychiatrist, Melbourne, Vic.
Stephen Leeder, Faculty of Medicine, University of Sydney
Bernadette McSherry, Faculty of Law, Monash University
Nick O’Neill, President, New South Wales Guardianship Tribunal
Beverly Raphael, Director, Centre for Mental Health, New South Wales Dept. of Health
Sandy Simpson, Waitemata District Health Board, Auckland, New Zealand
Loane Skene, Faculty of Law, Melbourne University
Justice Patricia Staunton, Member of the Industrial Relations Commissions of New South Wales
George Tomossy, Faculty of Law, University of Sydney
Hjalmar van Marle, Erasmus University Medical Centre, Rotterdam
Thomas Wenzel, University Hospital for Psychiatry, Vienna
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The International Academy of Law and Mental Health is founded on the belief that issues arising from the interaction of law and mental health can best be addressed through multidisciplinary and cross-jurisdictional approaches, drawing on law, the health professions, social sciences and humanities. Members of the Academy receive a subscription to the International Journal of Law and Psychiatry. For further information or to become a member of the Academy, visit the IALMH web site at: www.ialmh.org
This year’s Pre-Conference – “Medicine and Industry” – follows the Academy’s tradition to hold a special symposium to precede its Annual Congress with the aim to bridge the fields of ethics, law and medicine. This year’s theme will also have an important public policy dimension, canvassing the impact of global developments in the corporatisation of medicine and growth of the pharmaceutical and biotechnology industries.

We are privileged to honour Justice Michael D. Kirby of the High Court of Australia as the recipient of the Academy’s Prix Yves Pélicier for 2003. The Prix Pélicier will be bestowed on behalf of the IALMH by Prof. Ron McCallum, Dean of Law at the University of Sydney.

The Academy is grateful for the support of the National Health and Medical Research Council and the Centre for Applied Philosophy and Public Ethics, Charles Sturt University, towards the realisation of this symposium, and also wishes to acknowledge the collegial assistance of the Monash University Centre for Human Bioethics, the Australian Institute of Health, Law and Ethics and Medicines Australia in promoting this event.
Monday, Sept. 28, 2003

Registration: 8:45–9:30

Opening Session: 9:30–10:30

Chair: Alan Pettigrew, CEO, National Health and Medical Research Council of Australia

Welcome by the Chair

Presentation of the International Academy of Law and Mental Health Prix Yves Pélèier by
Ron McCallum, Dean, Faculty of Law, University of Sydney

Pélèier Address:
Money, medicine and the masses: Ethical choices in an age of global biotechnology
The Hon. Justice Michael D. Kirby AC CMG, High Court of Australia

Response by
Belinda Bennett, Faculty of Law, University of Sydney

Closing Remarks by the Chair

Break: 10:30–11:00

Medicine and Industry: 11:00–12:30

Chair: Richard Day, School of Medical Sciences, University of New South Wales

Understanding the origins of the academia-industry accommodation in biomedical research
Nicolas Rasmussen, School of History and Philosophy of Science, University of New South Wales

The construction of the pharmaceutical marketplace: Legal implications
David Healy, University of Wales College of Medicine

Markets for trust and betrayal
M. Gregg Bloche, Faculty of Law, Georgetown University

Discussion

Lunch: 12:30–13:30

The Business of Health: 13:30–15:00

Chair: Paul Satchell, CIO, Merck Sharpe Dome Australia

Emerging paradigms in human research ethics
George F. Tomossy, Faculty of Law, University of Sydney

Medicine and the Pharmacy Shop: Early reflections on a study of the relationship
Paul McNeil, Dept. of Community Health Sciences, University of New South Wales

Pharmaceutical companies, ethics and obligation
Deborah Zion, Centre on Human Bioethics, Monash University

Discussion

Break: 15:00–15:30

Genetics and Commercialisation: 15:30–17:00

Chair: Ronald Trent, Faculty of Medicine, University of Sydney

Upstream and downstream: Commercialisation issues in genetics
Don Chalmers, Dean, Faculty of Law, University of Tasmania

Marketing, media and the popular representations of genetics
Timothy Caulfield, Canada Research Chair in Health Law and Policy, University of Alberta

Genetic tests and patents: Can the relationship work?
Dianne Nichol, Centre for Law and Genetics, University of Tasmania

Discussion

Pre-Conference Cocktails & Dinner: 18:30
### Conflicts of Interest

**Chair:** Susan Alder, Medicines Regulation Consultant, Sydney

**Conflict of interest in the development of drugs for dementia**

*Peter J. Whitehouse, Fairhill Center on Aging, Case Western Reserve University*

**Monitoring research in a competitive environment: Potential conflicts of interest**

*Loane Skene, Faculty of Law, Melbourne University*

**Policy politics: Conflicts of interest, industry and research**

*Jocelyn Downie, Director, Health Law Institute, Dalhousie University*

**Discussion**

Break 10:30–11:00

### Global Health, Innovation and Commerce

**Chair:** Belinda Bennett, Faculty of Law, University of Sydney

**Multinational medicine: Clinical trials and cultural values?**

*Colin Thomson, Faculty of Law, University of Wollongong*

**International health research – Whose responsibility is it?**

*Udo Schüklenk, Faculty of Health Sciences, University of the Witwatersrand*

**Stem cell research and the global biotech industry**

*Susan Dodds, Dept. of Philosophy, University of Wollongong*

**Discussion**

### Lunch

12:30–13:45

### Changing Paradigms

**Chair:** Danuta Mendelson, School of Law, Deakin University

**The E-health chicken-and-egg: Is law driving the technology or playing catch-up?**

*Nicolas Terry, St. Louis University Law School*

**Epistemic capture: Industry and government in the setting of medical research priorities**

*John Merson, School of History and Philosophy of Science, University of New South Wales*

**Discussion**

Break 14:45–15:15

### Ethics, Industry and the Professions

**Chair:** The Hon. Michael Black AC, Chief Justice of the Federal Court of Australia

**Regulating the bio-economy**

*Derek Morgan, Faculty of Law, University of Cardiff*

**Business ethics in medicine**

*Tom Campbell, Centre for Applied Philosophy and Public Ethics, Charles Sturt University*

**On the limits of an internal morality in law and medicine**

*David N. Weisstub, Philippe Pinel Professor of Legal Psychiatry and Biomedical Ethics, Faculté de médecine, Université de Montréal*

**Discussion and Closing Remarks by the Chair**

Conclusion 17:00
Money, medicine and the masses: Ethical choices in an age of global biotechnology

The Hon Justice Michael D. Kirby AC CMG, High Court of Australia

The speaker is a member of the International Bioethics Committee (IBC) of UNESCO, of the Ethics Committee of HUGO and Honorary Adviser to the High Commissioner for Human Rights on Bioethics and Human Rights.

Amongst the many issues that have been addressed by the IBC, none is more sensitive and controversial than that concerning intellectual property rights with respect to genomic inventions and discoveries. Within the IBC, Justice Kirby was rapporteur of a working group that prepared a report on the response which the international community should make to the ethical dilemmas presented by the differing patenting practices observed throughout the world. The Universal Declaration of Human Rights (1948) upholds the principle of intellectual property rights. The Universal Declaration on the Human Genome and Human Rights (1997) emphasises that the human genome is part of the common heritage of humanity. According to the latter Declaration, in its natural state, the human genome should not give rise to financial gain. The TRIPS Agreement of the World Trade Organisation (WTO) insists upon respect within the global economic community of the intellectual property rights upheld by the law of member countries. How are these principles to be reconciled in an effective, practical and ethical way?

Because of his role in the IBC, Justice Kirby has been involved in some of the leading debates about the global response to the issues of patenting. A number of developed countries, led by the United States of America, insist on the ethical and legal justifications of intellectual property protections. Without such protections, it is unlikely that the huge investments necessary to translate raw genomic knowledge into medical tests and therapies will get off the ground. On the other hand, representatives of most developing countries are concerned with the flood of patent applications; with the provision of protection with respect to what they see as “discoveries” not “inventions; and with the potential distortion of pharmaceutical manufacturing policy to lead the triumph of the mapping of the human genome into profit-making activities relevant to the developed world rather than the urgent medical challenges of the developing world. In short, wrinkles before malaria.

The IBC working party urged that, if discussions with WTO do not produce appropriate exceptions from intellectual property obligations, to safeguard the needs of public health in the developing world, a moratorium should be introduced against further such patents until a more suitable global intellectual property regime is put in place. The proposals of the working party were adopted by the IBC. They were considered by the Intergovernmental Committee on Bioethics of UNESCO in June 2003. A recommendation on the subject will be debated at the General Conference of UNESCO in October 2003. It may be expected that UNESCO, with the United States having just rejoined as a member, will adopt a position on the subject. Fireworks can be anticipated.

Somehow, the world must reconcile the legal and ethical rights of manufacturing industry engaged in the production of medicines and pharmaceuticals with the human rights of individuals everywhere to enjoy life, health and access to essential therapies and tests. Translating international developments in this sphere into municipal law is also a great challenge. These issues lie at the heart of the contemporary debates over policy concerned with the genome.

It is appropriate, on the fiftieth anniversary of the discovery of DNA by Watson and Crick, to address these issues in a session that honours Professor Yves Pélicier, whose dedication to medical ethics must now take on an even wider focus in an age of extraordinary biotechnology.
**Medicine and Industry**

**Understanding the origins of the academia-industry accommodation in biomedical research**  
*Nicolas Rasmussen, School of History and Philosophy of Science, University of New South Wales*

This essay examines how efforts on the part of early-20th century ‘scientific medicine’ reformers to impose higher standards on the testing and promotion of pharmaceuticals led both to the intended disciplining of the drug industry and also, as a reciprocal but unintended consequence, to much greater involvement with industry among biomedical scientists. Exploring the mutual accommodation between ethical drug firms and academic clinical and preclinical researchers (and institutions) as it was taking shape in the interwar period helps to illuminate the basic patterns of exchange that still prevail today.

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**The construction of the pharmaceutical marketplace: Legal implications**  
*David Healy, University of Wales College of Medicine*

Within the psychiatric domain pharmaceutical companies have an increasing and unappreciated power to shape both how we all experience nervous problems, how those problems are labelled by mental health professionals and how the problems are treated. Most people “feel” that there must be a brake on this process somewhere. The regulators, along with university researchers, must in some way design or have a significant input into the protocols for trials that get drugs onto the market, analyse the data that comes from those trials, and store the data for future reference should adverse events occur. University researchers are generally credited with writing these data up for academic publication. In fact companies design the studies, collect and analyse the data, and store the data rather than give it to regulators, in addition to writing the “scientific” articles that purport to represent that data, to which they append the names of prominent academics. More than 50% of the literature in pharmacotherapeutics is at present ghost-written in one form or another. A substantial proportion of that literature does not in important legal and clinical respects reflect the underlying data, which it purports to represent.

The legal role of the regulators in the approval process is to act as a set of auditors, and they take a very similar approach to company data on drugs as financial auditors such as Arthur Andersen take to corporations such as Enron. Their primary task is to check on a selected case basis for correspondence between tabulated data and clinical records. They then approve labelling for the drug written by the company. These details of drug development are important at a time when clinicians claim to practice according to the evidence and claim that they are uninfluenced by sales gimmickry. There is little clinical appreciation that sales tactics are a later stage of marketing, and that one of the first steps in marketing is to select clinical indications, an appropriate set of trials, along with target journals and key academics. The failure of clinicians to appreciate this means that plaintiffs in legal settings are increasingly less likely to be able to find an expert to represent them.

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**Markets for trust and betrayal**  
*M. Gregg Bloche, Faculty of Law, Georgetown University*

Should the law allow doctors, patients, and health insurers to contract out of the medical profession’s traditional ethic of undivided loyalty to patients? Some financial and organizational arrangements between insurers and health care providers depart from this ethic by creating economic and other rewards for frugal practice. Many providers (and some bioethics commentators) object to such arrangements as violations of long-standing medical ethics tradition. Proponents of an expanded role for markets in the health sphere dismiss these objections as undesirable, guild-created barriers to competition. I will offer a third “story.” There is a market for medical ethics, shaped by fluctuating consumer and citizen demand for professional trustworthiness, as well as changing provider willingness to meet this demand. Ethical norms shift over time in response to these fluctuations. Because ethical norms are responsive to consumers’ and citizens’ evolving needs, they are, in general, socially desirable. But collective price-setting, barriers to market entry, and other anticompetitive activities that benefit providers without producing corresponding benefits for patients and consumers are undesirable and ought to be objects of antitrust regulation. A challenge for public policy is to distinguish between the two – to support ethical norms that respond to patients’ and consumers’ needs while identifying and suppressing anticompetitive collusion that furthers “guild” interests at society’s expense.

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The Business of Health

Emerging paradigms in human research ethics
George F. Tomossy, Faculty of Law, University of Sydney

Increasingly, discussions in bioethics are commanding a “paradigm shift” in research ethics and regulation – a new approach to developing policy, monitoring conduct and defining governance frameworks. This call has been issued in the area of clinical research but also echoed in other domains, including public health ethics and the humanistic or social science disciplines.

The transition to a new “paradigm” in the area of research involving human participants is readily argued on the basis of perceived inabilities of current governance structures to afford adequate protection to human research participants in the light of the rising burdens placed on systems of ethics review. The justification for a “paradigm shift”, however, runs deeper. It arises in response to fundamental changes in the research universe that have both accelerated the demand for reform as well as introduced new controversies for deliberation. These changes are the expression of two forces: globalisation and corporatisation. While both are linked to one another, this paper will focus on the latter, describing how corporatisation requires a re-conceptualisation of some of the core ethical, legal and regulatory paradigms that have dominated human research ethics and regulation.

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Medicine and the Pharmacy industry: Early reflections on a study of the relationship
Paul McNeill, Dept. of Community Health Sciences, University of New South Wales; Ian Kerridge, Director, Centre for Values and Ethics and the Law in Medicine, University of Sydney; David Henry, School of Medical Practice and Population Health, University of Newcastle

Early indications from our study of the pharmaceutical industry and the medical profession indicate that the relationship is complex. There is no simple typology that is appropriate, nor is there any simplistic moral stance that could adequately or appropriately characterise the relationship. Those who express strong views tend to make assumptions about what occurs and to found their position on moral certitudes and polemics. Typically the debate reflects a lack of understanding about the dynamics of the relationship and its social, political and moral context. Our research suggests that the relationship is an inevitable and necessary component of the health care system that is best seen as a duality (if not a plurality) of interests, each with its own valid concerns. The questions that emerge concern how to construe the health care relationship, and the relationship between the industry and doctors in the light of broader social, economic factors. It may be too early in our data analysis to be able to offer empirical findings from the study. It is intended however to reflect on some of the early indications from our research and consider the broader contextual questions that arise.

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Pharmaceutical companies, ethics and obligation
Deborah Zion, Centre on Human Bioethics, Monash University

Recently there has been much debate concerning the pricing of drugs for diseases like HIV/AIDS in the developing world, where many trials have been and continue to be conducted, but where access to drugs is limited by both cost and lack of health infrastructure. While much attention has been paid to the ethical duties that should be fulfilled by investigators and international agencies, less has been said about what kinds of duties should govern the conduct of pharmaceutical companies.

I suggest that duties based upon beneficence and justice also have an important role to play when considering the obligations of pharmaceutical companies. After giving accounts of both the Utilitarian and Kantian versions of the duty of beneficence, and briefly describing duties based upon the Kantian idea of justice, I discuss the way in which a claim based upon collectivity gives the duty of beneficence special force in this context. I draw upon the works of Henry Shue and Robert Goodin, and suggest that the clinical investigative process might work as a “mediating institution” that promotes justice and fairness. I conclude by suggesting some ways in which the changes brought about by gay communities in HIV/AIDS research might be relevant to such pharmaceutical companies.

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Genetics and Commercialisation

Upstream and downstream: Commercialisation issues in genetics
Don Chalmers, Dean, Faculty of Law, University of Tasmania

Government policy is directed to biotechnology with the national Biotechnology Strategy setting out required safeguards for health and the environment.

In the knowledge-value revolution, research, information and intellectual property are the new wealth creators. The valuation of the market- leader companies in these knowledge-based industries can exceed the annual budget of smaller nations. For example, in 2000 the computing giant Microsoft had a value of $US600 billion which was
larger than the total 1998 exports of Brazil, one of the three largest mineral export economies, by a factor of 10. Brazil is a country of 160 million; Microsoft employs 35,000.

There is deliberate government policy in many countries with active biotechnology research programs to encourage these collaborations, particularly with private industry contributing to the basic, or ‘upstream’ research effort. The terms ‘upstream’ and ‘downstream’ describe the two ends of the continuum from basic research findings (gene sequences and the like) through to marketable products (drugs, therapies and diagnostics, genetically modified plants, seeds and so on). Traditionally, upstream research has been the province of the public sector and the private sector has focused more on the downstream application of that research. At this stage of the biotechnology revolution, however, it is difficult to see how upstream research can continue to progress at the same pace without private sector support. This will be a private sector financed revolution.

The success of the biotechnology revolution depends on an array of interwoven factors, not the least of which is public trust in the science, the scientists and the regulators. In a survey conducted in the UK, the Wellcome Trust and Medical Research Council noted that the involvement of big business (both pharmaceutical and biotechnology companies) in medical research caused concern in the general public. In part, this is because of the broad ethical dilemma posed by mixing medicine and money. This paper will consider the increasing convergence of ethical and regulatory issues in the public and private sectors. It also considers some of the ways in which the commercialisation of biotechnology research can affect public trust and the roles of appropriate regulation, public consultation and social responsibility in protecting and restoring public trust.

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Marketing, media and the popular representations of genetics

Timothy Caulfield, Canada Research Chair in Health Law and Policy, University of Alberta

Genetics and related technologies get a lot of attention from the popular press. In addition, we are beginning to see more intense marketing of a variety of genetic services, including websites and a few examples of direct-to-consumer strategies. The public and professionals get most of their information about genetics from the popular press. As such, it has been suggested that media representations of genetics exaggerate both the benefits and the risks associated with genetics and genetic technologies, leading to a phenomenon that has been called “genohype” (Holzman 1999; Caulfield 2000; Fleising 2001). It has also been suggested that this genohype may have an adverse impact on the ability of the public to participate in policy discussions (Ransonhof and Ransonhoff 2001; Geller et al. 2002) and on the utilization of genetic services by creating “inflated perceptions” of the value of, for example, specific genetic tests (Melzer 2002). In turn, regulatory responses may be distorted by misplaced and overly positive or negative public concerns fuelled by inaccurate and sensationalist media reporting or directly by the research community.

In this paper, I will explore the available evidence on the accuracy, nature and impact of media representations of genetic technologies. For example, I will overview our analysis of 627 newspaper articles in 28 newspapers in Canada, Australia, Great Britain and the USA reporting on 111 papers in scientific journals from 1995-2002. Though we found a surprisingly high degree of accuracy (11% of newspaper articles had moderate-highly; 26.3% slightly, and 62.7% no exaggerated or erroneous claims), it is clear that the media isn’t entirely to blame for the reporting inaccuracy. Researchers, biotech companies, universities and public funding agencies have a role in the creation of the hype. Partly the result of the close ties with industry and the intense competition for public research dollars, researchers are increasingly expected to provide information on the practical applications of research – which usually means overly optimistic speculation about the development of therapeutic products. The enthusiasm is understandable. But, again, it can lead to a less than accurate picture of our genetic future.

Paradoxically, the biggest casualties of the hype could be the genetic research community and the biotechnology industry. The public may stop listening. And without public trust and support, genetic research is doomed.

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Genetic tests and patents: Can the relationship work?

Dianne Nichol, Centre for Law and Genetics, University of Tasmania

Advances in genetics are increasing the range and quality of diagnostic tests for genetic diseases. The commercial nature of much of this research requires that appropriate steps are taken to secure return for investment, usually by taking out patents. The appropriateness of patenting genetic technologies, particularly gene sequences, is a matter of ongoing controversy. There is growing concern that certain patents may have a detrimental effect on diagnostics-based research and the delivery of diagnostic genetic tests to consumers. This paper reports the results of a survey of laboratories offering diagnosis of genetic disorders in Australia conducted in late 2002 and early 2003. Participants were asked a series of questions relating to the tests they perform, whether they pay any patent licence fees or royalties for the performance of those tests and whether they have received any notifications from patent holders about patents associated with particular tests. They were also asked for their views on patents. In contrast with an earlier study in the USA, at the time that the survey was conducted there was little or no indication that gene patent holders or their licensees are currently actively enforcing their patents in Australia. However, in
at least one case it is likely that such enforcement action is imminent. Moreover, participants generally view the impact of patents in this area as negative. These results support the need for discussion of the legal avenues for clarifying the validity of gene patents and licensing options. Some of these avenues will be discussed.

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Conflicts of Interest

Conflict of interest in the development of drugs for dementia

Peter J. Whitehouse, Fairhill Center on Aging, Case Western Reserve University; Jesse Ballenger, Institute of the History of Medicine, The Johns Hopkins University; Jason Karlwisch, Faculty of Medicine, University of Pennsylvania

Conflicts of interest are inevitable. In fact the recognition that competition between different values exists offers a mechanism for social change. The class of conflicts of interest that bring professional responsibilities and personal gain into juxtaposition are of particular interest in the development of medications to treat diseases. For the past 20 years I have been involved in the translation of basic research findings into more effective therapies for persons labelled with Alzheimer’s disease. At such I have received numerous grants and payments as a consultant to the speaker for practically all the companies in the world developing medications for dementia. During this time I have seen the evolution of concern about conflict of interest and a variety of methods used to address the issue. The stakes appear to be high as gains in personal income and prestige may occur but contribute to the loss of trust in the medical enterprise as a whole.

I will present three cases studies that illustrate the evolution of concern and the challenges which lie ahead in dementia drug studies. The first involves the approval of the first drug for Alzheimer’s disease, namely tacrine. The original clinical research reported in a prestigious medical journal was full of questionable study design issues as well as an undisclosed conflict of interest. Attempts to conduct follow-up studies were marred by unwise proposed methods of reimbursement to the sites involved in the studies. The establishment of quasi-independent foundations to allocate profits from the approval of tacrine provided some insulation of the experts from the profits. As the field of Alzheimer’s disease continued to develop and other medications were approved, the intimate relationships between the experts needed to conduct studies and the industries that support many of them became more challenging. Ethics committees need to balance the interest of the investigators, their organizations and those of society. Finally I present my current situation in which for a brief period time I owned currently valueless stock in a company developing web based approaches to assess age-related cognitive changes. This final experience will address the difference between ownership in stock and cash payments of varying magnitudes. Disclosure of general issues surrounding conflicts of interest and of one’s own specific conflicts are certainly part of the process of preserving what appears to be a growing and in my opinion legitimate distrust of the medical industrial establishment.

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Monitoring research in a competitive environment: Potential conflicts of interest

Loane Skene, Faculty of Law, Melbourne University

Research, funding awards, publication and commercialisation of research outcomes are increasingly important to the employment and career prospects of medical and scientific researchers. All of these activities are monitored and assessed by specialists in particular fields. Job applicants, especially within the academy, are interviewed by selection panels comprising – or including – experts in the field. Researchers seeking funding for initial or ongoing research have their applications vetted by expert assessors who advise funding agencies like the National Health and Medical Research Council (NHMRC) or the Australian Research Council (ARC) concerning scientific, ethical, commercial and other aspects of proposed projects. Researchers must also obtain ethical approval from Human Research Ethics Committees (HRECs) before any trial involving human subjects; and possibly from other more specialist committees as well, if their work involves genetic manipulation, gene therapy, xenotransplants and the like. When the research is completed and the researcher seeks publication, other experts examine it during the editorial process before it is accepted. Similarly, when research is commercially developed, experts from bodies like the Therapeutic Goods Administration advise on safety and efficacy.

Australia has a relatively small population. The number of “specialists” is commensurately small. The more specialised the field, the fewer the experts and the greater the chance that they will know – or have links with – the person under review. The potential for conflict of interest is apparent. The author outlines a series of potential conflicts – some of which may be surprising. She then discusses what should be done if potential conflicts arise. Is it enough for those involved to declare an interest? Should they abstain from voting? Or remove themselves entirely from the process?

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**Policy politics: Conflicts of interest, industry and research**

**Jocelyn Downie, Director, Health Law Institute, Dalhousie University**

Much attention has been focused on conflicts of interest of researchers (e.g., the Gelsinger case) and their institutions (e.g., the Olivieri and Healy cases). Less has been focused on conflicts of interest of policy-makers and those who advise policy-makers. This paper will explore the very real conflicts that have arisen for and through these two groups – specifically, health care ethics and law experts, and research funders and regulators – as these conflicts have, to date, been largely unrecognized and unmanaged. The author will illustrate concerns about the “experts” through reference to the recent Canadian experience with policy-making around stem cell research. Concerns about the funders and regulators will be illustrated through reference to the Canadian experience with the two largest national health research funding agencies (Genome Canada and the Canadian Institutes of Health Research) and the two federal government departments most relevant to health research (Health Canada and Industry Canada). These experiences will no doubt resonate with participants from many different countries as the issues are not specific to Canada. The author will reflect on the need to first learn to recognize these conflicts and second to manage them. She will explore solutions including: increasing capacity-building efforts; removing conflicted individuals from certain policy-making processes; reducing matching funds requirements; clarifying mandates for various existing institutions; and creating new institutions for the governance of research involving humans.

**Global Health, Innovation and Commerce**

**Multinational medicine: Clinical trials and cultural values?**

**Colin Thomson, Faculty of Law, University of Wollongong**

Clinical trials to test the efficacy and safety of an increasing quantity of new pharmaceutical products need to recruit increasing numbers of participants. The goal of trials is the generation of data that will be of acceptable quality for agencies in western developed countries as the basis for granting marketing approval and access to opportunities to recoup some or all (or even more than) the large costs of drug development.

Although the major market for pharmaceuticals remains western developed nations, increasingly trials are conducted in other less developed and developing countries. To ensure that the data generated by these trials is of acceptable quality, the process for their approval and conduct includes the role of a research ethics committee, a type of civic jury, that reviews and then approves the initiation of trials if “ethically acceptable.” These processes are well established in western countries and have there led, over about five decades, to the definition of those ethical values and principles from those cultures by which these trials are assessed and approved.

Developing countries, perhaps attracted to the economic and industry benefits of hosting trials, as well as industry sponsors of those trials, need to establish similar civic jury systems of research ethics committees to review proposed trials. Difficult choices are presented that include whether to develop, in a very short time, a set of ethical values and principles reflective of their own culture, to use in assessing trials, or, adopt, on an interim basis, the values and principles familiar to western countries. Will the second alternative, by the very process for which it is adopted, come to embed those values into the national culture? Or are the values that have emerged for this purpose sufficiently universal? If so, is that apparent universality related to multinational medicine?

In this paper, these and related questions about the nature of ethics and research ethics and the process of clinical trial approval are addressed, with particular reference to some of the initiatives being developed to address the needs of populations and clinical trials in developing countries.

**International health research – Whose responsibility is it?**

**Udo Schüklenk, Faculty of Health Sciences, University of the Witwatersrand**

In the international debate on standards of clinical care in research undertaken in developing countries as well as in debates on appropriate community benefit after trial conclusion many commentators have been highly critical of the role played by pharmaceutical multinational companies pricing policies and research agendas. While I do empathize with the criticism raised by such commentators, I do believe they beg the question of why the pharmaceutical industry has any more of a moral responsibility for the provision of essential drugs in developing countries than, say Daimler-Chrysler. My presentation attempts to address the question of which players should take responsibility for the development of drugs needed in developing countries, and for the affordability of those drugs. I will argue that while indeed a moral argument can be constructed that would require pharmaceutical companies to do more than they do currently, it is also clear that developing countries should invest substantially more into research for locally needed drugs and delivery infrastructure than is currently the case. The failure of the current IPR regime to facilitate commercial research pertaining to tropical illnesses killing millions of people in developing countries is strongly indicative of a more fundamental problem with regard to the financing of drug development R&D for developing world peoples. Alternatives to the current modus operandi of providing research incentives by means of patents will be presented.

Attention: The email addresses provided are not visible in the natural text.
**Medicine and Industry**

**Stem cell research and the global biotech industry**

_Susan Dodds, Dept. of Philosophy, University of Wollongong_

Recent moves to legislate in the area of human embryonic stem cell research in Canada and Australia introduce legislative regulation to a sphere of activity (human research ethics) where control previously took the form of guidelines and policy advice. The global biotechnology industry is a new and fast developing area of commerce. Governments keen to reap economic benefits from publicly supported research infrastructure welcome the opportunity to enter this global market, but are also concerned to control or limit the scope of research that is recognised to raise profound ethical issues within liberal democratic societies. This paper examines the process of policy making in this rapidly changing realm and asks whether recent policy moves are able to recognise the ethical issues raised by the commodification of stem cell lines and the biotechnology market. I argue that the recent policy and legislative moves are better able to capture concerns relating to the ethical status and agency of individuals than the effects of markets and commodification on health care.

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**Changing Paradigms in Medical Law and Ethics**

**The E-health chicken-and-egg: Is law driving the technology or playing catch-up?**

_Nicolas Terry, St. Louis University Law School_

The core inquiry of this paper is the extent to which the legal system has comprehended and adapted to the commercialization of healthcare delivery and the evolution of technology-focused health businesses and practices. To provide context, the paper examines several contemporary medico-legal phenomena that are proving troublesome to mature legal systems. These are: (1) Online Medical Advice, that features the traditional interplay between liability for harmful content, defamation (in the case of third party trust-marking systems) and constitutional norms that protect speech. (2) Adverse Results and Medical Error, where our legal constructs seem ill-prepared to deal with innovations such as clinical practice guidelines, computerized physician order entry and clinical decision support systems. (3) Online Practice and Pharmaceutical Marketing & Distribution, where jurisdictions are re-writing their licensure or practice rules to capture cross-border Internet prescribing and dispensing, increasing the regulation of intrastate and interstate practice, and potentially chilling innovation. (4) Privacy and Confidentiality, where generalized privacy rules are being adapted to the complex patient health information domain in an attempt to limit health provider externalization of the privacy costs associated with emerging e-health models.

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**Epistemic capture: Industry and government in the setting of medical research priorities**

_John Merson, School of History and Philosophy of Science, University of New South Wales_

This paper will address the issue of ‘epistemic capture’, or the argument that industry has an inherent interest in controlling the epistemic or knowledge base of medical practise and the setting of public health priorities. The paper will explore these issues in relation to the development and promotion of drug treatments for ADHD (Attention Deficit/ Hyperactivity Disorder) and chronic stress-related illnesses. It will be argued that it is not just the pharmaceutical and medical insurance industries that are driving this process, but the short-term interest of medical practitioners and the consumers of their well marketed drug-based therapies. However, despite the obvious utilitarian principle implicit in this constellation of interests, it will be argued that this is not necessarily in the public interest. The process by which such medical treatments are developed tend to involve the corporate funding of narrow research fields, the promotion of only positive findings through medical journals, the legitimation for evidence -based strategies, and the marketing of commercially profitable drugs. This increasingly results in the treatment of symptoms, and in the process avoids the public health issue of addressing the more difficult psychological, social and economic causes of illness. While it is commercially legitimate for corporations to pursue their self interest in this regard, there is an obvious need to balance this process with a strong independently funded and more inter-disciplinary medical research culture. This is not only essential for the development of new and more innovative preventative strategies in areas of public and occupational health, but also to provide regulatory agencies with genuine independence from commercial interests and bias. With the increasing dependence of medical schools on funding from the pharmaceutical industry, and the relative decline in government funding for academic research, there is a legitimate concern that the knowledge base which shapes medical practise and legitimates norms will gradually be distorted, hence the notion of ‘epistemic capture’. This can arise where industry, government regulators, professional practitioners and academic researchers are too commercially interdependent, as has been reported in a number of scientific fields. This paper therefore argues that there is a need for reform in the funding and priorities of medical and health-related research to address this issue, especially in the context of what some critics have described as the growing power and influence of a globalised ‘medical-industrial-complex’.

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Regulating the bio-economy

**Derek Morgan, Faculty of Law, University of Cardiff**

Stan Davis and Christopher Meyer have suggested that the next economy is gestating right now; it is the bio-economy. Biotechnology will be the next great wave after information technologies. It will begin in areas like pharmaceuticals and agriculture and, ultimately, spread throughout every economic sector, just as computers did before the true economy of most of the twenty-first century—will be like. It will be characterised by pharmacogenetics, nanogenetics, globalisation and telemedicine, but alchemised in potent ways with results that we do not know, indeed that we cannot predict. In this way, the bio-economy is a paradigm reflection of the sub-politics of medicine in what Ulrich Beck has called the ‘risk society.’ I suggest that unless we begin to think how to regulate this emergent bio-economy, the shape and nature of which we cannot yet know and possibly not even predict, we condemn ourselves to a relationship with it that will further undermine the rule of law and disenfranchise us. Regulating the bio-economy is about identifying and elaborating a concept of scientific citizenship which will tax the resources of what I have elsewhere called ‘biomedical diplomacy.’

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Business ethics in medicine

**Tom Campbell, Centre for Applied Philosophy and Public Ethics, Charles Sturt University**

Much controversy surrounds the issue of whether the practice of medicine should be a business and how the business aspects of medical provision should be regulated so as not to conflict with the rights and interests of patients and health providers. Ethical critiques of medical practice tend to be hostile to business intrusion into medical services and stress the nature of medicine, not business, as the basis for the ethical practice in health provision. However, there is, in varying degrees, a business aspect within all health services, so that it is necessary to raise the question about business ethics standards in medical practice as a matter that is to some extent separable from issues in bioethics or medical ethics. It can be argued that there are examples of inadequate business ethics in health care provision that would not be tolerated in other industries. Moreover, some of these deficiencies in business ethics derive from the values and assumptions that are intrinsic to medical ethics and traditional medical practice. The conflict between medical ethics and business ethics is explored with respect to such matters as restrictive practices, medical paternalism, conflicts of interest, sale of goods, unconscionability and fair trading.

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On the limits of an internal morality in law and medicine

**David N. Weisstub, Philippe Pinel Professor of Legal Psychiatry and Biomedical Ethics, Faculté de médecine, Université de Montréal**

Both law and medicine, as dominant models of professionalism, have proffered the idea that there are sets of principles or ideals that underlie their practices. Even if it is the case that some persuasive arguments can be made in favour of internalism, there are many reasons why a consensus about such values is increasingly difficult to obtain. In order to avoid widespread public and professional cynicism about universal values in the professions, it is useful to reflect on recent arguments about relativism. The legal system itself is an important area to consider as a reference for defining the concept of professional ethics. Such an investigation requires distinguishing between professional standards and moral criteria. Locating the source of both ideals and standards within and outside of the professions remains a major challenge. Psychiatry, as a field of medicine, is a testing ground for sorting out the relation between humanistic values and therapeutic practice. Because psychiatry has within it ambiguous overlaps with legal, social and political functions, its historical debates about professional integrity and identity with respect to values is deserving of attention.

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The Plenary Theme for the 28th Congress – “Social Justice within Diversity” – will address issues of equity and access to justice to mental health services and the law within a multicultural society such as Australia. We are delighted to welcome our distinguished keynote speakers, chairs and discussants who will provide a valuable contribution to debate on this rich area of law and social policy.

We are privileged to honour Lady Justice Brenda Hale of the Royal Courts of Justice, United Kingdom, as the recipient of the Academy’s Prix Philippe Pinel for 2003. The Prix Pinel will be bestowed on behalf of the Academy by Senator John Tierney, Senator for New South Wales.

We are further honoured by the presence of the Hon. Morris Iemma MP, Minister of Health for New South Wales, who will deliver the closing address for this year’s plenary. A reception, hosted by the State Government of New South Wales, will follow the plenary, and will be graced by the Hon. Bob Debus MP, Attorney-General of New South Wales, who will give an address welcoming the Congress delegates.

The Academy is grateful for the support of our state and federal government partners in realising this Plenary, including in particular the Centre for Mental Health of the New South Wales Dept. of Health, the Mental Health and Special Programs Branch of the Commonwealth Dept. of Health and Ageing, the Policy & Crime Prevention Branch of the New South Wales Attorney-General’s Dept., and the Crime Prevention Branch of the Commonwealth Attorney-General’s Dept.
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<td>Julio Arboleda-Florez, Chair, Dept. of Psychiatry, Queen’s University, Canada</td>
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<td>Introductory Remarks by Incoming IALMH President</td>
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<td>Hjalmar van Marle, Professor of Forensic Psychiatry, Erasmus University Medical Centre, Rotterdam</td>
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<td>Philippe Pinel Address: Justice and equality in mental health law: The European experience</td>
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<td>Geneva Richardson, Professor of Public Law, Queen Mary &amp; Westfield College, University of London</td>
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<td>Court diversion in New South Wales: An innovative approach?</td>
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<td>Chair: Duncan Chappell, President, Mental Health Review Tribunal, NSW</td>
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<td>Indigeneity, mental health service responsiveness and the potential for innovation</td>
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<td>Mason Durie, Professor of Maori Research and Development, Massey University, New Zealand</td>
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<td>Putting community risk in perspective: A look at correlations, causes, and controls</td>
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<td>Virginia Aldigé Hiday, Professor, Department of Sociology and Anthropology, North Carolina State University</td>
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<td>Discussant: Laurence Tancredi, Clinical Professor of Psychiatry, New York University School of Medicine</td>
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<td>Chair: David N. Weisstub, Philippe Pinel Professor of Legal Psychiatry and Biomedical Ethics, Faculté de médecine, Université de Montréal</td>
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<td>Unequal treatment: Race, ethnicity and discretion in health systems</td>
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<td>M. Gregg Bloche, Professor, Faculty of Law, Georgetown University</td>
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<td>Michele Goodwin, Faculty of Law, DePaul University</td>
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<td>The Hon. Morris Iemma MP, Minister of Health, Government of New South Wales</td>
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<td>Reception at Parliament House Hosted by the New South Wales State Government</td>
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Justice and equality in mental health law: The European experience

The Hon. Lady Justice Brenda Hale
Royal Courts of Justice, United Kingdom

There are currently three forces at work in the development of UK mental health and incapacity laws: the Government’s controversial proposals for a new mental health law, the Law Commission’s less controversial proposals for a new mental incapacity jurisdiction, and the incorporation of the European Convention on Human Rights into UK law. Traditional human rights instruments on the western model have principally been concerned with protecting individual liberty and freedom from unjustified interference by the state. Traditional mental health and incapacity laws have likewise principally been concerned with legitimising interference with liberty and freedom for the good of the individual or the protection of others. Neither has had much to say about securing the appropriate care and treatment for all who need it or about doing so without discrimination on grounds such as gender, ethnicity or social grouping. This paper will explore the experience of mental health and incapacity laws under the European Convention on Human Rights. It will inquire how well the Convention has fulfilled its traditional role in protecting liberty and freedom. But it will also inquire whether the Convention has the potential to develop a more positive view of the state’s obligations to provide the appropriate care and treatment. This is becoming more urgent as institutional care and treatment is becoming less appropriate. There may also be a role for Article 14, which prohibits discrimination in the enjoyment of the rights and freedoms set forth in the Convention, in developing the concept of positive obligations.

Balancing access, autonomy and public protection: Challenges of contemporary mental health policy making

Genevra Richardson, Professor of Public Law, Queen Mary & Westfield College, University of London

Many developed legal systems maintain a separate statutory structure to govern the provision of mental health care and treatment. Thus mental disorder is legally distinguished from physical disorder and is treated in accordance with its own set of principles. Possible justifications for this singling out of mental disorder include the need to provide access to services, the need to protect the patient from the effects of mental disorder and the need to protect the public from the feared consequences of mental disorder in others. This paper will argue that the last two of these justifications can lead to a denial of respect for the autonomy of those with mental disorder and may therefore compound the discrimination suffered. The paper will then examine the consequences of that discrimination and will consider whether specific mental health legislation, which goes beyond the simple provision of access for those who lack capacity, can ever be justified. It will discuss the implications of the introduction of a single incapacity framework to provide for decisions to be made on behalf of all those who lack mental capacity, for whatever reason. Finally it will consider what the various reactions to any proposals which seek to embed provision for mental disorder within a broader incapacity framework reveal about our attitudes to mental incapacity in general and to mental disorder in particular.

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Court diversion in New South Wales: An innovative approach?

David M. Greenberg, Director of Community and Court Liaison Services for Corrections Health, NSW

New South Wales remand centres/prisons currently have a disproportionate number of mentally ill and mentally disordered persons relative to the community. For summary matters, these persons can potentially be diverted back to the health system by way of sections 32 & 33 of the NSW Mental Health (Criminal Procedure) Act 1990. The NSW State-wide Community Court Liaison Service which has been rolled out across seven metropolitan and seven regional areas, takes a whole government approach to the initial planning of the state-wide service. This paper reviews opportunities and difficulties with the development and implementation stages of the service, including diversionary measures and liaison openings with area mental health services. Successful output data and satisfaction outcomes from stakeholders have produced a unanimous endorsement of the service. It is argued that Court Diversion and Court Liaison have resulted in immediate access for mentally ill and mentally disordered persons in courts to mental health services. It has also enhanced inter-agency and intra-agency relationships with all stakeholders. Benefits provided to selected clients with relatively minor charges include a move away from criminalization of the mentally ill and potential improved health and judicial outcomes.

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Risk and Community

Indigeneity, mental health service responsiveness and the potential for innovation

Mason Durie, Professor of Maori Research and Development, Massey University, New Zealand

Indigenous world-views form the foundations for a system of knowledge largely built on assumptions about the relationship of people to the natural environment. While there are several points of intersection, an indigenous knowledge system is distinct from other knowledge systems such as science. Most indigenous peoples however, live at the interface between indigenous knowledge and science. This paper explores the interface by focussing on the way in which Mäori values, perspectives and beliefs have been factored into mental health services in New Zealand. Implications for society generally, and mental health services in particular, are considered within the framework of a knowledge interface where Mäori world-views and the world-views of a wider (global) society meet. Case studies in risk-assessment, psychotherapy, and the measurement of outcomes provide a basis for concluding that there can be synergies between the two systems. While there is potential for conflict at the interface, there are also opportunities for innovation and the development of new approaches that accord with Mäori perspectives and recognise scientific advances and professional practice.

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Putting community risk in perspective: A look at correlations, causes, and controls

Virginia Hiday, Professor, Department of Sociology and Anthropology, North Carolina State University

Much research, but not all, appears to show that persons with severe mental illness are more dangerous and violent than others; but it is misleading and feeds the stigma cannon. This paper critically reviews the correlations, examines the statistical confounds, highlights studies which seek causal mechanisms rather than associations, points to what those causal mechanisms tell us about controlling risk in the community, and reviews legal attempts to control community risk in light of those causal mechanisms.

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Towards Inclusive Policies for Mental Illness in a Changing World

Restorative justice, social justice and diversity

John Braithwaite, Professor, Faculty of Law, Australian National University

Justice is conceived as an immanently holistic concept. So while there are important differences between social justice, restorative justice, and procedural justice, the existence of one has some tendency to facilitate the other. These differences will be explained. I used to think that restorative justice was not especially important to social justice; now I think it is quite important to social justice and important to a holistic vision of justice. In this paper I seek to explain this change of heart. One reason for it is the increasing importance to patterns of social justice in the world of the globalisation of diseases like AIDS and multiple drug resistant tuberculosis. Another is the increasing importance to the elimination of poverty in knowledge economies of human and social capital and the growing evidence of how criminal justice institutions destroy these kinds of capital for the poor. In Australia, this applies with special force to our Indigenous peoples. Restorative justice is about pluralizing the voices in justice processes. It conceives of listening to peoples’ stories as an underestimated form of empowerment. The idea that, because injustice hurts, justice should heal, is of special significance to disenfranchised minorities.

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Unequal treatment: Race, ethnicity and discretion in health systems

M. Gregg Bloche, Professor, Faculty of Law, Georgetown University

Health care is an endeavour replete with hidden opportunities for exercising discretion. Science answers few of the questions that clinicians face daily. The resulting space for discretion opens myriad possibilities for racial bias at the bedside and in the design and administration of health systems. This presentation will explore the connections between hidden discretion and racial and ethnic disparities in health care provision. It will highlight the influence of economic and regulatory pressures. It will then offer proposals for institutional, legal and cultural change. Finally, it will suggest some broader conclusions that we might draw, about the psychology and social expression of bias, from the persistence of racial disparities in health care provision within societies that have rejected racism’s overt forms.

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The International Academy of Law and Mental Health is founded on the belief that issues arising from the interaction of law and mental health can best be addressed through multidisciplinary and cross-jurisdictional approaches, drawing on the law, health professions, social sciences and humanities. To this end, the Academy is delighted to welcome over 350 speakers, keynotes, discussants, panellists and chairs participating in some 72 Parallel Sessions of the 28th Congress. It is hoped that this historic first meeting of the IALMH in the Southern Hemisphere will not only serve as a valuable educational forum for Australians, but will also provide an opportunity for Australian and foreign delegates establish long term collaborations, thereby contributing to the development of social policies that will improve the lives of persons with mental illness and enhance the mental health of people in general.

We are privileged to include a number of keynote speakers, including addresses by the Hon. Kevin Andrews MP, Commonwealth Minister for Ageing, and the Hon. John Watkins MP, New South Wales Minister for Police. We are likewise honoured by presence of a number of distinguished legal officers who have graced this year’s program.

The Academy is grateful for the support of our state and federal government partners in realising sessions of this Congress, including the Centre for Mental Health of the New South Wales Dept. of Health, the Mental Health and Special Programs Branch of the Commonwealth Dept. of Health, the Policy & Crime Prevention Branch of the New South Wales Attorney-General’s Dept., the Crime Prevention Branch of the Commonwealth Attorney-General’s Dept., the Commonwealth Office for an Ageing Australia and New South Wales Police.

The Academy would also like to thank the members of the Scientific Committee for their contributions towards the planning of these sessions. In particular, we wish to acknowledge the collaboration of various professional, academic and government institutions with whom a number of day themes are jointly convened. These include: Australian Guardianship and Administration Committee; Australian Association of Gerontology; Centre for Law and Genetics, University of Tasmania and Melbourne University; Commonwealth Office for an Ageing Australia; Crime Prevention Branch of the New South Wales Attorney-General’s Dept.; Faculty of Law, University of Sydney; Mental Health and Suicide Prevention Branch of the Australian Government Department of Health and Ageing; Mental Health Tribunals of Australia; New South Wales Dept. of Health; and New South Wales Police.
# Parallel Sessions and Themes of the
## 28th International Congress on Law and Mental Health

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<td>8:30-10:00</td>
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### Wednesday, Oct. 1, 2003

#### Mental Illness at the Intersection of Health and Justice (p. 23)
- Perth Room (3rd Floor)
  - The New South Wales Experience
  - International Perspectives
  - Diversion & Court Assessment

#### The Patient-Therapist Relationship (p. 27)
- Sydney Room (3rd Floor)
  - Psychiatry, Ethics and the Law
  - Accountability of Mental Health Professionals
  - Therapeutic Relationships

#### Guardianship and Mental Health Tribunals (p. 33)
- Melbourne Room (3rd Floor)
  - Consent to Medical Research
  - Protection & Self-Help: Complementary Approaches to Guardianship
  - Guardianship & Mental Health Tribunals: Roles & Expectations
  - Decision-Making in Guardianship & Mental Health Tribunals (ends at 17:45)

#### Therapeutic Jurisprudence (p. 39)
- Brisbane Room (3rd Floor)
  - Law Enforcement and Mental Illness (p. 41)
  - Law Enforcement and the Mentally Ill
  - International Approaches to Crisis Intervention

#### Forensic Systems (p. 47)
- Boardroom 1 (Ground Floor)
  - Psychiatric Injury Litigation (p. 45)
  - The Netherlands
  - Decision-Making in Guardianship & Mental Health Tribunals (ends at 17:45)

#### Indigenous Justice and Mental Health (p. 52)
- Boardroom 2 (Ground Floor)
  - Indigenous Justice and Mental Health
  - Mental Health and Indigenous Communities
  - Work, Disability and Mental Health

#### Work, Stress & Disability (p. 55)
- Boardroom 2 (Ground Floor)
  - Indigenous Justice and Mental Health
  - Mental Health and Indigenous Communities
  - Work, Disability and Mental Health

### Evening Events:

#### Continuing Legal Education Seminars
*Restricted to pre-registered delegates (surcharge applies).*

1. **Causation and Evidence in Health Litigation** (p. 141)  
   *Boardroom 1* 18:00-19:30
2. **Work and Stress** (p. 140)  
   *Boardroom 2* 18:00-20:00
3. **Evening Q & A** (p. 41) (Closed session to NSW Police)  
   *Brisbane Room* 18:00-20:00

CONGRESS SOCIAL EVENT – BUSH BBQ on Bradley’s Headland
Mental Illness at the Intersection of Health and Justice

In collaboration with the New South Wales Department of Health

Wed. Oct. 1, 2003 (8:30–17:45)  
Perth Room (3rd Floor)

Registration 8:00–8:30

The New South Wales Experience 8:30–10:00

Chair: Beverly Raphael, Director, Centre for Mental Health, New South Wales Dept. of Health

SESSION KEYNOTE – “Mental illness and criminally offending behaviour: A human rights challenge for the legal system”
The Hon. Justice Patricia Staunton, Industrial Relations Commission of New South Wales

PANEL DISCUSSION
Stephen Allnutt, Dept. of Psychiatry, University of New South Wales
Vicki Arender, Newtown Local Area Commander, New South Wales Police
Duncan Chappell, President, Mental Health Tribunal of New South Wales
Jonathan Carne, Forensic Psychiatrist, Sydney
Doug Humphreys, Director, Criminal Law, Legal Aid Commission of New South Wales
Ron Woodham, Commissioner, Corrective Services New South Wales

Break 10:00–10:30

International Perspectives 10:30–12:30

Chair: The Honourable Justice Frank Vincent, Supreme Court of Victoria, Court of Appeal

Outcome of psychiatric admission through the courts: Pathways from criminal justice through court diversion to hospital
David James and Frank Farnham, North London Forensic Service

Collaboration between the mental health and criminal justice systems in the Netherlands
Mathieu Verhagen and Jos Poelmann, Pompestichting Nijmegen, The Netherlands

Forensic mental health services in Toronto: Policy and practice
Gail Czukar and Howard Barbaree, Centre for Addiction & Mental Health, Toronto, Canada

A state, public and academic joint program for deflection from jail to mental health treatment
Abraham Frenkel, Dept. of Psychiatry and Behavioral Medicine, University of Illinois

Break 10:30–10:30

Diversion and Court Assessment 13:30–17:30

Chair: Helen Syme, Deputy Chief Magistrate of New South Wales

The management of mentally impaired offenders in the south Australian court system:
Reflections on four years of diversion
Michael Burvill, Magistrates Court Diversion Program, South Australia

Female offenders with mental illness and the under-utilisation of diversionary mechanisms in New South Wales
Tamara Walsh, Faculty of Law, Queensland University of Technology

Sentencing mentally disordered offenders to treatment
Stuart Ross, Dept. of Criminology, University of Melbourne

Patients or prisoners? Forensic status and homicide in New South Wales
Tessa Boyd-Caine and Duncan Chappell, Mental Health Review Tribunal of New South Wales

Discussant: Ben Nielsen, New South Wales Dept. of Health, Sydney

Break 15:30–16:00

Characteristics of the Newcastle Mental Health Court Liaison Service
John Sharples, Terry Lewin, Patrick Johnston and Gregory Coles, Centre for Mental Health Studies, University of Newcastle

Court diversion in London – Does it still work?

Queensland’s Mental Health Court: The first twelve months
Joan Lawrence, James Wood and Donald Grant, Mental Health Court, Brisbane

Abstracts

Mental Illness at the Intersection of Health and Justice – International Perspectives

Outcome of psychiatric admission through the courts: Pathways from criminal justice through court diversion to hospital

David James and Frank Farnham, North London Forensic Service

Concerns about people with serious mental disorders ending up in prison inappropriately have prompted new service developments in the UK over the past decade. This paper will outline the workings of a comprehensive psychiatric service to police stations, courts and prisons in north London, which aims to identify those with mental disorder when they enter the Criminal Justice System and facilitate their access to treatment and care. Factors associated with efficacy and lack of efficacy in such services will be identified and discussed in the context of outcome data. Data from a large controlled outcome study of admissions to hospital from court diversion schemes will be presented.

david.james5@ntlworld.com

Collaboration between the mental health and criminal justice systems in the Netherlands

Mathieu Verhagen and Jos Poelmann, Pompestichting Nijmegen, The Netherlands

For many years the main theme in forensic psychiatry in the Netherlands has been the clinical long term treatment of severe personality disordered delinquents under the tbs-measure. Treatment of psychotic delinquents took place in mental health services, while treatment in prison was ‘not done’. But, by now, things are changing rapidly. Tbs-clinics, mental health services and prisons have started to collaborate on old and new target groups (for instance youth, domestic violence, prevention of recidivism and long stay). However this is not an easy job, due to constraints in legislation, public policy, differences in culture and working-methods. In this presentation we want to discuss how to overcome these constraints.

t.verhagen@pompestichting.nl

Forensic mental health services in Toronto: Policy and practice

Gail Czukar and Howard Barbaree, Centre for Addiction & Mental Health, Toronto, Canada

The central theme of this presentation is the appropriate allocation of forensic mental health resources to people with mental disorders who come before the courts. The paper will describe the legal and policy context, the client population, and the forensic mental health system in Toronto, Ontario, Canada, with a focus on the increasing demand for services, especially beds. A study that examined the mental health services provided in and through the Toronto courts, including the specialized Mental Health Court, will be discussed. The presentation will address ways in which demand for the most intensive forensic mental health services, i.e., hospital beds, may be reduced.

gail_czukar@camh.net

A state, public and academic joint program for deflection from jail to mental health treatment

Abraham Frenkel, Dept. of Psychiatry and Behavioral Medicine, University of Illinois

About 10% of inmates in jails and prisons at any given time suffer from serious mental illness. The majority are incarcerated for misdemeanours or non violent felonies. Many times these individuals do not receive adequate psychiatric care and may end up in the correctional system for extended periods of time, only to be released and re-incarcerated shortly thereafter. Factors contributing to the problem are unsatisfactory level of awareness on the part of law enforcement and legal system, overburdened and undersized public mental health system, and lack of communication among the various stakeholders. This paper presents the design and implementation of a successful comprehensive program for assessment of mental health needs of newly arrested individuals and effective disposition to the mental health system based on these needs. The program involves initial data collection on the current local situation in the correctional, legal and the mental health systems, then mobilizing and coordinating all stake holders – government, community, legal and correctional – to create a coordinated program, including training and quality improvement measures to effectuate the desired outcome: deflecting all appropriate cases of mentally ill persons to the appropriate resources, eventually leading to reduced need for incarceration and better integration in the community.

ramyf@uic.edu

Using the mental health broom to sweep criminal problems: Deportation and post sentence detentions

George Alexander, Faculty of Law, Santa Clara University

New York State has a record of shipping mental patients out of state to ‘nursing homes’ in places in which locked facilities are more acceptable. The result has left numerous disabled people in the equivalent of mental health institutions without the benefits of New York’s mental health law protections. At the same time, courts are approving summary mental confinement of sexual offenders after they have served their penal sentence without the benefit of most criminal law and mental health law safeguards. While that practice is presently limited to sexually violent predators, the ever expanding definition of such offenders demonstrates that, like the resettlement of mental patients, it has no inherent limits. This paper examines both practices against the background of social welfare and criminal alternatives to assess their vitality and wisdom.

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**Mental Illness at the Intersection of Health and Justice**

### Diversion and Court Assessment

The management of mentally impaired offenders in the south Australian court system: Reflections on four years of diversion

**Michael Burvill**, Magistrates Court Diversion Program, South Australia

This presentation describes in brief the Magistrates Court Diversion Program for mentally impaired offenders, an initiative within the South Australian judicial system. It also discusses some of the findings from two independent evaluations of the program. The focus of the evaluations was on the pilot phase of the program, between July 1999 and June 2000, and data generated once the program was funded on an ongoing basis, up until July of 2002. More recent data will also be available at the time of presentation. The presentation examines the rationale for and operational aspects of the program and identifies a range of issues that have emerged over the ensuing years. It will be of interest to both scholars and practitioners working with mentally impaired persons who come into contact with the criminal justice system.

**michael.burvill@courts.sa.gov.au**

Female offenders with mental illness and the under-utilisation of diversionary mechanisms in New South Wales

**Tamara Walsh**, Faculty of Law, Queensland University of Technology

Women in prison suffer from mental illness at a rate significantly higher than their male counterparts. Many avenues for diversion exist in current NSW law, but judges and magistrates have demonstrated a reluctance to utilize them. This paper will outline the diversionary mechanisms available to female mentally ill offenders and speculate on why they are under-utilised. Some recommendations for reform will be made including the use of imprisonment as a last resort, creative use of probation, bonds and conditional release orders, and the expansion of the existing court liaison service. However, it will be concluded that the availability of community-based services to which judges and magistrates may refer offenders is central to the effective operation of this area of law. Since judges and magistrates will not release mentally ill offenders into a “void”, adequately funded social services must be available to provide necessary support, treatment and supervision.

**tamara.walsh@qut.edu.au**

Sentencing mentally disordered offenders to treatment

**Stuart Ross**, Dept. of Criminology, University of Melbourne

This paper presents the results of two studies concerned with the way that judges and magistrates sentence mentally disordered people, and in particular with how they decide whether the sentence should require the defendant to undertake some form of mental health treatment. The first study analysed an archival dataset of community orders using a non-linear multi-variate analysis method (CHAID segmentation) to identify offender and case variables that predicted whether a treatment sentence was made. This model showed that current and past treatment history best predicted whether an order included a treatment requirement. The second study used a computer-based sentencing simulation to examine magistrates’ cognitive processes of information selection, inference and judgment. The simulated sentencing exercises showed that sentencers represent the special issues associated with mental disorder within a legal framework that takes account of expert clinical advice. While magistrates are keenly aware that expert advice can be of varying quality, where it comes to the court from a reputable source, sentencing decisions will generally be consistent with an expert recommendation. The research shows sentencers struggling to reconcile inconsistent and ambiguous goals of proportionality, rehabilitation and community protection within a decision framework that is limited both by the law and their own understanding of their role.

**s.ross@muprivate.edu.au**

Patients or prisoners? Forensic status and homicide in New South Wales

**Tessa Boyd-Caine and Duncan Chappell**, Mental Health Review Tribunal of New South Wales

Currently there is no publicly available information on the demographics, characteristics and trends of the forensic patient population of NSW. This paper presents original data on forensic patients in NSW, based on the unique records of the NSW Mental Health Review Tribunal (MHRT). This paper draws on the inaugural census of NSW forensic patients conducted by the MHRT in 2003, to establish a framework for the basic demographics of the NSW forensic population. The paper then reports on the findings of a unique study into the outcomes of forensic patients whose index offence was homicide, and who have been found not guilty by reason of mental illness, or transferred into the forensic system following a finding of guilt. This study compares the homicide forensic population with the homicide offender population in NSW to examine patterns in the processes, outcomes and time spent by individuals in each system.

**TessaBoyd-Caine@mhrt.nsw.gov.au**

Characteristics of the Newcastle Mental Health Court Liaison Service

**John Sharples, Terry Lewin, Patrick Johnston and Gregory Coles**, Centre for Mental Health Studies, University of Newcastle

**Aim/Background:** In August 1997, a Mental Health Court Liaison (MHCL) service began at the Newcastle Court Complex. The aims of the current project were to: 1) document the establishment and role of the MHCL service;
2) describe the characteristics of clients referred during its initial period of operation and their patterns of service contact; and 3) examine relationships between client characteristics and offence profiles and, if possible, identify other distinguishing features.

Methods: Records for all clients referred to the MHCL service between 1998 and 2000 were included in a service audit – there were 971 clients (767 males, 204 females), 35.5% with a comorbid substance use diagnosis, and they were involved in 1,139 service episodes. For each service episode, we coded basic socio-demographic information, clinical characteristics, service episode details, and criminal charge details, which were subsequently grouped into 19 ‘offence categories’ and three overall offence types (‘offences against people’, ‘offences against property’, and ‘offences against public order’).

Results: There were approximately 4-5 offences by males for every offence by females. However, the pattern of offences for MHCL clients was reasonably similar to that for Hunter Region offenders as a whole – except that among MHCL clients there were proportionately more offences against justice procedures (e.g., breaches of AVOs) and fewer driving offences and ‘other offences’. Additionally, male MHCL clients revealed proportionately more malicious damage and robbery offences and lower rates of offensive behaviour.

Conclusions: The new service appears to have forged more effective links between the mental health and criminal justice systems; for example: improved exchange of information; advocacy for offenders already being treated by the mental health service; and timely assessments and practical management options for persons with no prior or recent contact with the mental health services.

John.Sharples@hunter.health.nsw.gov.au

Court diversion in London – Does it still work?

Court Diversion in London: does it still work? The authors will present 3 years statistics (2000-2002) from one of the largest Court Diversion schemes in England, based in Horseferry Road Magistrates’ Court, Central London. After a brief description of the scheme’s structure, its funding and its aims, we will describe the total number of clients assessed and the outcomes of the assessments made. The presentation will include statistics showing the number of clients admitted to hospital, how long on average they have to wait for a bed, the mode of admission (i.e., whether voluntary or under a Section of the Mental Health Act) and the level of security they are admitted to. This scheme grew out of the one originally established by Dr Phil Joseph, described in the British Journal of Psychiatry in 1993. We will compare our statistics with those in the original article and comment on the differences between the two and how they reflect the changes in psychiatric services and attitudes towards mentally disordered offenders over the intervening 9 years. We will describe problems the scheme has encountered in the process from assessment to admission and conclude by suggesting ways in which Court Diversion may be developed in the future.

timamor@doctors.org.uk

Queensland’s Mental Health Court: The first twelve months
Joan Lawrence, James Wood and Donald Grant, Mental Health Court, Brisbane

In 1984, Queensland’s Mental Health Act introduced a system unique to that State with the establishment of a Mental Health Tribunal to determine:

a.) Issues of criminal responsibility
b.) Fitness for trial in mentally ill offenders, and
c.) Their future management bearing in mind their health needs and the protection and safety of the community.

This innovation has been developed and refined since 1984, culminating in the Mental Health Court, which was established under the Mental Health Act 2000 that came into effect on 28 February 2002. The Court is constituted by a Supreme Court Judge, currently Justice Margaret Wilson, assisted by two of a panel of three Assisting Psychiatrists. A Registrar with an assistant currently provides all administrative support.

This paper will briefly describe the structure and function of the Court and provide outcome data (performance and clinical) for the first twelve (12) months (1 March 2002 to 28 February 2003) of its operations. The Mental Health Court has been well received and applauded by psychiatrists, the judiciary, lawyers and the community overall. Time will tell if the Mental Health Court can overcome the criticisms by those in the community who fear the mentally disturbed and stigmatise all as potentially violent and criminal and see the Tribunal as a “cop out” from punishment. Some issues of concern pertaining to mentally ill offenders will be highlighted, particularly drug abuse in causation of mental illness and criminal responsibility and the role of Forensic Orders.

The Court reflects the partnership between the Mental Health Services, The Law and Police and Corrective Services.

joanl@mailbox.uq.edu.au
**The Patient-Therapist Relationship**


**Sydney Room (3rd Floor)**

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<td><strong>Psychiatry, Ethics and the Law</strong></td>
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<td>Walking the tightrope: Confidentiality, ethics, best interests?</td>
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<td>Patient confidentiality and mental health: When is it legal for psychiatrists to disclose information about a patient to the patient’s carer?</td>
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<td>Accountability frameworks for mental health services: A comparative review and synthesis</td>
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<td>Kathleen Hartford, Lawson Health Research Institute, University of Western Ontario; Evelyn Vingilis, Beth Mitchell and Ake Blomqvist, London Health Sciences Centre, University of Western Ontario</td>
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<td>The role of the state in settling claims by victims of medical malpractice</td>
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<td><strong>Therapeutic Relationships</strong></td>
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<td>Chair: Robin Woellner, Dean, College of Law and Business, University of Western Sydney</td>
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<td>The impact of E-health and the changing nature of the doctor/patient relationship</td>
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<td>Robin Woellner, Dean, College of Law and Business, University of Western Sydney; Julie Zetler, Division of Law, Macquarie University</td>
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<td>The search for certainty and the burden of trust: Psychiatrists’ experience of moral distress</td>
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<td>Wendy Austin, Leon Kagan, Marlene Rankel and Vangie Bergum, Faculty of Nursing, University of Alberta</td>
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<td>Codes of Ethics and Ethical Dilemma</td>
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<td>Ginette Pagé, Counsellor, Quebec, Canada; Howard J. Coleston, Jr., Attorney-at-Law, Oakland, CA</td>
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<td>Fit for purpose? Promoting the human side of mental health nursing</td>
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<td>Medical procedures and decisions. Valid (as opposed to informed) consent – Some normative reflections</td>
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<td>Livia Iacovino, School of Information Management and Systems, Monash University</td>
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<td>Moira Paterson, Faculty of Law, Monash University</td>
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Walking the tightrope: Confidentiality, ethics, best interests?

**Frank Walker and Robert Ramjan, Schizophrenia Fellowship of New South Wales**

The issue of patient confidentiality versus the needs of carers to information is a vexed one and indeed a tightrope for all involved. Each of the key stakeholders confronts a different set of difficulties in negotiating their tightrope. Debate has waxed and waned over many years without any real solution being identified. The legal basis for confidentiality will be examined with attention given to the intent of the law. The role of the carer in the provision of mental health care will also be discussed. An exploration of current practice and legislative change will identify advances and continuing weaknesses and difficulties. This will include the Australian draft Model Mental Health Legislation project. The Fellowship made recommendations to this project which provided criteria that guided the transfer of critical information to carers whilst balancing the rights of the consumer. Finally some potential solutions and strategies will be offered. The use of enduring advanced directives will be explored. Focus will be given to the outcomes of discussion regarding confidentiality between consumers, carers and mental health workers in the development and writing of The Schizophrenias: guidelines for an holistic approach to clinical practice (2001) undertaken by the SFNSW for the NSW Health Department. Key stakeholders were able to identify improved ways to deal with this issue which should lead to better outcomes for consumers, carers and mental health workers.

Patient confidentiality and mental health: When is it legal for psychiatrists to disclose information about a patient to the patient’s carer?

**Karin Clark and Andrew North, Allens Arthur Robinson**

In what circumstances can a psychiatrist disclose information about a patient to a family or other primary carer? The question is often difficult to answer particularly because, quite aside from the sometimes vexed ethical issues to be considered, the law in this area is complex. Because the laws relating to patient confidentiality are found in many different sources and interact with each other in a complex way, it is understandable that some psychiatrists may take a conservative approach to disclosure. This paper argues that, when the laws relating to patient confidentiality are examined, it is apparent that psychiatrists may disclose certain information to their patients’ family and primary carers in many common situations and, indeed, have a duty to disclose information in some circumstances. This paper outlines briefly the legal issues surrounding the disclosure by psychiatrists of patient information to family and primary carers, and then offers some practical guidelines which can assist psychiatrists to look after the best interests of their patients in this difficult area.

Truth, morality and defensive reasoning in psychiatry

**Isabell Collins, Victorian Mental Illness Awareness Council**

Defensive Reasoning is a well documented process whereby everything is done to protect the organisation and the people who work in the organisation. Protecting staff morale is deemed far more important than ensuring natural justice and accountability. True learning from mistakes is denied because the root causes of problems are ignored. Those who refuse to engage in defensive reasoning practices are more often than not discredited with ‘untruths’ and if that does not work ‘lies’. This is done in order to protect the organisation and the people associated with it. Individual and organisational defensive reasoning practices pervade the mental health care system to such an extent that most patients who receive care and treatment within the public system are denied natural justice morally, ethically and legally. Whilst various Acts exist to protect the rights of patients with a psychiatric illness, in reality there is no law or independent organisation that provides mechanisms for justice. Rather, the law supports the maintenance of the status quo; that is, defensive reasoning practices.

Accountability of Mental Health Professionals

**Accountability of mental health professionals in Australia and New Zealand**

**Andrew Alston, School of Law, Flinders University**

Mental health professionals are accountable for their conduct in many ways. In each of the States of Australia, they are mainly accountable in: civil proceedings, particularly through actions for professional negligence; disciplinary proceedings; criminal law proceedings; specific provisions of mental health legislation. In New Zealand, mental health professionals are accountable in the same ways except that the accident compensation scheme ensures that, if injury occurs because of the negligence of a health professional, she or he will not be liable in civil proceedings. The consequences for mental health professionals of this are: New Zealand does not have a body of current common law decisions that set standards of conduct for health professionals; standards of conduct derive primarily from legislative codes in respect of such things as privacy, informed consent and mental health patients’ rights; there is more emphasis on disciplinary proceedings as a means of controlling conduct of health
Accountability frameworks for mental health services: A comparative review and synthesis

Kathleen Hartford, Lawson Health Research Institute, University of Western Ontario; Evelyn Vingilis, Beth Mitchell and Ake Blomqvist, London Health Sciences Centre, University of Western Ontario

As background for policy reform in a Canadian province, we conducted a comparative review and synthesis of published and ‘grey’ literature on accountability frameworks for mental health services. The literature review was supplemented by key informant interviews. Emphasis was placed on a comparative institutional perspective including North America and the United Kingdom, and on ‘shared values’ that are implicit in the choice of an accountability framework. The ability to measure and compare outcomes, at a variety of levels, is a prerequisite for accountability that is often missing. Where an adequate information base exists, evidence-based practices can provide a standard for the services that should be available to all people with mental illness. Support is growing for the routine use of outcome measures in mental health program and system planning, and for the requisite information infrastructure. Money matters, and an inherently under funded system cannot be saved by organizational redesign. Several mechanisms to establish accountability have been demonstrated with at least some degree of success. These include the English and Welsh model of centralised external review based on system-level standards, supply-side contracting within a fixed budget after the U.S. model of ‘managed care’, and legislation and litigation. The last category includes legislation setting standards of service availability and quality, as well as more general prohibitions against discrimination. Whether or not accountability frameworks have a legislative basis, they are a form of organizational technology, and should be chosen on that basis. Key elements of desirable accountability frameworks include major improvements in information systems, which will require additional resources as well as resolution of legal and ethical concerns about confidentiality; the (related) ability to track clients across institutional ‘silos’, including not only hospital and community but also separate ministries or agencies that may have responsibilities for health services, social care and income support; expanded opportunities for involving clients, and enhancing their capacity for effective involvement; and pilot studies to fund mental health-related services from a single budgetary envelope.

The role of the state in settling claims by victims of medical malpractice

David B Collins QC, Medical Practitioners Disciplinary Tribunal, New Zealand

From 1972 to 1977 a child and adolescent unit existed within a State-owned and managed psychiatric hospital in New Zealand. From 1995 to 2001 a number of revelations emerged about outrageous practices within the unit. Amongst other claims it was said young children were alleged to have been subjected to unmodified ECT and injected with paraldehyde as means of punishment. Investigations carried out by a retired High Court Judge revealed most of the allegations were correct. In 2001 the New Zealand Government resolved to make ex gratia payments to those who had been in the unit. This paper examines the role of the State in settling the victims’ claims, the nature of the abuses perpetrated, and the processes adopted by the New Zealand Government when it endeavoured to address the concerns of those who had been in the unit.

Duty of care to mental health patients in general hospital emergency departments

John Brayley, Division of Mental Health, Flinders Medical Centre

Mainstreaming of mental health care in Australia has led to the provision of emergency mental health care in the Emergency Departments of general hospitals. Delays in finding beds has meant that people in need of emergency inpatient care can spend prolonged times (>12 hours) in general hospital emergency departments (ED) waiting for a specialist mental health bed. Psychiatrists are concerned about their liability for adverse patient outcomes in the ED. This paper will consider the potential liability of hospitals and practitioners who treat patient in emergency departments for prolonged periods who need specialist inpatient care. This will be considered in terms of the foreseeability of risks, whether the service offers a guaranteed outcome to these patients that they will be kept safe, and who defines the standards of care for emergency mental health. Denning L.J. in Roe v Ministry of Health says: “A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work”, but is this satisfactory when psychiatrists have warned that conditions are inadequate. Edmon Davies J. in Thorn v Northern Group Hospital Management Committee says that there a greater degree of care and supervision required for patients with known, or, even suspected suicidal tendencies. The institution has a responsibility to ensure that suitably trained expert staff are available to minimize the risks posed by immediate aggression, behaviour influenced by psychotic thinking, or suicidal ideation. The detention of patient can set up further expectations. When a patient is detained to protect their health and safety, a reasonable assumption is that health and safety will be protected, and no harm will become them. Is this a guarantee? Is there a contract between the patient on one hand, and the doctor and institution on the other to keep a person safe? Is there a contractual
The search for certainty and the burden of trust: Psychiatrists’ experience of moral distress

Wendy Austin, Leon Kagan, Marlene Rankel and Vangie Bergum, Faculty of Nursing, University of Alberta

Experiences of moral distress encountered in psychiatric practice were explored in a hermeneutic phenomenological study situated at the John Dossetor Health Ethics Centre, University of Alberta, Canada. Moral distress was defined as the state experienced when moral choices and actions are thwarted by constraints. Psychiatrists described struggling “to do the right thing” for individual patients within a societal system that places unrealistic demands on psychiatric expertise. Certainty on the part of the psychiatrist is an expectation when judgments of dangerousness and/or the need for coercive treatments are made. This assumption, however, ignores the uncertainty and complexity of reality. Society entrusts psychiatrists to care for and treat those among its most vulnerable members: persons deemed to have severely diminished capacity for autonomy due to a mental disorder. Simultaneously, psychiatrists are held accountable by society for the protection of the public. Moral distress arose for psychiatrists in their efforts to fulfill both roles. They described an “outsider/insider” status and the ways in which they attempted to cope with moral distress.

Fit for purpose? Promoting the human side of mental health nursing

John Cutcliffe, Chair, Dept. of Nursing, University of Northern British Columbia

Currently, it can be seen that preparation of psychiatric/mental health appears to have a clear emphasis on overt, tangible, highly visible skills acquisition. Whilst few credible psychiatric/mental health nurses would argue with...
the need for some acquisition of skills during nurse preparation, it is the emphasis on skills acquisition at the expense of the development of certain qualities that is questionable. This paper argues that attempts should continue to be made to enable the development of qualities within P/MH nurses and importantly, that the ‘human side’ of P/MH nursing should not be forgotten or ignored.

In doing so, it draws attention to evidence of the invisibility of some P/MH nursing action, how a ‘human’ focused P/MH nursing practice may be inhibited by market forces, the pressures of economic restraints and current pre-occupation with ‘quick fixes’. It points out that within the field of psychiatry and mental health care, there is evidence that some have returned to 1930s, neo-Darwinian perspectives of the mind.

It suggests that it is unlikely that current mental health nurse training, with an emphasis on neurobiology and masculine approaches to care, adequately prepares aspirant mental health nurses for the methods of practice or ways of working with people, described in this paper as the proper focus of nursing. Additionally, it points out that a view of the development of mental health nurse training that includes more training in psychotherapeutic approaches to care is not evidence of a fanciful, unrealistic or Utopian view of mental health nurse preparation.

Ginette Pagé, Counsellor, Quebec, Canada; Howard J. Coleston, Jr., Attorney-at-Law, Oakland, CA

A professional code of ethics is a guide for decision-making in regards to ethical conduct. How codes are used in practice is greatly related to the context within which a situation occurs, the understanding of the situation and the meaning one gives to his/her practice. As such, a task oriented practice would be different from a comprehensive practice in the way to go about a situation such as allocation of scarce resources.

The case study method was used to analyse practice situations derived from Law and Nursing. It examines the individual, the group, the institution and the society’s implications in the decision-making process that challenges the codes of ethics.

The purpose of this paper is to reflect on the decisions made from professional practices addressing more specifically the concepts of confidentiality and responsibility. Furthermore, certain aspects of the ethical decision-making process will be discussed.

Aslak Syse, Faculty of Law, University of Oslo

In this paper, I will first outline the legal requirements as to a valid consent from an analytical and a normative perspective. Then I will examine if the provisions in the new Norwegian Patients’ Rights Act are in accordance with these requirements. The principle of emphasising a patient’s right to all necessary information in connection with medical examinations and treatment has been documented throughout the last 40 years of American legal practice. Most likely, it originates from the 1957 lawsuit of Salgo versus Leland Stanford Jr. University Board of Trustees. This lawsuit lead to a sentence that coupled the term “informed” with the patient’s “consent.” A consent may be deemed invalid if it has been obtained through irregular circumstances such as deception, coercion or other defects in the existence or quality of contractual assent, according to the provisions of contract law. A consent given may also be invalid if it does not comply with the formal requirements established for the field in question, or when attempts have been made to set aside inviolable legal rights, or when consent has been given by a person without the necessary capacity to consent. From a perspective of legal competence, a valid consent has to comply with three preconditions, in legal framework they may be called personal, procedural, and material competence.

The question of personal competence is, of course, of great importance in psychiatric practice. These three preconditions are, however, interdependent. The paper will examine these prequisites in more detail. A new Norwegian Patients’ Rights Act and a new Mental Health Act came into effect 1. January 2001. A general requirement for “informed consent” has not been set up, even though detailed obligations to provide information prior to medical examinations and treatment have been outlined. In accordance with the reasoning in this paper, the main question from a legal perspective is whether or not a given consent is valid. If a valid consent is unobtainable for hospitalisation into a psychiatric facility, civil commitment will be the legal alternative.

Confidentiality and Electronic Mental Health Records

Danuta Mendelson, School of Law, Deakin University
Lívia Iacovino, School of Information Management and Systems, Monash University
Bernadette McSherry, Faculty of Law, Monash University
Moira Paterson, Faculty of Law, Monash University

Electronic mental health records are becoming essential to the efficacious treatment of patients. They are ‘socially-critical’ communications because the therapeutic relationship between health professional and patient is based on trust. The problem facing our community is how to preserve trust and confidentiality of patient-mental
health professional communications in an environment where many therapeutic transactions have begun to be conducted by means of interactive systems of telemedicine. Moreover, evolution of distributed networks, such as the Internet, for health services and transactions has made it possible to move some aspects of mental health care online. These developments – driven by technological innovation – have occurred without any systematic ethical, legal or recordkeeping framework. To remedy this situation, the Health Information Network for Australia: Report to Health Ministers by the National Electronic Health Records, Taskforce July 2000 (Taskforce) has recommended the creation of a nationally coordinated distributed system of electronic health records. This session will explore the legal and ethical issues raised by electronic health records, particularly those relating to mental health, emphasising the importance of maintaining confidentiality in a networked environment.

Dr Danuta Mendelson will explore the applicability of the doctrines of breach of confidentiality, negligence and conversion to the creation, use and storage of electronic mental health records (including networked systems), and, where the traditional rules prove inadequate, develop novel legal principles to safeguard the risks to the patients’ welfare and the doctors’ professional integrity.

Livia Iacovino will concentrate on the impact of technology on the recordkeeping requirements of mental health professional-patient communications over time in the electronic networked environment, taking into account both general and health-specific recordkeeping standards; develop a conceptual model for linking elements of trust (confidentiality, privacy and ethics), identity, (ownership, access) and authenticity (evidence) to mental health professional-patient communications in order to minimise the risks to the patients’ welfare and the protect the mental health professional’s integrity.

Dr Bernadette McSherry will outline the ethical framework that has traditionally been used to justify confidentiality between mental health professionals and patients and the challenges to that ethical framework faced by the use of electronic health records including networked systems. She will explore the possibility of creating ethical guidelines for the use and storage of electronic health records and possible criminal offences relating to breaching confidentiality.

Moira Paterson will explore the issues of privacy and information security raised by electronic networks and the adequacy of the existing legal and regulatory framework, including the new Privacy Amendment (Private Sector) Act 2000. She will also summarise the position concerning ownership of, and copyright in, electronic records.

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<td>8:00–8:30</td>
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|              | **Research involving persons with impaired decision-making capacity:** An international dilemma  
  **George F. Tomossy**, Faculty of Law, University of Sydney |
|              | **Clinical trials in New South Wales:** Involving persons who cannot give a valid consent to their own treatment  
  **Nick O’Neill**, President, Guardianship Tribunal of New South Wales |
|              | **Balancing risks and benefits:** Legal and ethical dimensions in conducting clinical trials involving patients with impaired capacity  
  **Jennifer Fleming**, Medical Research Management and Ethics Consultant, Brisbane; **Ann Lyons**, President, Guardianship and Administration Tribunal of Queensland |
| 10:00–10:30  | Break                                                                 |
| 13:30–15:30  | Protection and Self-Help: Complementary Approaches in Guardianship |
|              | **Chair:** Julian Gardner, Public Advocate of Victoria               |
|              | **Securing freedom from protection:**                                 
  **Sue Tait**, Intellectual Disability Review Panel Victoria |
|              | **Living with mental illness:**                                     
  **Ulysses agreements, advance directives and state legislation**  
  **Meg Smith**, School of Applied Social and Human Sciences, University of Western Sydney |
|              | **NSW Experience of abuse of persons with disabilities and the role of the Guardianship Tribunal**  
  **Marion Brown**, Deputy President, Guardianship Tribunal of New South Wales |
|              | **Using guardianship to protect mentally incapacitated elders from financial abuse**  
  **Paula Scully**, The Adult Guardian of Queensland |
|              | **Discussant:** Charles Chiu, Chairperson, Guardianship Board, Hong Kong |
| 12:30–13:30  | Lunch                                                                 |
| 16:00–17:45  | Decision-making in Guardianship and Mental Health Tribunals          |
|              | **Chair:** Duncan Chappell, President, Mental Health Tribunal of New South Wales |
|              | **Protecting patients’ rights and interests:** Achieving a positive therapeutic outcome through the mental health review tribunal  
  **Frank Clair**, President, Mental Health Review Tribunal of Queensland |
|              | **The disclosure of documents by guardianship tribunals**            
  **John Blackwood**, Faculty of Law, University of Tasmania |
|              | **Alternative dispute resolution and people with cognitive disabilities**  
  **Jim Simpson**, Member, Guardianship Tribunal of New South Wales |
|              | **Discussant:** Terry Carney, Faculty of Law, University of Sydney   |
Research involving persons with impaired decision-making capacity: An international dilemma

George F. Tomossy, Faculty of Law, University of Sydney

“No type of research raises more problems than research with the mentally impaired, particularly those who are institutionalised for treatment” (Capron, 1999).

The dilemma posed by research involving persons with impaired decision-making capacity is that some research relating to conditions affecting such individuals can only be conducted without their direct informed consent. This of course violates a central tenet of research ethics and the law on consent, and is particularly problematic when it would involve interventions that are either non-therapeutic or pose “greater than minimal risk.”

This paper will outline the core legal and ethical challenge raised by these types of research, and will canvass various solutions that have been attempted (and in some cases legally challenged) in other jurisdictions.

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Clinical trials in New South Wales: Involving persons who cannot give a valid consent to their own treatment

Nick O’Neill, President, Guardianship Tribunal of New South Wales

Clinical trials in which new drugs, new procedures or new uses of established drugs or procedures are used on adults unable to give a valid consent to their own treatments present legal and ethical difficulties. In NSW these legal and ethical difficulties were addressed in legislation that came into effect in 1998. That legislation established a regime for approval to be obtained from the Guardianship Tribunal before anyone unable to give their own consents could receive the medical treatments within that trial.

This paper deals briefly with the legislative criteria that have to be met before approval can be given. Also, it reviews the kinds of clinical trials brought to the Tribunal for approval.

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Balancing risks and benefits: Legal and ethical dimensions in conducting clinical trials involving patients with impaired capacity

Jennifer Fleming, Medical Research Management and Ethics Consultant, Brisbane; Ann Lyons, President, Guardianship and Administration Tribunal of Queensland

Ensuring that the conduct of clinical trial research involving patients with impaired capacity is in keeping with optimal ethical and clinical scientific necessitates due regard of key regulatory, ethical, legal and risk management parameters. The safeguards of participants remains of paramount importance and is the responsibility of the Clinician/Principal Investigator, Pharmaceutical Sponsors, Human Research Ethics Committees, Health Institutions, Regulators and other key stakeholders. Within this wider context this paper will explore the interface between the conduct of international multicentre clinical trials involving participants with impaired capacity with the ethical, regulatory and legal environments. Via the exploration of a number of clinical trial case studies the paper will focus on the independent role of the Queensland Guardianship and Administration Tribunal in approving such clinical trials. A number of key risk management issues pertaining to the balance of risks and benefits in the conduct of clinical drug trials involving vulnerable populations will be examined.

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Securing freedom from protection

Sue Tait, Intellectual Disability Review Panel, Victoria

This paper takes an historical (and international) perspective about the ways people who have a mental illness or cognitive impairment have been treated. It looks at legal and ethical dilemmas associated with a protective or best interests model, contrasting this with a rights model. It challenges concepts about the impact of ‘reforms’ and poses a framework for empowering people who have a mental illness or cognitive impairment.

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Living with mental illness: Ulysses agreements, advance directives and state legislation

Meg Smith, School of Applied Social and Human Sciences, University of Western Sydney

People living with a mental illness have had relatively little input into the crafting of legislation that affects them. There are a number of reasons for this: the disabling effects of mental illness can inhibit or prevent social and political involvement, and there is often a lack of economic resources to fund involvement in social action groups. Other factors include reluctance by professional groups to include service users in service and policy planning. But one of the main reasons may be that few of us accept that one day we may not be able to decide on medical treatment for ourselves and are unable or unwilling to confront symptoms of mental illness that may prevent
management of our own affairs during episodes of mental ill health. Recurrent and episodic mental illnesses such as bipolar mood disorder and schizophrenia may mean that future hospital or involuntary medical treatment is likely. Many people find their first involuntary hospitalisation traumatic. Strained family and friend relationships, police involvement, confusion about symptoms of illness and emotional reactions to life stresses are characteristic of first episodes of psychotic illness.

Many people understandably are reluctant to face the issues of mental illness after recovery from a first episode and hope that such a trauma will not happen again. Traumatic experiences of forced medical treatment and institutionalisation however leave the person with a sense of hopelessness and powerlessness as well as mistrust of family and caregivers who are in a position to take action to initiate involuntary treatment and hospital care. Proactive arrangements to manage future episodes of mental ill health can empower people and give back some control about the treatment and how it is delivered. Ulysses agreements, living wills and contracts with family and service providers can be developed to minimise inappropriate involuntary care.

Studies exploring the benefits of advance directives have concluded that such directives have a number of functions for the person who is the subject of the directive. Planning an advanced directive can focus on future health care needs, clarify the person’s wishes for family and care givers and encourage the subject person to take responsibility for his or her health care needs.

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NSW Experience of abuse of persons with disabilities and the role of the Guardianship Tribunal

Marion Brown, Deputy President, Guardianship Tribunal of New South Wales

In the year 2000 the NSW Guardianship Tribunal undertook a survey of applications and hearings undertaken by the Tribunal over a 2 month period. This paper will discuss the findings of that survey, the various types of abuse exposed and the role the Tribunal can play in seeking to protect adults with disabilities from abuse and exploitation.

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Using guardianship to protect mentally incapacitated elders from financial abuse

Paula Scully, The Adult Guardian for Queensland

Promoting mental health includes protecting elders from abuse. Ostensibly, guardianship takes away some freedom of an elder to make his/her own decisions. This principle can be misused to prevent access to guardianship by mentally incapacitated elders who need its protection. This paper will show the tensions between health care and social work professionals and the legal system in using guardianship to protect interests and rights. Despite these tensions, the protective and advocacy role adopted by the Hong Kong Guardianship Board has persuaded social workers and doctors to use guardianship therapeutically. In the absence of a Public Advocate or an independent Public Guardian, the Hong Kong Guardianship Board has expanded its role to draw attention to abuse of elders. It has already released Fact Sheets on how the Guardianship Board can help for abuse of mentally incapacitated elders and adults with an intellectual disability, and run workshops and briefing sessions to raise awareness of such abuse. Case examples are used as tools to persuade policymakers to introduce policy, legal and system changes to services and laws impacting on mentally incapacitated elders. Currently it is concluding draft guidelines on financial abuse, particularly of bank accounts, which will assist front-line bank staff, staff in old aged homes, medical and community social workers, doctors and police to identify and prevent financial abuse of mentally incapacitated elders. This paper will give case examples of the dissonance between the roles of the Hong Kong Government Social Welfare Department, Hospital Authority and old aged homes, to take care of mentally incapacitated elders, and how their systems may unwittingly facilitate financial abuse. It will also illustrate successful use of emergency and normal guardianship orders to prevent financial abuse, (which may include preventing an elder being removed from Hong Kong to Mainland China), despite the limited powers of the Guardianship Board in the financial area.

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Guardianship and Mental Health Tribunals: Roles and Expectations

All care and whose responsibility?

John Lesser, President, Mental Health Review Board of Victoria

The presenter, the President of the Mental Health Review Board of Victoria since September 2000, has been a legal member of the Board since 1993. The Board is a quasi-judicial tribunal, comprising lawyers, psychiatrists and community members, whose primary role and functions are to conduct reviews of, and hear appeals by, people with serious mental illnesses who are subject to involuntary treatment and care mandated under the Mental Health Act 1986 (Victoria). Under the Act, the formal parties to the Board hearing are the involuntary patient and the Authorised Psychiatrist of the treating mental health service. However, there are many others interested in the hearings process and outcome of the Board’s decision-making role. In particular, members of the patient’s family, who also take on primary carers’ roles in many cases, are often directly affected by the Board’s determination. Ideally therefore, it stands to reason that, whenever possible, the Board should take into account the information provided and views expressed by these important people in the lives of the people who are subject to the Board’s
Guardianship and Mental Health Tribunals

review. There are, however, a number of impediments – some statutory and others practical – which inhibit the capacity for the Board to fully capitalise on the range of information carers can provide about the patient’s mental health, treatment program, and social circumstances and supports. In this presentation, the presenter will outline a number of the relevant issues, tensions, and constraints as well as some suggestions for improvements as they relate to the review process. By doing so, it is hoped that the various policymakers, stakeholders and interest groups can consider ways of making the review process a more beneficial and positive element in the treatment continuum of those people affected by involuntary treatment and care under the Act and similar legislative schemes.

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Civil commitment and review: Tensions in law and in practice
Neville Barber, President, Mental Health Review Board of Western Australia

In recent decades, there has been a growing trend for jurisdictions to include in their mental health legislation a mechanism for either judicial or quasi-judicial review of the decision to make a person an involuntary patient. This trend has increased since the passing in 1991 of the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

Whilst recognising the importance of legal protections, this paper challenges the trend towards increasingly legalistic reviews of civil commitment that, it is suggested, will inevitably fail to meet the expectations made of them.

Against the background of the ascendancy of the legal paradigm in mental health matters in the last fifty years, the limited research literature available suggests that review bodies are not performing their functions adequately. In general terms, the solutions proffered to address this problem include increasingly strict laws (despite the failure of such laws in the past) and more education for the key players in reviews (in the apparent hope that those applying the law will do so strictly though, arguably, without regard to its context). Thus, the solution presently on offer for the alleged poor performance of review bodies is more law, and more strictly controlled lawyers (and others).

This paper outlines research conducted into the role of review bodies and challenges the mentioned orthodox views about review bodies, which, it is suggested, appear neither to pay sufficient regard to the complex environment within which review bodies operate nor the realities of serious mental illness.

Findings of the research conducted (including observations of reviews of civil commitment observed in a number of jurisdictions) will be presented and discussed in the paper.

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Whose needs? Dilemmas for guardianship tribunals – A review of recent overturned decisions
Ron Joachim, Deputy President, Guardianship and Administration Tribunal of Queensland

In this paper three recent judgments overturning or varying the appointment of Guardianship Tribunals are discussed and analysed. One matter involved the re-hearing of an application for the appointment of a guardian in the Victorian Civil and Administrative Tribunal (VCAT), whilst the other two judgments concerned appeals to the Queensland Supreme Court against decisions of the Queensland Guardianship and Administration Tribunal. One Tribunal had dismissed a guardianship application and the other made a limited administration order. The court overturned the guardianship decision and varied the administration order. The concept of need is examined in some detail in this paper as these judgments have significant implications for Tribunals when considering the need for appointments of guardians and administrators for persons with impaired decision making whilst taking into account the principle of minimal interference in a persons life.

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How guardianship law serves people with a history of being “difficult”
Ian Boardman and John Stannard, Office of the Public Advocate for Queensland

Queensland Public Advocate, Ian Boardman, will canvass the location of his Office as the only independent systems advocacy body within the Australian guardianship regime and then discuss guardianship and people who challenge the service system. The Office of Public Advocate is housed within the Justice portfolio of the Queensland Government. It is charged with reporting annually to the Queensland Parliament on the services, facilities and systems that serve people with a decision-making disability. The Office’s statutory function is restricted to systems advocacy only and it therefore does not have the tension of individual issues pulling at its resource base and remains unconflicted in its relationship with service providers. What does it mean to be a systems advocate? What does this approach offer? As a preliminary point, a literature search on systems advocacy and related legislation will be discussed. The address will then focus on the current application of the law in Australia to those people with intellectual disability, or autistic spectrum disorder or an acquired brain injury who have missed all mainstream services and are foundering on the margins of the criminal justice and mental health systems.

It is estimated that people with intellectual disability are between four and five times over-represented in the New South Wales prison system (New South Wales Law Reform Commission Report No. 80, People with an Intellectual Disability and the Criminal Justice System, at 25). Specifically, the paper examines how the rights given to people
Guardianship and Mental Health Tribunals

with a decision-making disability may be used by substituted decision-makers in such a way to lead to their civil containment. What does this mean for a person’s “best interests”? In these circumstances, does guardianship amount to civil commitment? What is the place of community protection? Australia is without a bill of rights. In Queensland, as in most other states, tribunals appoint a personal decision-maker who can determine that the person will be contained for their own safety, even where that person objects in some way. It is a basic tenet of law that an express legislative intent is needed before depriving a person of their liberty. This is invariably absent in Australian guardianship legislation. Does the application of guardianship laws to the containment of people demonstrate the limitations of a rights-based analysis of the needs of people with a decision-making disability? How realistic is it to expect rights to describe the cultivated field of a fulfilled life? Is imprisonment the inevitable alternative? 

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Decision-making in Guardianship and Mental Health Tribunals

Protecting patients’ rights and interests: Achieving a positive therapeutic outcome through the mental health review tribunal

Frank Clair, President, Mental Health Review Tribunal of Queensland

The paper deals with the extent to which there are lessons of benefit for mental health review tribunals to be learned from the integrative or interest-based approach to dispute resolution as opposed to the adversarial approach, and the value of the methods explored in the area of therapeutic mediation espoused enthusiastically by some of the North American authors. It addresses in particular the need for such tribunals to be aware of the following issues:

• identifying the rights of the patient that are given protection under the involuntary treatment provisions;
• examining the concurrence between those rights and the patient’s interests and the extent to which interests can be protected under the review system;
• informalising procedures sufficiently to engage the parties – particularly the patient – in a meaningful way;
• using the tribunal hearing in a way which achieves a positive therapeutic outcome going beyond a mere adjudication of rights.

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The disclosure of documents by guardianship tribunals

John Blackwood, Faculty of Law, University of Tasmania

Guardianship and Administration Tribunals in all States and Territories are bound by the rules of natural justice. A succession of High Court cases have held that, ordinarily, those rules require that a person whose interest is likely to be affected by an exercise of power should be given an opportunity to deal with adverse information that is credible, relevant and significant to the decision to be made. This procedural rule applies particularly to documentary evidence in the possession of the parties to a hearing as well as the relevant Tribunal. It is clear that the guardianship Tribunals in the various States and Territories have very different rules and procedures in relation to the production and or disclosure of documents to the parties at a hearing conducted by the Tribunal. Some have legislation that requires the disclosure of some documents to some of the parties; others have issued practice directions or have policy statements dealing with the issue, while in others the matter is not addressed at all.

The purpose of the paper is first to establish, if possible, what the relevant procedural rules are in relation to the disclosure of documents particularly in the jurisdictional context of guardianship Tribunal hearings. Secondly to establish what the practice is in each of the jurisdictions; and thirdly to assess to what extent the Tribunals are complying with the procedural rules. In the latter regard the paper will draw on the results of a study being undertaken in Tasmania, which is examining the application and operation of the rules of evidence and procedure in four quasi-judicial Tribunals including the Guardianship and Administration Board. While the study is not yet complete, initial results show that in 55 of 57 cases the Guardianship and Administration Board of Tasmania did not provide a copy of the documents which it relied upon in coming to its decision but that in a number of cases the source and content of the relevant documents were otherwise disclosed to the parties.

The courts have consistently stressed that the rules of procedural fairness are flexible and adaptable to particular circumstances and do not call for an inflexible application of a fixed body of rules but fairness in the circumstances. The paper examines the extent to which the rules of procedural fairness operate in the very different guardianship context. The jurisdiction is essentially a protective one and a decision can only be made – for example to appoint a guardian or an administrator – once it is determined that a person has a disability and lacks the capacity to make reasonable decisions. In reaching this decision the Tribunal will have to take into account personal and confidential information, which is often documented. The courts had indicated that documents containing adverse and critical information need not be produced by the Tribunal if there is a compelling need for confidentiality, secrecy or speed. However the nature of this exception and its application in particular circumstances remains unclear. Similarly, it has been said that procedural fairness does not necessarily require disclosure of all details adverse to a party or his or her interest – it may be sufficient that the substance of the information that may be relied upon is brought to his or her attention. Again however the courts have rarely
if ever articulated when and in what circumstances a summary of documentary information may suffice. The paper examines the relevant law and discusses examples from the Tasmanian study where documentary evidence was summarised to the parties present at the hearing. Finally the paper will discuss whether the practice in the various jurisdictions is satisfactory and may make recommendations for change.

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Alternative dispute resolution and people with cognitive disabilities

Jim Simpson, lawyer, mediator and tribunal member, Sydney

People with mental illnesses, dementia and other cognitive disabilities are at great risk in alternative dispute resolution (ADR) with its emphasis on parties identifying and bargaining around their interests. However, with appropriate safeguards, ADR has much to offer, especially in producing outcomes that are likely to be implemented. Safeguards can include one or more of: assisting the individual’s participation in the process, use of advocacy models, other parties protecting the person’s interests, adjusting the role of the mediator or other independent, and statutory safeguards.

This paper explores these issues with a particular emphasis on guardianship cases in which ADR is currently being trialled in New South Wales.

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**Therapeutic Jurisprudence**

**Oct. 1, 2003 (8:30–12:30)**

**Brisbane Room (3rd Floor)**

**Registration** 8:00–8:30

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**Therapeutic Jurisprudence** 8:30–12:30

**Chair:** Ian Freckelton, Barrister-at-Law, Vic.

**Therapeutic jurisprudence in Australia: Paradigm shift or pragmatic incrementalism?**

*Arie Freiberg, Faculty of Arts, University of Melbourne*

‘INSIGHT’ from a duty lawyer’s perspective: Examples from real life

*Paghona-Peggy Kerdo and Chris Thwaites, Victoria Legal Aid, Melbourne*

**Divarications in civil commitment law**

*Ian Freckelton, Barrister-at-Law, Vic.*

**Break** 10:00–10:30

**International exchange and debate: Findings and reflections upon involuntary detention and civil commitment**

*Kate Diesfeld, National Centre for Health and Social Ethics, Auckland University of Technology*

**Lunch** 12:30–13:30

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**Abstracts**

**Therapeutic jurisprudence in Australia: Paradigm shift or pragmatic incrementalism?**

*Arie Freiberg, Faculty of Arts, University of Melbourne*

This paper examines the influence of therapeutic jurisprudence in Australia, particularly in relation to the operation of the courts and corrections. It argues that recent changes to court practices manifested in drug courts, domestic violence courts, mental health courts and Koorie courts can be generalised to the wider judicial and correctional system through an understanding of the key features of problem-oriented courts and the theory of therapeutic jurisprudence. It argues further that both therapeutic jurisprudence and restorative justice have in common a recognition of the importance of factors such as trust, procedural fairness, narrative competence, emotional intelligence and relational interaction which, if applied more broadly, can provide a constructive alternative to the flawed adversarial paradigm which presently dominates the criminal justice system.

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**‘INSIGHT’ from a duty lawyer’s perspective: Examples from real life**

*Paghona-Peggy Kerdo and Chris Thwaites, Victoria Legal Aid, Melbourne*

What does ‘insight’ mean? Definitions and understandings of ‘insight’ may be worlds apart depending on whether the meaning comes from a lawyer, a psychiatrist or an involuntary psychiatric patient. Drawing on examples gained by representing involuntary patients before the Mental Health Review Board in Victoria, Peggy and Chris hope to covey some of the difficulties that face the patient who is attempting to overturn involuntary status. ‘Lack of insight’ is often the reason presented by the treating psychiatrist to the MHRB for not permitting release from hospital. Yet the definition of ‘insight’ is nebulous and adds to the confusion and a very real sense of injustice that involuntary psychiatric patients have when their circumstances take them within the mental health realm. Peggy and Chris will argue that there needs to be a consensus between the legal and psychiatric professions as to the exact meaning and expectations that the term ‘insight’ imubes. This is necessary at the very least for consistency, and at the very most for therapeutic jurisprudential treatment and respectful understanding of the involuntary patients whose lives are affected.

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Divarications in civil commitment law

Ian Freckelton, Barrister-at-Law, Vic.

Freckelton identifies crucial points of ideological division in civil commitment cases where those of either a paternalist or civil libertarian disposition consistently disagree. Utilising these points, he plots ways of classifying decision-making and unmasking covert positions that may go unrecognised in cases involving potential self-harm, distress consequent upon symptoms of Bipolar Affective Disorder, risk of danger to others, personality disordered patients and persons with eating disorders. He argues that consciousness of clinician and decision-maker orientation is a constructive and legitimate part of decision-making across the spectrum of involuntary detention of persons with psychiatric illnesses.

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International exchange and debate: Findings and reflections upon involuntary detention and civil commitment

Kate Diesfeld, National Centre for Health and Social Ethics, Auckland University of Technology

What are the current over-arching themes in mental health law that bridge geographic boundaries? This session is designed to reveal recurrent themes that have emerged from research across disciplines and by academics, consumers and practitioners in: Europe and North America; New Zealand and Australia. These themes include the research devoted: to the distinction between voluntariness and involuntariness; the non-clinical factors that determine admission and discharge decisions; approaches to mandated outpatient treatment; and narratives of the voiceless. This session will introduce the research by, and encourage debate regarding the contributions of, researchers who have published chapters in Diesfeld, K and Freckelton, I (eds) (2003) Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment. London: Ashgate. The intention is to foster reflection upon our practices and to encourage fertile exchange regarding the future of mental health law across jurisdictions.

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Coerced community treatment: International trends and outcomes

Virginia Hiday, Department of Sociology and Anthropology, North Carolina State University

This presentation will describe historical conditions influencing the origin of coerced community treatment in the United States and historical conditions influencing its development both in the United States and in other nations. These historical conditions framed the discourse on the merits of mandatory community treatment and the questions of empirical studies on outcomes. The presentation will critically review those empirical studies, dividing them into two sets based on the questions addressed. It will give more attention to recent studies which randomized subjects to experimental and control conditions, and offered enhanced services.

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Throwing away the key. People with intellectual disability and involuntary detention.

Kelley Johnson, Australian Institute Of Family Studies; Sue Tait, Director, Intellectual Disability Review Panel of Victoria

This paper is concerned with the experiences of people with intellectual disabilities who are involuntarily detained. We argue that institutional care which formed the main service offered to people with intellectual disabilities in the past was a form of involuntary detention. We also argue that the discourses which framed institutionalisation continue to influence in the way involuntary detention is currently practised with this group of people now. More particularly in this paper we explore the following questions: Was institutionalisation of people with intellectual disabilities a form of involuntary detention? What was the rationale for it? Why does involuntary detention occur now? What forms does it take? How does the law address involuntary detention of people with intellectual disabilities? And what possibilities for change are there in relation to involuntary detention for people with intellectual disabilities? The paper concludes that a particular discourse of intellectual disability shapes the ways in which this group of people is involuntarily detained and leads to practices which differentiate this group from others who experience involuntary detention.

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# Law Enforcement and Mental Illness
## Point of First Contact

*In collaboration with New South Wales Police*

**Oct. 1, 2003 (13:30–17:30)  
Brisbane Room (3rd Floor)**

## Registration
13:00–13:30

## Law Enforcement and the Mentally Ill
13:30–15:30

**Chair:** Terry Collins, Assistant Commissioner and Southern Region Commander, NSW Police

**Welcoming Address**

*The Honourable John Watkins MP*, New South Wales Minister for Police

**Police treatment – Treatment for the new dual diagnosis**

*Jane Moses*, NSW Police

**Police and mental health in Queensland: Working day to day**

*Marilyn Kelly*, Royal Brisbane Hospital

**Police contacts with the seriously mentally ill and the associated costs in a mid-size Canadian city from 1998-2002**

*Kathleen Hartford, Lisa Heslop and Hazel Rona*, Lawson Health Research Institute, University of Western Ontario; *Ted Schrecker*, London Police Service

**Sudden unexpected death during restraint – Beyond positional asphyxia. A systems based approach**

*Chris Lawrence*, Defensive Tactics Training Section, Ontario Police College; *Sharon Lawrence*, Pharmacy Department, London Health Sciences Centre; *Wanda Mohr*, College of Nursing, Rutgers University

## Break
15:30–16:00

## International Approaches to Crisis Intervention
16:00–17:30

**Development and implementation of a multi-jurisdictional crisis intervention training program**

*John Hutchings*, Sergeant, Olympia Police Department

**The effects of Crisis Intervention Training on ‘point of first contact’ situations between the police and individuals with mental health problems**

*Shaun Parsons and Jonathan Dowd*, University of Newcastle, Newcastle upon Tyne

**Implementation and development of the crisis intervention team concept for the Seattle Police Department: Police partnering with mental health providers to better our response to persons in crisis**

*Lisa Eddy*, Sergeant, Seattle Police Department

## Closing Remarks by the Chair

**Coffee, Tea & Sandwiches**
17:30–18:00

(for registered evening Q & A session delegates)

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## International Expert Panel – Question & Answer Session
18:00–19:30

*This is a closed session to registered delegates from New South Wales Police from the afternoon session. “Law Enforcement and Mental Illness: Point of First Contact.”*

**Chair:** Geoff Beresford, Chief Inspector, Bankstown Local Area Command, NSW Police

**International Expert Panel**

*Shaun Parsons and Jonathan Dowd*, University of Newcastle, Newcastle upon Tyne

*Kathleen Hartford*, Lawson Health Research Institute, University of Western Ontario

*Chris Lawrence*, Defensive Tactics Training Section, Ontario Police College

*Sharon Lawrence*, Pharmacy Department, London Health Sciences Centre

*Lisa Eddy*, Sergeant, Seattle Police Department

*John Hutchings*, Sergeant, Olympia Police Department

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Police treatment – Treatment for the new dual diagnosis

Jane Moses, NSW Police

The specificity of the Mental Health Act 1990 definition of what is considered a mental illness or mental disorder for the purposes of involuntary treatment in a hospital, or in the community, is increasingly resulting in police referrals not being admitted, or being admitted under the disorder provisions and not being able to be admitted on more than the statutory 3 admissions per month. In crude terms this means police are processing the same people many times and requesting a mental health assessment, primarily due to the police belief that the person has a mental illness or that their duty of care can only be discharged if the person has such an assessment. It is likely that many of these clients have multiple disorders, apart from their regular offending, e.g. repeated self harming gestures or behaviours, and that the client, person of interest or POI has several difficulties, e.g. borderline intellectual disability, an addiction problem drugs/alcohol, or violent or assaultive or aggressive behaviour, or very dependant behaviours and clinging habits, endlessly ringing 000 for a chat, claiming to have been bashed, raped, robbed etc...

Police have limited support agencies in the community to assist with these POI’s and have come to rely on the mental health services as the one size fits all opportunity to assess the POI. This strains the inter-professional relationships and doesn’t improve the situation for the client who has multiple problems. The court system has been reluctant to sentence multiple macro nuisances, and have abused section 32/33 of the Crimes (Mental Disorder) Amendment Act to send untreatable people to hospital. This results in the behaviour escalating over time and a more potentially dangerous situation arising, which is dangerous for everyone. It emerges that the only treatment that these people are receiving is “police treatment”, when in custody they are monitored very closely, (duty of care obligations), if the custody officer feels it is needed they receive a medical assessment to check for head injuries, cardio/thoracic/medical illnesses, but as for specific responses to control or diminish the behaviour? Nothing. What is needed is a statute that provides for public sector assessments and mandated residential or institutional services for clients who at the moment fall outside the mental health act, that addresses behaviour that is unsafe, eg assaultive due to brain injury etc, multiple self harming, multiple threats of self harm, chronic inebriation, chronic addictions that result in life threatening crises or other lives being adversely impacted. At present the services that provide these services are in the corrective services group, but to access these services a guilty finding and a sentence are required. My suggestion is to shorten the process and mandate assessment and treatment where it would assist, prior to a history of multiple offending, to provide resources that police can call on when they encounter these POI’s early in their career. This would encourage mental health to concentrate only on treatable mental illness rather than having to do repeat assessments of clients who have a borderline intellectual disability and personality disorder, and provide police with another group of professionals to assess our client group.

The civil libertarians may shudder at the thought of more legislation to mandate intervention, even behavioural intervention, and their concerns should not be treated lightly. A civilised democracy that has nothing to offer a person who frequently calls 000, repeatedly slaps up, ingests poison, overdoses, drinks to a stuporous state then who comes near, who smears faeces and urine, who sprays the immediate environment and people with their own depandent behaviours and clinging habits, endlessly ringing 000 for a chat, claiming to have been bashed, raped, robbed etc...

Police and mental health in Queensland: Working day to day

Marilyn Kelly, Royal Brisbane Hospital

The 1974 Queensland Mental Health Act was reviewed and the new Mental Health Act was passed in 2000. The new act brought Queensland more into line with the other states and allowed for much greater flexibility between the Police and Ambulance Services and Mental Health Services. In order to effectively implement all aspects of the new act, we needed much greater communication and cooperation between these three services. To initiate this process, Queensland Health developed a Memorandum of Understanding with the Queensland Police Service. This MOU was signed off by the Director of Queensland Health and the Commissioner of Police on 24th May 2001. Each District Mental Health Service was then instructed to develop local Protocol Agreements or Partnership Agreements with the Police Services within their district, to be signed off by the District Manager and the Assistant Commissioner for the local Police District. The Queensland Health template, once trialled, was used to develop the local agreement with the freedom to develop procedures that were relevant to the area, whether CBD, urban, rural or remote. This presentation will demonstrate how the Royal Brisbane Hospital Division of Mental Health Services implemented the Mental Health Act and developed its Protocol Agreement, using joint policies and procedures, improved communication and education and training with the local police and ambulance services.

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Police contacts with the seriously mentally ill and the associated costs in a mid-size Canadian city from 1998-2002

Kathleen Hartford, Lisa Heslop, and Hazel Rona, Lawson Health Research Institute, University of Western Ontario; Ted Schrecker, London Police Service

The London Police Service (LPS) maintain a database of all contacts. In order to identify the seriously mentally ill (SMI) target population within the database, all records were searched for variables identified as a definite, probable or possible diagnosis of SMI. The cost analysis was based on the LPS 2001 budget, the number of events involving individuals with SMI and the number of officer hours attached to those events. Results: The number of SMI-definite individuals who had contact with the police increased 25% over the study period; no different than the rate of increase in the general population. 50% of SMI-definite/probable individuals had contact with the police > 5 times in any year, compared with 9% of the general population officers dealing with SMI-definite individuals spent considerably more time (68%), laid more charges and made more arrests in 2001 than in 1998. 54% of SMI-definite/probable individuals were charged and/or arrested at least once during the study period as compared to 31% in the general population. Specifically, 21% more mischief charges were laid in 2000 than in 1998. SMI-definite individuals convicted on an offence were more likely to be fined and more likely to spend time in custody in 2000 than in 1998. Events involving SMI-definite/probable individuals cost LPS between 4.6% and 8.7% of the total budget. hartfork@lhsc.on.ca

Sudden unexpected death during restraint – Beyond Positional Asphyxia. A systems based approach

Chris Lawrence, Defensive Tactics Training Section, Ontario Police College; Sharon Lawrence, Pharmacy Department, London Health Sciences Centre; Wanda Mohr, College of Nursing, Rutgers University

Law enforcement officials and health care providers are involved in restraining psychotic patients for the patient’s safety and the safety of others. On occasion the patient suddenly and unexpectedly dies during or immediately after being restrained. The results can be very costly in human, financial and public relations terms. At present only two efforts to replicate and study restraint methods have been conducted each resulting in opposing conclusions. The issues surrounding a sudden and unanticipated death proximal to restraint are re-examined using a multi-discipline approach. A systems based methodology is used to describe a typical incident, a typical at-risk encounter and a ‘point of first contact’ encounter between the police and individuals with mental health problems. The study was specifically aimed at ‘point of first contact’ encounters between sufferers of mental disorders and police officers – where officers can act as ‘gatekeepers’ to the Mental and Criminal Justice systems. Kelleher and Copeland (1972) and Teplin (1992) have found that police officers can satisfactorily identify individuals who may have psychiatric illness. The existing literature in this area generates critical debate over the powers invested in police officers to detain people with mental health problems when officers consider these individual’s condition to pose a threat either to themselves or the public. The central theme of this criticism revolves around the lack of training provided to, and therefore the lack of understanding of, police officers. (Dunn and Fahy 1987, Janus 1979, Laing 1999, Pogrebin 1987, Ruiz 1993, Monahan & Monahan 1986.) The focus of the study was on the Crisis Intervention Training programme (CIT) currently delivered to operational officers in Oregon and Washington States in the United States of America. In England and Wales, no such training programme exists and the very basic insight gained about psychiatric patients is expected to last them for the next 30 years of front line operational service. The research aim was to determine whether CIT affected the attitudes of police officers in Oregon and Washington states towards individuals with mental health problems who have contact with the police. The attitudes of operational officers in England were also assessed. Comparisons were then made between the attitudes of both CIT trained and non trained officers in the U.S. and the U.K. to assess the potential benefit to the Police Service in the U.K. of CIT adoption. s.parsons@ncl.ac.uk

International Approaches to Crisis Intervention

The effects of Crisis Intervention Training on ‘point of first contact’ situations between the police and individuals with mental health problems.

Shaun Parsons and Jonathan Dowd, University of Newcastle, Newcastle upon Tyne

The results of an International study in which the effects of structured mental health training on the attitudes and behaviours of operational uniformed police officers towards the mentally ill are presented. The study was specifically aimed at ‘point of first contact’ encounters between sufferers of mental disorders and police officers – where officers can act as ‘gatekeepers’ to the Mental and Criminal Justice systems. Kelleher and Copeland (1972) and Teplin (1992) have found that police officers can satisfactorily identify individuals who may have psychiatric illness. The existing literature in this area generates critical debate over the powers invested in police officers to detain people with mental health problems when officers consider these individual’s condition to pose a threat either to themselves or the public. The central theme of this criticism revolves around the lack of training provided to, and therefore the lack of understanding of, police officers. (Dunn and Fahy 1987, Janus 1979, Laing 1999, Pogrebin 1987, Ruiz 1993, Monahan & Monahan 1986.) The focus of the study was on the Crisis Intervention Training programme (CIT) currently delivered to operational officers in Oregon and Washington States in the United States of America. In England and Wales, no such training programme exists and the very basic insight gained about psychiatric patients is expected to last them for the next 30 years of front line operational service. The research aim was to determine whether CIT affected the attitudes of police officers in Oregon and Washington states towards individuals with mental health problems who have contact with the police. The attitudes of operational officers in England were also assessed. Comparisons were then made between the attitudes of both CIT trained and non trained officers in the U.S. and the U.K. to assess the potential benefit to the Police Service in the U.K. of CIT adoption. s.parsons@ncl.ac.uk

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**Law Enforcement and Mental Illness**

**Development and implementation of a multi-jurisdictional crisis intervention training program**

*John Hutchings, Sergeant, Olympia Police Department*

In this paper the implementation and evaluation of Crisis Intervention Training in the Olympia Police Department in the United States of America will be presented. The paper will be focused upon the coalition building, curriculum, policy development and tactical supervision of calls to the police involving dangerous mentally ill subjects. The Olympia Police Department has recognized the need to further enhance the abilities of law enforcement officers in their response and interactions with people in crisis. This countywide CIT course is the first of its kind in Washington State and the first in the USA using a multi-jurisdictional approach. Typically, police agencies adopt a CIT course as a result of a major crisis, or use of deadly force incident against a mentally ill subject. The Chief of Police in Olympia decided not to wait for such a crisis and supported the immediate creation of a CIT course. The author was designated the CIT coordinator, in March of 2001. He worked to form a coalition of mental health professionals and was aided by the local president of the National Alliance for the Mentally Ill (NAMI). Subsequent to forming the community partnership, national research was conducted and a curriculum was created. The first CIT class was conducted November 2001. Since that time the author has hosted 3 additional classes for a total of 101 first responders, receiving this training. These courses were comprised of first responders from fifteen (15) separate agencies and three different counties. Present in the courses were Washington State Patrol, Nisqually Tribal Police, Fire personnel, The Evergreen State College Police and correctional staff, from the city and county jails. Approximately 45% of the Olympia Police Department personnel have received the 40-hour CIT course. The national average is about 25% and as classes continue that average grows. Helping to provide a safe, effective and respectful resolution of incidents involving persons with mental illness. Olympia police are also involved in two closely related initiatives which both compliment and enhance the CIT program. Firstly, the CIT co-coordinator also acts as an alternate law enforcement representative on the Dangerous Mentally Ill Offenders (DMIO) committee, held in Olympia. This program identifies convicted mentally ill felons preparing for release, and provides them with services designed to assist their reintegration into society therefore acting pre-emptively to reduce episodes of crisis in the community which may necessitate calls to the police. In addition the CIT co-coordinator is involved with the creation of a mental health court in Olympia. This seems an appropriate extension of the CIT program. Currently, only Seattle courts offer such a program for misdemeanant mentally ill offenders.

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**Implementation and development of the crisis intervention team concept for the Seattle Police Department: Police partnering with mental health providers to better our response to persons in crisis**

*Lis Eddy, Sergeant, Seattle Police Department*

Police departments typically start to realize the need for change, after a significant event occurs, or after a series of significant events. The Seattle Police Department had been much like other departments in Washington State, and more specifically the King County region, when it came to the handling of calls involving persons in mental health crisis. There are nearly 5000 contacts each year, between the Seattle Police and a person suffering from a mental disorder. The basic training academy provides only 4 hours of training, on dealing with mental disorders. The speaker is a 24 year police veteran with the Seattle Police Dept, who has been involved in crisis negotiation since 1981. In 1992, she was promoted to team leader of the Crisis Negotiations Unit. In 1997, Sgt. Eddy determined that a large number of calls concerning barricaded/suicidal persons, involved persons suffering some type of mental disorder. She suggested to the Chief Police Officer that more training was necessary for this specialist team, in dealing with persons suffering mental illnesses. The Chief determined a larger and improved overall response to persons with mental illness should be developed and as a result of this Sgt. Eddy was appointed as part of a committee involving persons from the community, mental health providers, prosecutors and police department personnel. The committee adopted the concept of the Crisis Intervention Team that was modelled upon a successful program developed in Memphis, Tennessee. The Seattle program began in 1998 and in 2000 Sgt. Eddy became the coordinator. Since then the role and response of the specially trained CIT officers has been expanded. In addition, Sgt. Eddy has continued to develop relationships with the County Designated Mental Health Professionals, community mental health providers, Department of Corrections, Mental Health Crisis Triage Unit, and the City of Seattle Municipal Mental Health Court. Washington State has a program called Dangerous Mentally Ill Offenders. Sgt. Eddy serves on a committee to select participants who, once identified, receive numerous services to assist them in trying to reintegrate into society after serving a prison sentence. Monitoring these somewhat unstable offenders requires collaboration from the police, Department of Corrections, and mental health providers. There is an officer assigned to the CIT office, who works closely with these agencies. In addition to training police officers the CIT program has been enhanced to include other aspects of police response to the mentally ill. There is significant follow up of police contacts with individuals with mental health problems and partnering with other agencies occurs, to ensure the best response to those who offend, because they happen to have mental health problems. Sgt. Eddy will be presenting the development, and enhancement of CIT for the Seattle Police Department.

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Abstracts

Psychiatric Injury Litigation

Negligent psychiatric harm in the courtroom – are law and medicine on a collision course?

**Prue Vines**, Faculty of Law, University of New South Wales; **Yega Muthu**, Division of Law, Macquarie University; **Barbara Ann Hocking**, Faculty of Law, Queensland University of Technology; **Ben Zipser**, Selbourne Chambers, Sydney

An apparent contradiction in the trend of judicial decisions in negligence has emerged with the High Court decision in Annetts & Anor v Australian Station Pty Ltd [2002] HCA 35. It is argued that there is a long-standing trend in judicial decisions in this area reining back the law of negligence, a trend which Annetts appears to confound. However, it can also be argued that there are deeper trends in the judicial decision-making process in Australia in this context, trends with which this apparently contradictory decision actually conforms. Duty emerges from these cases as law’s gatekeeper and this concept assumes that gatekeeper role precisely because the plaintiffs in these cases do suffer psychiatric illness. Whether the plaintiff had suffered a recognised form of illness depends on the language of psychiatry as encapsulated in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV -TR). In most cases that proceed to trial, the appellate court makes a linguistic interpretation as to what psychiatric illness is. Is there a legal definition for cases of this type? Whatever legal attributes the court gives, it must have meant something more than a psychiatrist attaching a diagnosis with a medical sounding name to the complainant’s condition. Practically cases are decided on a judicial assessment of the character of the plaintiff as a person of normal disposition as in Annetts. The truth in such cases is not psychiatric but a legal one. The rules may appear transparent and lucid but psychiatric cases are frequently complex or lead to contradictory judgments as was demonstrated in Tame v Morgan [2002] HCA 35. Hence, it is argued such a case is not decided on psychiatric ground at all and psychiatric evidence is a facade created by expert witnesses in the courtroom. This is also an area of law where judges have had to construct a biography of the plaintiff going back to his or her schooldays’ and where virtually every incident in the plaintiff’s life can be adduced as evidence of his or her personality. This is substantiated with a litigant’s frequent grandiose and absurd testimony so as to enable a judge to make his or her own assessment of the plaintiff’s obsessional psychological state and substitute it with the judge’s own detailed biographical account of the plaintiff’s life before and after the accident. This observation could be made of the plaintiff(s) both in the early High Court case of Chester v Waverley Municipal Council (1939) 62 CLR 1 and the recent case of Annetts. Why did these parents have to prove they loved their children when the carelessness of another had contributed to their deaths? With the imposition of its own peculiar notion of what constitutes ‘proven’ psychiatric illness in the nervous shock context, law has allowed itself little alternative to this judicial biography. Why is law and medicine at a collision course, which requires mentally traumatized people to go to court and prove that they have strong feelings of love and affection towards another? The answer to the question seems to lie in the assessment for damages, when compensation is sought for the negligent infliction of psychiatric injury, where the events might be observation of the negligent death or severe injury of a loved one or shock to oneself having observed some event, the courts look at the practical consequences of not extending the boundaries of liability of the defendant because of the floodgates and...
Psychiatric Injury Litigation

policy arguments. Judges in the courtroom in cases where damages are sought for psychiatric or other mental harm face the difficult task of placing a monetary value on the harm. This section, through an examination of judgments considers the monetary value placed on mental harm by courts in Australia; and compares the monetary value placed on mental harm to the monetary value placed on physical harm.

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Bullying at schools: The next development in legal liability for psychiatric injury?

Des Butler, Faculty of Law, Queensland University of Technology

In late 2000 a Victorian jury awarded substantial compensation to a school who claimed to have been bullied by fellow students. The case signalled a foray into previously unexplored territory: whether the duty of care a school owes its students extends to protecting them from psychological harm intentionally inflicted by a third party. However, in light of the growth in claims against employers for bullying in the workplace, the development was perhaps not entirely unexpected. Nevertheless the decision (and a similar one in the New South Wales courts) raises a number of interesting questions including the appropriate response to the risk of bullying, susceptibility and contribution as well as the nature of a school’s responsibility and liability towards its students. Does it make any difference how old the student is, what his or her socio-economic background is, whether the school is same sex or co-educational or whether the school is public or private? These issues are among those that will be examined, along with the question whether as a matter of public policy an all-government response like that recently adopted to workplace bullying by the Queensland Government is warranted.

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The rise of psychiatric injury as a cause of action – Bodily injury, the Warsaw Convention and innovative judicial interpretation

James Harb, PrizewhitehouseCoopers Legal, Sydney; Kishan Manocha, Forensic Psychiatrist, London; Yega Muthu, Division of Law, Macquarie University

There is no qualitative difference between a ‘broken body’ and a ‘broken mind’. The House of Lords affirmed the decision of the Scottish Court of Session in King v Bristow Helicopters Ltd. [2001] Vol.1 95 interpreted the phrase ‘any other bodily injury’ to include psychiatric injury suffered by an aircraft passenger pursuant to Article 17, Warsaw Convention (a French Text) as applied by the Carriage by Air Act 1961 (domestic law). It also extended to non-international carriage as in this case. Here the plaintiff suffered Post Traumatic Stress Disorder because of being involved in a helicopter accident. The court concluded that ‘any other bodily injury’ were words of expansion, not restriction. They were clearly intended to give the Article a wide import and that any ‘bodily injury’ whatever was recovered. Therefore, the plaintiff was awarded compensation on this interpretation. However, the English Court of Appeal in Morris v KLM Royal Dutch Airlines [2001] 3 All ER 126 distinguished King and disallowed compensation to a plaintiff who suffered from clinical depression as a result of a man who sexually assaulted her whilst asleep on board an aircraft. The court had to consider whether the plaintiff’s illness was caused by an accident and constituted any other bodily injury within the original meaning of Article 17. The court opined that no mention was made of liability for psychiatric injury in the course of the negotiations that resulted in the Warsaw Convention, 1929. Hence, the drafter’s of the convention used the phrase ‘bodily injury’ and intended a natural meaning – physical injury and did not envisage an extension to a different type of harm – psychiatric injury. Accordingly those who drafted the convention intended the phrase ‘bodily injury’ to turn on the jurisprudence of the individual state applying the convention. Yet, the disparity between the Scottish and English decision, leaves the state court in a blind alley.

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Stalking on cyberspace: Is it sufficiently ‘proximate’ to give rise to a claim for psychiatric injury within the DSM and ICD classifications?

Yega Muthu, Division of Law, Macquarie University

This paper will explore that harassment via the internet is turning into a growing problem and many people in ‘chat rooms’ do not comprehend the potential risks. Women have been pestered by e-mail or had offence messages or images downloaded onto their computers. It is alarming, while this can be terrifying itself, the behaviour of internet stalkers may cause an individual to suffer from a psychiatric disorder. The perpetrator’s action can be threatening, intimidating and invading one’s privacy. Consequently a psychotherapist would need to be engaged in order to deal with one’s paranoia and fears.

With hindsight and the future legal implications of stalking on the Internet and as the images over the Internet are reported in text, it is possible for someone interacting with it to become victims whose ‘bodily integrity’ is violated or the relevant degree of proximity to give rise to a claim of psychiatric injury. This paper will argue that this may manifest into Post Traumatic Stress Disorder (PTSD) within the context of the Diagnostic and Statistical Manual For Mental Disorder (DSM-IV-TR) and International Classification of Diseases (ICD-10) classifications.

This paper demonstrates that an individual may bring an action in the law of torts for unlawful infliction of psychiatric injury, however, the paper goes on to raise the wider question as to whether Australian law recognizes a claim such as an individual who has been traumatized as a result cyberspace stalking.

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Abstracts
Building a Forensic System – The Netherlands Experience

Strategic policy in bridging forensic psychiatry in judicial institutions and mental health organisations
Pim Hoevenaar, MHO Groningen and Forensic Psychiatric Hospital, Groningen

In the Netherlands, Forensic Psychiatry has mainly evolved in separate Judicial Institutions under the auspices of the Ministry of Justice (known as TBS clinics or Forensic Psychiatric Hospitals). This has created a partition...
between these clinics and regular mental health care. They have become isolated, which is detrimental to the development of the care. A development is now taking place in the Netherlands promoting renewed close cooperation between forensic psychiatry in Institutions under the Ministry of Justice and public mental health care. The advantages of this will be considered extensively. It is argued that forensic psychiatry should be part of regular mental health care, and that this should include the Judicial Clinics as well as the mental health care provided in prisons and during probation. The role seen for the Justice Department is one of providing the precondition for forensic care; that is to ensure the safety of the general public. How to do and how will it interfere with the care?

Building a forensic psychiatric circuit

**Geerhard Schaap**, MHO Groningen and Forensic Psychiatric Hospital Groningen

In this presentation I will give an outline of the development and building of a Forensic Psychiatric Circuit, in the northern part of the Netherlands. The core of the Dutch policy is aimed at intensive cooperation of Forensic and Public Mental Health Services and at the development of Regional Forensic Psychiatric Circuits. In the past five years we succeeded in building a good working, well developed Forensic Psychiatric Circuit. I will describe the demographical and geographical situation in the northern part of the Netherlands and give a brief overview of the judicial and forensic psychiatric facilities and services. The development, the coordination and stimulation of cooperation by projects and invitational conferences will be highlighted; also who is in control and responsible! The pillars of the FPC, namely active will to cooperate, shared ownership and responsibility, decision to delegate power, common education courses and research, will be discussed. Our mission is to provide effective forensic psychiatric services to people who have both a severe mental disorder and a criminal history or who present a serious risk of such behaviour. We expect our future to be... challenging and rewarding!

**What goes first, care or security? A model for forensic psychiatric care**

**Martin Tervoort**, Division Forensic Psychiatry, MHO Drenthe

Forensic psychiatric care in The Netherlands is fragmented. This care is offered in general mental health institutions, in specific forensic mental health settings, in so-called judicial TBS-hospitals and in prisons. Cooperation between mental health partners in care is emerging, but differences in cultures, treatment philosophies, interests, needs and methods still act as a barrier to change. In addition there is a lack of transparency and consensus with respect to priorities. A shared philosophy and reference framework is missing. On the other side: Forensic psychiatric patients must be admitted because there is a need for psychiatric care and security. A general model is proposed by putting these two basic principles into a hierarchical order: When there is a primacy for legal restraint a detention setting is needed, in which treatment can be offered when healthcare is needed. When there is a priority for treatment or nursing, mental health-clinics are needed, which can be closeds for safety reasons. So four different types of settings can be distinguished: closed mental health-settings for treatment, closed mental health-settings for long term nursing, detention settings with possibilities for treatment and detention settings with possibilities for nursing.

**The importance of a Forensic Psychiatric Circuit for the clients of the Probation Service**

**Alien Uitham and Jan Verhoeff**, Dutch Probation Service, District of Leeuwarden

The Dutch Probation service is a part private, part public organization supplied by the Ministry of Justice. It works with psychiatrically disturbed offenders to provide supervision, enforcement, control and treatment. Balancing public safety and the treatment of offenders in our care are key elements in realizing the objectives of the probation program and the requirements of the courts. In order to achieve the goals of treatment, it is important to have access to, and utilize, the best available offender management practices and state-of-the-art risk-assessments. The probation service is currently exchanging information on best practice methods with several other countries. The importance of intensive cooperation between the partners in the forensic and mental health network cannot be overstated. Establishing close cooperation between these service providers including the probation service will enhance the continuity of care for offenders with mental health problems. A more coordinated, comprehensive service is likely to contribute to the reduction of recidivism.

**Building an infrastructure for forensic psychiatric research**

**Rob van den Brink**, Department of Psychiatry, University of Groningen; **Jozica Kutin**, Forensic Psychiatric Clinic, MHO Drenthe; **Marinus Spreen**, Forensic Psychiatric Hospital, Gronigen; **Durk Wiersma**, Department of Psychiatry, University of Groningen

Forensic psychiatric research in the Netherlands is concentrated in individual care facilities. Involvement of university departments of Psychiatry is rare. Recently two developments altered this situation in the Northern part of the Netherlands. First, judicial and mental health facilities in forensic care have been integrated into a regional
Building a forensic psychiatric circuit by education

Joop van Velzen, Forensic Psychiatric Hospital, Groningen

The recent cooperation between the judicial and mental health organizations in the northern part of the Netherlands has resulted in a common educational program for professionals working at different levels in the Forensic Psychiatric Circuit. The aims of this program are: (1) to guarantee the professional level of the employees, (2) to offer opportunities for interchange and dialogue between employees of different Circuit members, and also (3) to stimulate the development of mutual knowledge, and a standardized language and attitude, resulting in the development of a common treatment culture. These aims are necessary for an effective treatment of this extraordinary target group. Also, the problem and solutions in organizing this will be presented.

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Treatment in forensic psychiatry: Integration of treatment and security

Corstiaan Bruinsma, Forensic Psychiatric Hospital, Dr S van Mesdagkliniek

The Dr. S. van Mesdagkliniek is the largest Forensic Psychiatric Hospital in the Netherlands. It has a capacity for 181 only male patients. There is large variety of psychiatric problems, but the most patients are treated because of a psychotic disorder or a personality disorder often in combination with drugs related problems. The crimes are related with the pathology of the patients: there is a diminished responsibility assessed with the offenders. The Mesdag Clinic is working together with the Mental Health Organization of Groningen and is part of the Forensic Psychiatric Circuit of the northern part of the Netherlands. The Clinic provides a patient oriented treatment. The focus of the treatment is the ambition to urge the patient to actively accept his responsibility for both his treatment and his crimes and consequences to the victims. To fulfil this ambition the Dr. S. van Mesdagkliniek attempts to combine and integrate two cultures: one focusing on control and security (a prison climate), and the other focusing on treatment and change (a hospital climate). In order to integrate these different cultures the clinic has chosen to introduce a treatment method that integrates both cultures accompanied by an educational program for its personnel. Various aspects of this process of integration will be illustrated.

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Forensic psychiatric treatment as part of mental health care

Peter Lambers, Forensic Psychiatric Ward, Zuidlaren, MHO Groningen

Because of the increasing number of mentally disordered offenders (mostly with a psychotic disorder) and the difficulties in admitting patients from forensic psychiatric institutions to public mental health care, so called FPA’s, i.e. forensic psychiatric wards in general psychiatric hospitals, have been established as part of mental health care. Their aim is to function as a gateway, so that psychiatric patients in criminal justice institutions, such as prisons and forensic psychiatric hospitals can take part in regular mental health care, like out patient clinics, sheltered care homes and home treatment. Furthermore, people with specific court or probation orders for compulsory care can be admitted. Because of the relatively low level of security, admission criteria with the emphasis on potentially dangerous behaviour are used, for example the absence of or sufficient control on aggressive behaviour, no need for constant confinement, no specific restriction order and no risk for acute relapse into criminal behaviour. Treatment motivation is also an important criterion. During treatment, previous results and data from diagnostic reports constitute the basis for further treatment. A combination of forensic psychiatric methods, such as risk assessment and mental health care methods, for instance carefully balanced medication, rehabilitation and psycho-educational programs, is used. This is an effective way to make forensic patients deal with their illness, minimalising the risk of relapse and to equip them to life “outside” with the help of mental health care.

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Forensic crisis-cards: A new development in forensic psychiatry in the Netherlands

Jožica Kutin, Rik Koopman and Martin Tervoort, Division Forensic Psychiatry, Assen, MHO Drenthe (presented by Rob van den Brink)

Progressively more and more referrers were requesting a preventative method for clients with a forensic psychiatric background. Recurring admissions and/or re-offending were a continuous topic of concern. Through extensive consultation with referrers and clients it became apparent that a new and innovative method was required to support...
clients, their families and referrers. The idea of the crisis-card was born. This program empowers clients in seeking and getting an immediate safe environment in time of crisis, that is a short-term admission (max. 5 days) which bypasses the usual admission procedures. This presentation will describe the Crisis-Card program, including its history, the goals and objectives, referral criteria, and its evaluation. To date 31 patients have been referred to the program. The research project included interviews with 20 patients and their carers, key-stakeholder interviews, and the detailed analysis of two cases. Patient files were also reviewed and a comparison of patients who were referred to the program with those who were not was conducted using the hospital’s registration database. Initial results of the evaluation will be presented, highlighting the program’s strengths and weaknesses, and the characteristics of patients referred. The project and its evaluation were funded by the Open Ankh Foundation.

Psychoanalytic treatment of an adult paedophilic man with serious identity disturbances: A case study
Klaas van Tuinen, Division Forensic Psychiatry, MHO Drenthe, Assen

Alongside specific transference and counter-transference aspects throughout the whole treatment, the focus in this case was directed on the development and strengthening of the patient’s identity. This case study will deal with poor self/object representations in his intra-psychic world, his distortions of reality, the threat to people in his environment and his rigid defences. This demands un-classical conditions in the therapeutic relationship, which makes psychic growth possible.

A National Forensic Mental Health System – Ireland

Overview of service developments in the National Forensic Mental Health Service: Research and development
H Kennedy, H O’Neill, D Mohan, M Gallagher, P Braham, P Gill and J Broe, National Forensic Psychiatry Service, Dublin, and Dept. of Psychiatry, University of Dublin

Objectives: The management of change in a forensic psychiatry service founded in 1850 is described.

Methods: Needs assessment aggregated at the level of current service users presents a limited picture of the unmet need elsewhere. Population based estimates of morbidity provided quantitative information. Studies of the interaction between forensic and local adult psychiatric services outlined systemic strains which lead to forensic presentations. Dynamic models for length of stay were used to model future service configuration and processes.

Results: Aggregated needs assessment of current service users identified an unmet need for multi-disciplinary treatment and rehabilitation programs. Population based estimates demonstrated large numbers of psychotic people with co-morbid drugs and alcohol problems in the prison populations, with varying security needs. Service models demonstrated a reciprocal relationship between local service resources and forensic service use. Dynamic modelling of length of stay offers a three compartment model. Each ‘compartment’ has a median length of stay (half life) and a notional size (bed numbers). These are independent of level of security.

Conclusions: Reconfiguring the existing service can be planned using modern service modelling methods. Bringing the proposed change about requires change management involving all stakeholders. Legal and organisational reform all depend on political interest, driven to some extent also by international conventions.

Mapping the forensic psychiatric population: Deprivation and population density
Dearbhla Duffy, Dept. of Psychiatry, University of Dublin; Helen O’Neill, A. Kelly and Katherine Curtain, National Forensic Psychiatry Service, Central Mental Hospital, Dublin

Objectives: Ecological relationships between deprivation and forensic psychiatric admission rates may differ in urban and rural areas. We aimed to compare the relationship between material deprivation and forensic admission rates in rural and urban areas for a whole-national service in Ireland over a three-year period.

Methods: All Irish forensic admissions from 1997 to 1999 were allocated to the appropriate small area. Material deprivation scores were calculated from census data. Mean annual admission rates and Bayesian standardised forensic admission ratios for small areas were aggregated by material deprivation score and population density.

Results: At small area level, there were significant non-linear increases in forensic admissions with increasing deprivation. The increases in urban areas (population density >10/Hectare) were absent in less densely-populated areas. Results for imprisonment rates will also be presented.

Conclusions: Deprivation alone may not be the key factor in predicting forensic service utilisation. Factors associated with specifically urban deprived areas may be of greater relevance in planning services.
Psychiatric morbidity in the Irish Prisons populations: Women prisoners
H O’Neill, B Wright, D Duffy, S Linehan, K Curtain, D Mohan and H Kennedy, National Forensic Psychiatry Service, Central Mental Hospital, Dublin

Aims: To estimate the prevalence of psychiatric morbidity and substance abuse problems among female prisoners in the Irish prison population.

Method: Female prisoners represent approximately 3% of the Irish prison population. In June 2001 there were 93 female prisoners in custody. We surveyed 83 remanded and sentenced women prisoners. The Schedule for Schizophrenia and Affective Disorders, Lifetime Version (SADS-L) was administered to detect lifetime and 12-month prevalence of major mental illness. Substance misuse was measured using the SADS for alcohol and the Severity of Dependence Scale for other intoxicants.

Results: The twelve-month prevalence of psychosis (ICD-10 F11.5-F34) was 2.4%, for major depression 28.9% and for anxiety disorders 12.0%. The twelve-month prevalence of deliberate self-harm was 7.4%. The prevalence of harmful use or dependency on alcohol or drugs (ICD-10 Research Diagnostic Criteria) in the year prior to committal was 62.5%. Self reported rates of infection with Hep C and HIV were 35.8% and 9.5% respectively and 42% reported a lifetime history of intravenous drug use.

Comments: The high rates of mental illness among female prisoners have implications for the provision and delivery of mental health services to this special population. The high rates of substance problems and related health problems are also cause for concern.

Race and ethnicity in the Irish prisons and forensic mental health populations
B Wright, K Curtain, D Duffy, S Linehan, and H Kennedy, National Forensic Psychiatry Service, Central Mental Hospital, Dublin

Objectives: To determine whether Irish Travellers are over-represented amongst transfers from prison to psychiatric hospital. If so, to determine whether this represents an excess over the proportion of Irish Travellers committed to prison.

Methods: Irish Travellers admitted to the National Forensic Psychiatry service were identified from a case register over three years 1997-99. New prison committals were sampled and interviewed as part of the routine committal screening to identify ethnicity.

Results: Irish Travellers accounted for 3.4% of forensic psychiatric admissions compared to 0.38% of the adult population. Travellers transferred from prison to psychiatric hospital had more learning disability and less severe mental illness than other groups, while black and other ethnic minorities had a higher proportion of severe mental illness. Travellers accounted for 6% (95% CI 3% to 11%) of 154 male committals and 4% (95% CI 2% to 12%) of 70 female committals. The estimated annualised prison committal rate was 2.8% (95% CI 2.4% to 3.3%) of all adult male Travellers in Ireland and 1% for female Travellers (95% CI 0.8% to 1.3%). Male Travellers had a relative risk of imprisonment compared to the settled community of 17.4 (95% CI 2.3 to 131.4), the relative risk for female Travellers was 12.9 (95% CI 1.7 to 96.7). Imprisoned Travellers had greater rates of drugs and alcohol problems than other prisoners (Relative risk 1.46, 95% CI 1.11 to 1.90).

Conclusion: There is gross over-representation of Travellers in forensic psychiatric admissions. This reflects the excess of Travellers amongst prison committals.
Petrol sniffing in the Northern West of South Australia; The State Coroner finds a crisis in Anangu Pitjantjatjara communities

Christopher Charles, Aboriginal Legal Rights Movement, Adelaide

In May 2002 the South Australian Coroner Wayne Chivell held inquests into the deaths of 3 Aboriginal people [Anangu] from the Anangu Pitjantjatjara lands in the north west of South Australia. His findings included that:

- the practice of sniffing petrol is widespread and has been increasing [166 active sniffers of a population of 2500 people in 2000];
- each of the deceased had led lives characterised by illness, hopelessness violence and alienation from their families; and
- being chronic sniffers [a constant habit of more than 10 years] they were brain damaged by the time they died from respiratory depression, having fallen asleep over their petrol cans.

Following D’Abbs, the coroner recommended primary, secondary and tertiary interventions, dependent on the degree of cognitive deficits and physical deterioration individuals had suffered. Criticisms were made of government responses to the ongoing crisis caused by sniffing. The Coroner’s findings and recommendations constitute a blueprint for government in dealing with a crisis in policy, public health and policing in AP Lands. Recommendations include changing police imposed sanctions to those that would be effective in causing sniffers to abstain, increased emphasis on diversion and assessment of cognitive deficits in individual cases, a role for neuropsychologists in assessment, and locally based treatment and detention facilities. The success of interventions would depend on the resources provided and their coordination across the region. No individual ‘solution’ was likely to be effective on its own. Reflection on the Role of the Coroner as a survival from medieval English jurisprudence to a modern safeguard of public health and community safety for remote Aboriginal Communities.

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Equivalence is a right for Aboriginal and Torres Strait Islander mental health

Len Kanowski, Mental Health Service, Queanbeyan, NSW; Tom Brideson, Djirruwang Aboriginal and Torres Strait Islander Mental Health Program, Charles Sturt University

Aboriginal mental health is a relatively recent development in the context of the mainstream mental health system in Australia. A highly skilled and effective mental health workforce is required to address the issues of mental health in Aboriginal communities. Aboriginal mental health workers require support in the development of mental health skills. The Djirruwang program at Charles Sturt University in Wagga Wagga provides tertiary level education to Aboriginal and Torres Strait Islander people in the mental health field. The program has created a Clinical Handbook and Course Competencies document consistent with the following areas.

1) At a National level in recent times the Office for Aboriginal and Torres Strait Islander Health (Commonwealth Health and Ageing) has facilitated three important documents:
   - National Aboriginal and Torres Strait Islander Health Strategy, Consultation Draft
   - National Strategic Framework for the Aboriginal Health Workforce 2002

2) Three other very important National developments have taken place recently:
   - Royal Australian and New Zealand College of Psychiatrists Position Statement No 50 relating to the Aboriginal Mental Health Workforce in 2002
   - National Practice Standards for the Mental Health Workforce in 2002
   - Consultation Paper, National Mental Health Plan 2003 - 2008

3) In NSW a process to revise the NSW Aboriginal Mental Health Policy, 1997 has begun.

Each of the above documents stresses the need for a highly skilled and effective Aboriginal mental health workforce. To ensure an ongoing quality workforce the Djirruwang Program has used the information contained within these and incorporated it into the course structure. In particular the National Practice Standards for the Mental Health Workforce is the basis for the development of the Clinical Handbook and Course Competency document used by students when undertaking clinical practice. The Djirruwang Program is an initiative that is attempting to ensure Aboriginal and Torres Strait Islander people have opportunities to gain formal qualifications in order to seek meaningful careers in the field of mental health. Details of the development of the program, course content and course competency document will be presented in more detail.

Len Kanowski in close consultation with Tom Brideson are the authors of the Clinical Handbook and Course Competency document. Aboriginal and Torres Strait Islander people experiencing mental health problems have a right to ‘at least’ equivalent service delivery that meets community needs. The Program is contributing to the building of a highly skilled and effective workforce.

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Indigenous self-determination, self-esteem and their relation to the legal rights and therapeutic capacity associated with the industry of bioprospecting

Christopher Jones, Centre for Environmental Law & Warawara Department of Indigenous Studies, Macquarie University; Bruce Jones, Psychologist, Fort Myers, Florida

Using a multi-disciplinary focus of Psychology, Law, Indigenous Studies and Feminist Ethics, this paper will engage the effect of severe oppressive social contexts upon Indigenous Peoples and more specifically the manner in which this impairs the mental faculty of imagination. Particularly in regards to the capacity to positively ‘imagine oneself otherwise’.

This is an important discourse as it contributes to understanding the apparent insufficiency of many social, health and legal programs developed towards the purpose of facilitating indigenous self-determination. At times, social programs and funding are insufficient, often because the oppressive contexts on specific levels remain which impair the capacity to use these resources to create a positive vision of the future. Focus will turn specifically towards the legal and therapeutic issues associated with the industry of bioprospecting. This is for three reasons. First it reveals an example of an undisclosed oppressive context that is continuing, systematic and institutionalised (and worth more than 25% of the world’s pharmaceutical market). Second, it affords an opportunity to engage and take seriously some of the spiritual concerns of Indigenous Peoples. While third, by including in education programs the vision of how indigenous knowledge is of great value, on a spiritually intrinsic level, as well as on an economic level to western civilisation, this offers a unique therapeutic capacity by its potential to enhance self-esteem and confidence in indigenous children and youth.

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**Indigenous Justice and Mental Health**

**Paths to youth suicide: Aboriginal, Maori and Inuit perspectives**  
**Colin Tatz, Politics and International Relations Dept., Macquarie University**

This is an assessment of Western systems that are believed to have an impact on indigenous youth suicide in Australia, New Zealand and the Canadian province of Nunavut: the criminal justice system and incarceration or removal of youth from homeland; and the medical/mental health model that maintains both surveillance and care of ‘mental illnesses’ believed to be causal factors in the high suicide rates. Another perspective is to look at external values and behaviours that may be contributory factors: alcohol, substance abuse, ‘Westernisation’, unemployment; and internal mechanisms that may be relevant, such as parenting problems, sexual abuse, grief cycles, and illiteracy. The presence or absence of suicide as a concept and of depression as a cultural norm, in earlier or phases of these cultures is relevant. A case is made for the separation, not the mainstreaming, of this growing problem, and for the development of entirely different approaches to youth suicide in these societies.

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**Indigenous Justice and Mental Health**

**Restorative justice and indigenous people**  
**John Boersig, Faculty of Business and Law, University of Newcastle**

The gross over-representation of Indigenous Australians in the criminal justice system is well documented. The NSW Government recognizes this problem, and is seeking to develop alternative mechanism for diverting Indigenous offenders from the criminal justice system. In this context the notion of ‘Restorative Justice’ is put forward as a new framework for the sentencing process. After initially outlining the evidence of adverse contact of Indigenous people with the criminal justice system, the paper goes on to review recent restorative justice initiatives in NSW. Questions are raised about the impact of the sentencing process upon Indigenous people. Is an Indigenous-based solution possible within the current criminal justice framework? The paper moves on to consider why ‘restorative justice’ initiatives may provide a pathway forward for Indigenous people.

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**Mental health and legal issues arising from uranium mining in the four corners of the United States**  
(Issues affecting indigenous people)

**Omie Baldwin, Faculty of Law, University of Wisconsin-Madison**

Uranium mining has had a profound effect on the life of the Navajo (Indigenous) people ever since mining operations began in the late 1940s. Mining Companies carried on their exploitation of the land and resources without providing protections for the miners, their families, and or others living in these area, without warning of the dangers of exposure to uranium ore and the consequences of mining work. As a result many workers have died as a direct result, and others have been living with debilitating illnesses. This has had a profound effect on the lives of their wives, children, and other family members throughout the years. The companies left worked out areas without any concern for the environment, leaving whole districts contaminated and polluted. For the past 40 years the Navajo Nation has been struggling to get compensation for these workers and their families, as well as for clean-up and rehabilitation of the contaminated land through the federal government (Super Fund, RECA) and other sources. The struggles continue to take their toll on the mental health and well-being of the members of the Navajo Nation.

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**Maori gambling: Issues of justice, equity and public health**

**Lorna Dyall, Faculty of Medical and Health Sciences, University of Auckland**

This paper will present findings of interviews with 15 Maori problem gamblers and 30 key informants involved in Maori health service delivery, provision of Crown policy advice and involved in the business of gambling. Evidence will be presented why we need to wear ‘bifocals’ in New Zealand in the development of a unique public health strategy which recognises the Treaty of Waitangi and addresses Maori gambling related harm. The position of Maori and other indigenous populations will also be discussed in recognition that gambling is a serious health issue which requires indigenous peoples to take control over their health and become actively involved in the development and review of government policies and the development of their own health services and research agendas.

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Abstracts

Work, Disability and Mental Health

New social security paradigms in disability: Implications for exclusion/inclusion

Bettina Cass and Sarah Parker, School of Sociology and Social Policy, University of Sydney

This paper explores transformations in the form, purpose and administration of income support policies for people with disabilities in the Australian social security system since the early 1980s. It identifies a paradigm change which has reinforced a medicalised model of the concept and measurement of disability, effectively removing from policy discourse and practice recognition of the social and economic factors that influence the capacity for participation. The paper examines the ways in which the current “welfare Reform” agenda of the Commonwealth Government has further elaborated a disability discourse which constructs the individual as the ‘problem’ within the welfare system, rather than addressing the labour market conditions and the embedded structural and attitudinal barriers which people with disabilities face in attempting to engage in both social and economic participation (the key-words of the “new welfare”). Changes to eligibility criteria and assessment procedures for disability income support are increasingly based on conceptions of an ‘a-social’ impaired body, while, paradoxically, welfare reform is increasingly focussed on the necessity to meet “mutual obligation” through social/economic participation. Such an approach inherent in the new welfare initiatives has been widely criticised
by disability organisations and welfare groups. This paper explores the extent to which these policy transformations actually constrain social participation opportunities for people with a chronic disability, asking: does a medical model of disability, compared with a socially-contextualised model, facilitate or impede social and economic participation, thus impacting on capacity-building for social inclusion and autonomy?

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Prevention and compensation for psychological harassment at work: Recent legislative developments in France, Belgium and Quebec
Katherine H Lippel, Faculty of Political Science and Law, Université du Québec à Montréal

This paper will describe the concept of psychological harassment in the workplace as described in mental health literature and as defined in recent legislation proposed or adopted in several francophone jurisdictions. Psychological harassment, which includes both the concepts of bullying and mobbing, has been the subject of much debate in some European countries and in French Canada, and this debate has led to the adoption of legislative provisions in force in France and Belgium since 2002. In late 2002, the Minister of Labour of Quebec tabled new legislative proposals which are currently the object of parliamentary debate. Each jurisdiction has taken a distinct approach to the phenomenon, France looking both at civil and penal provisions, Belgium emphasising the importance of multi-disciplinary teams to promote prevention, and Quebec proposing to introduce legal provisions governing both prevention and compensation. The Quebec proposal, which focuses on the employer’s obligation to provide a harassment-free workplace, introduces new rights and obligations by amendment to existing Minimum Standards legislation applicable to all workers, whether they are covered by a collective agreement or not. In Quebec, for more than a decade, workers’ compensation legislation has been relied upon to provide compensation for psychiatric disability attributable to workplace harassment. An overview of the case law regarding compensation for disability will illustrate different situations that are currently brought before the compensation tribunals and illustrate the limitations of exclusive reliance on workers’ compensation to meet the needs of victims of harassment. Using information gleaned from this overview we will explore the new legislative provisions to see how they can be used to prevent psychological harassment before it leads to the onset of chronic psychiatric disability.

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Insurance + Depression = Discrimination
Nicole Highet, Ingrid Ozols and Bernard McNair, Beyondblue – The National Depression Initiative, Melbourne

Ms Z currently has a case running against one of the top 5 banks. They have refused to issue her income protection insurance as it is their company policy not to issue insurance to people who are on anti-depressant medication. They will however issue policies to individuals on anti-epileptic medication. Beyondblue – the national depression initiative & the Mental Health Council of Australia (MHCA) have been inundated with similarly themed stories. Gaining insurance, whether in the form of income protection, life or travel policies and the like is a nightmare for those who openly disclose a diagnosis of depression &/or anxiety disorders. The price for honesty is exclusion. Why? Beyondblue together with the MHCA has been working closely to educate the sector about these disorders. The intention has been to develop a collaborative approach from all stakeholders that will drive changes in the industry to encourage understanding rather than perpetuate myths & the negativity that surrounds these disorders. A successful collaboration has the power to destigmatise those living with these vulnerabilities & aid their rehabilitation & recovery. This presentation will discuss these issues from a consumer perspective and outline work conducted in the area in an attempt to address the issue of insurance discrimination with respect to depression.

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Strategies for accommodating mental illness in the workplace
George Woods, Department of Psychiatry, Morehouse College of Medicine, Atlanta, Georgia

Accommodating mental illnesses in the workplace is a complex issue. Determining specific disability to working conditions or requirements is necessary for successful accommodation. Issues of confidentiality can permeate the process, and poison well-intentioned attempts on the side of the employee as well as the employer. Strategies for Accommodating Mental Illness in the Workplace will provide theoretical and concrete approaches to standardizing the approach to determining qualified disabilities and will show creative ways to develop accommodations. Materials will be provided.

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Sequelae of sexual harassment: What do we know and what do jurors think?
Jane Goodman-Delahunt, Christopher M. Shanahan, Regina A. Schuller and Juliana Charlson, School of Psychology, University of New South Wales

Systematic research on consequences of sexual harassment has lagged behind studies of perceived liability. Until more is known about common outcomes, assessments of damage awards and juror understanding of these relationships, systems for compensating victims cannot be evaluated. More than 70 publications, including over thirty empirical studies of individuals who experienced sexual harassment and reported consequences, revealed that even mild sexual harassment is consistently associated with negative outcomes that fall into 3 major groups:
Work and Stress

It’s our problem? Managing depression in the workplace
Nicole Highet, Ian Hickie, Bernard McNair and Ingrid Ozols, Beyondblue – The National Depression Initiative, Melbourne

Half a million full work days are lost every month and workers cut down their activity on another one million days in one month due to depression. Depression will touch everyone – including employers – either directly or indirectly in today’s world. Depression currently represents a major social and economic challenge, particularly in today’s workplace. Many employers realise the importance of staff retention and motivation in creating a harmonious work environment, but in today’s climate it is also important to monitor the well being of staff. Lack of awareness and understanding in the workplace leads to difficult situations which may arise from prolonged absence or excessive sick-leave. In response to this important issue, Beyondblue is a national depression initiative has developed training resources for the delivery of a brief workplace-based depression awareness program. This presentation will highlight the key features of this program, and demonstrate its impact on changing attitudes and teaching managers and colleagues how to manage depression in a workplace environment more effectively.

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Mental health of lawyers: Treat or protect?
Linda Haller and Heather Green, Law School, University of Queensland

The nature of legal practice means that many lawyers are at high risk of stress-related illness. Although mental illness appears to figure highly in disciplinary cases, the courts have shown little tolerance for signs of mental weakness in lawyers. This issue was investigated with an analysis of the records of disciplinary actions for solicitors in Queensland, Australia between 1930–2000. This paper will discuss the implications of the court’s attitude for the detection and treatment of mental illness amongst lawyers.

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Mental health nursing and clinical supervision
Edward White, Faculty of Nursing, Midwifery and Health, University of Technology Sydney

The Senate Community Affairs References Committee (2002) recently reported on the ‘added stress on mental health staff, which arises from poor working conditions, heavy workloads and lack of resources, within a culture in which there is a large degree of burnout, low morale, lack of job satisfaction, poor status, insensitivity and indifference’. This remains particularly so for mental health nurses whom, above all others, create the ambience in clinical settings and substantially influence, if not determine, the organisational culture within which care is delivered. The personal and privately experienced cost for mental health nurses who cope in these circumstances is little understood and has become a worthy focus for research and practice development. A system to support frontline nursing staff, known as Clinical Supervision, is now found reflected in the central policy themes of health service provision around the world. However, although the Australian Health Ministers’ Advisory Council National Mental Health Working Group (1997) recommended that staff who work in mental health services should have access to formal and informal clinical supervision, the concept is presently underdeveloped in Australia (Yegdich, 2001). This presentation will dwell on the largest Clinical Supervision study yet conducted (Butterworth, Carson and White et al, 1997) and the contribution Clinical Supervision may make to better nursing care and improvements in patient outcomes.

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### Thursday, Oct. 2, 2003

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**Parallel Sessions and Themes of the 28th International Congress on Law and Mental Health**

**Perth Room (3rd Floor)**
- Interactive Workshop: “Privacy: A weapon or a tool?”
- Roles, Perceptions and Expectations
- Current Issues in Mental Health Care in Australia
- Mental Health Promotion

**Sydney Room (3rd Floor)**
- Migration and Human Rights
- The Migrating Mind
- Immigration, Detention and Mental Health
- Torture, Terror and the Migration process

**Melbourne Room (3rd Floor)**
- Who is Responsible for Care of the Frail Aged?
- Intergenerational Rights and Responsibilities
- Advance Care Directives and End of Life Decision Making
- When is Old Age a Basis for Special Legal Provision?

**Brisbane Room (3rd Floor)**
- Culpability, Responsibility & Mental Illness
- Mental Capacity
- Automatism *(ends at 17:45)*

**James Cook Room (5th Floor)**
- Genetics and Public Policy *(starts at 9:00)*
- Genetic Research – Tissues, Consent and Testing
- Genetics, Health and Information *(13:30 to 15:00)*
- Genetics and Social Values *(15:30 to 16:30)*

**Boardroom 1 (Ground Floor)**
- Mental Health Nursing in the Forensic Setting
- Managing Risk
- Patterns of Comorbidity
- Crime, Violence & Substance Abuse *(ends at 17:45)*

**Boardroom 2 (Ground Floor)**
- Forensic Expertise *(p.94)*
- Young Offenders
- Dangerousness & Risk Assessment
- Patterns of Violence

**Evening Events:**
- **CONGRESS SOCIAL EVENT – Sydney Harbour Dinner Cruise**
**Consumers, Families and Carers**

*In collaboration with the Mental Health and Suicide Prevention Branch, Australian Government Department of Health and Ageing*

### Thurs. Oct. 2, 2003 (8:30–17:30)  |  Perth Room (3rd Floor)

#### Registration 8:00–8:30

#### Interactive Workshop: “Privacy: A weapon or a tool?” 8:30–10:00

**PANEL**

- **Michael Fleming**, Consumer consultant, St. Vincent’s Hospital Mental Health Service, Melbourne
- **John Lesser**, President, Mental Health Review Board of Victoria
- **Barbara Robb**, Member Family/Care Participation Committee, St Vincent’s Hospital Mental Health Service, Melbourne
- **Isabel Collins**, Consumer Advocate Director, Victorian Mental Illness Awareness Council
- **Sue Tait**, Human Rights Lawyer, Melbourne
- **Beth Wilson**, Victorian Health Services Commissioner

#### Break 10:00–10:30

#### Roles, Perceptions & Expectations 10:30–12:30

**Chair:** **Mary Chiarella**, Chief Nursing Officer, New South Wales

Advocacy in forensic psychiatry – A carer perspective
- **Gillian Holt**, Department of Psychology, University of Wollongong

Gatekeepers, proxies, advocates? The evolving role of relatives and carers supporting adults with learning disabilities and mental health problems
- **Kirsty Keywood**, School of Law, University of Manchester

Caring for the seriously mentally ill: An Unseen duty of care
- **Lynette Joubert**, Dept. of Social Work, University of Melbourne; **C Harvey and G Meadows**, Dept. of Psychiatry, University of Melbourne

“I can put it in his soup, Doctor”
- **Josephine Wong**, Dept. of Psychiatry, University of Hong Kong

#### Lunch 12:30–13:30

#### Current Issues for Mental Health Care in Australia 13:30–15:30

**Chair:** **Terry Carney**, Faculty of Law, University of Sydney

- **Dermot Casey**, Mental Health Programs Branch, Commonwealth Dept. of Health

Removing the barriers to cross-border mental health services
- **Bruce Paterson**, Mental Health Branch, Dept. of Human Services, Victoria

Critical issues in Australian mental health care: Reviewing the impact of legislation and insurance
- **Grace Groom, Carmen Hinkley** and **Neil Wildman**, Mental Health Council of Australia, Canberra

Complaints Mechanisms – Where do I complain? Who will listen? Will they act?
- **Vivienne Topp**, Mental Health Legal Centre, Victoria

#### Break 15:30–16:00

#### Mental Health Promotion 16:00–17:30

**Chair:** **Barbara Robb**, Member Family/Care Participation Committee, St Vincent’s Hospital Mental Health Service, Melbourne

Community awareness, knowledge and attitudes about depression
- **Nicole Highet**, Beyondblue, The national depression initiative, Melbourne

An alternative way of thinking about and treating Borderline Personality Disorder patients
- **Melanie Higgins**, **Mark Swinton** and **Simon Bainbridge**, Ashworth High Security Hospital, Liverpool, UK

Promoting the prospects for relatedness: How medico-legal decision making processes can contribute to connectedness (and don’t have to stipulate that each person must be an island!)
- **Brendan O’Hanlon** and **Mark Furlong**, Faculty of Health Sciences, La Trobe University
Abstracts
Interactive Workshop: “Privacy: A weapon or a tool?”

Privacy: A weapon or a tool?
An interactive workshop about people who experience mental illness, their families, carers, and service providers and the privacy and confidentiality issues that arise in mental health treatment.

A diverse group of concerned people who experience mental illness, family members, service providers, therapists and human rights advocates have devised an interactive workshop based on a hypothetical scenario that raises questions such as:

- Have ‘human rights’ laws improved the connectedness of people who experience mental illness and their families with each other and with the broader community?
- What is the role of ‘family’ in treatment for a mental illness?
- How does a concerned family member find out about what is happening to their loved one once he or she is admitted to hospital?
- Who judges whether someone is able to make rational decisions about involving family members in treatment or care?
- How do psychiatrists and other service providers negotiate their way through laws about privacy and confidentiality to deliver a holistic therapeutic response?
- What if there are issues of suspected family pathology?
- Does permission to release information or involve family members need to be given in writing?
- Can the permission be withdrawn at any stage of the therapy?
- How relevant is the age of the person?
- How relevant is the history of the person’s mental illness?
- How confidential is confidential and confidential from whom?
- Where does the right to treatment for a person conflict with the rights of other family members?
- How do stigma and prejudice influence the flow of information?

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Roles, Perceptions and Expectations

Advocacy in forensic psychiatry – A carer perspective
Gillian Holt, Department of Psychology, University of Wollongong

This paper is given from the perspective of a carer of a forensic patient in NSW. My son has spent time in Silverwater Gaol and Long Bay Hospital. My experiences as a carer provide valuable insights into the difficulties in accessing treatment for young people, particularly those with dual disorders (mental health and substance use). For many of these young people there is a very real risk of eventual collision with the law. Individual and systemic advocacy is needed to ensure appropriate and cost effective outcomes for these mental health consumers, including timely diversion to treatment. I will explore the critical role that carers can play in advocacy in forensic situations. Through carer participation in the legal process and within the forensic system, the rights of consumers will be more effectively promoted. However carers feel helpless, marginalised, and powerless to make a difference in the forensic environment. They require support and practical assistance to navigate the complex and confusing mental health legal and institutional structures. The mental health services and the legal profession should collaborate to provide the necessary education and to facilitate carer involvement. Carers need to be provided with opportunities to provide information and raise concerns. Assertive strategies can be implemented to ensure that consumers are able to maintain positive relationships with family and friends. Nurturing and promoting the role of carers and other support persons will lead to improved outcomes for consumers and contribute to positive reforms of the forensic system.

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Gatekeepers, proxies, advocates? The evolving role of relatives and carers supporting adults with learning disabilities and mental health problems
Kirsty Keyword, School of Law, University of Manchester

Generally speaking, parents and carers have no special role to play in English Law in making health care decisions on behalf of people with learning disabilities and mental health problems. In reality, however, their ongoing support is crucial to ensure access to and take up of health care services. Their role is set to change under proposals to amend mental health and mental incapacity law in England and Wales. Drawing on the legal arrangements made in other jurisdictions, together with an examination of the psychology and sociology of family dynamics and
its impact on vulnerable people, this paper explores some of the legal and practical consequences for relatives and carers under the proposed law reforms. It also challenges the reluctance of legal and health care personnel to recognise the family as an important locus of power, which at its best can provide an emancipatory forum for health care decision-making and at worst can exclude vulnerable adults from any meaningful role in decisions taken about their health.

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Caring for the seriously mentally ill: An unseen duty of care

Lynette Joubert, Dept. of Social Work, University of Melbourne; C Harvey and G Meadows, Dept. of Psychiatry, University of Melbourne

Aim: The process of de-institutionalization in the treatment of mental illness and the move to community mental health programs has resulted in increased responsibility and an increased duty of care being placed on carers of clients receiving services. Different models of community care such as the “shared care” one which is currently being developed in Australia, can result in different levels of carer burden. “Shared care” of psychiatric disorders involves mental health team input coordinated with general practitioner intervention. This study explores issues related to burden of care among carers of clients referred into shared care in the North West of Melbourne.

Methodology: “Pai and Kapur” family interview data was collected from the carers of 55 clients transferred into shared care arrangements with general practitioners. The clients in shared care had a number of standard clinical status measures conducted. Perceived need for mental health care of clients was sampled with an instrument developed for the Australian National Mental Health Survey.

Results: Forty five percent of carers reported high “subjective” burden. Carers expressed lower levels of “objective” burden particularly in areas of finance and disruption of family leisure. There was moderate disruption of routine family activities and family interaction. Forty eight percent of carers rated themselves as experiencing problems with their own psychological health. Most clinical variables were stable and some improved; however there was substantial unmet perceived need among clients for help with the development of social networks.

Discussion: Carers in this particular community care setting carry considerable burden. Even if such a model of community care delivers satisfactory levels of medical care and symptom control, it might risk the promotion of social isolation of the client with disorder. Carer burden could be intensified as a result of this. Support for carers and the promotion of social opportunities for clients should be part of the community mental health care package.

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“I can put it in his soup, Doctor”

Josephine Wong, Dept. of Psychiatry, University of Hong Kong

‘I can put the medicine in his soup, Doctor.’ The practice of covertly putting medication in patient’s food or drink has been condemned by some and condoned by others, thus it remains a controversial issue in clinical practice. Those who object consider this practice as patient deception and an unacceptable infringement of patient autonomy, posing a risk of abuse. Others have suggested that covert administration of medication to mentally incapable persons may be justifiable in certain very limited circumstances, for example where there is no other way to give needed treatment, and when giving treatment in this way represents the least restrictive option. Previous commentators had suggested that covert medication administration may be acceptable if patients have a permanent mental incapacity (for example mental retardation or dementia) and they refuse needed treatment. Ethical, legal and clinical considerations become more complex when the mental incapacity is temporary and when the covertly administered medication actually serves to restore autonomy. The author will illustrate these dilemmas with the case of a young man with paranoid schizophrenia. When he was unwell, he harboured persecutory delusions about his mother and had assaulted her in the past. During a recent psychotic relapse, he again became paranoid against his mother. He refused to take his mother’s advice to see his psychiatrist. In desperation, his mother started giving antipsychotics to him in his soup, with very good effect. The patient recovered and no longer had psychotic symptoms, but he continued to refuse psychiatric follow-up and to take antipsychotic medication since he saw no need for either. His mother requested further prescriptions from the psychiatrist such that she can continue to administer antipsychotics in his soup. She wanted to keep him well, and to keep herself safe. Should the doctor continue giving the mother the prescription when the patient is now mentally well and most likely to be mentally capable? Should the doctor stop giving mother the prescription knowing that it will precipitate a schizophrenic relapse with possible risk of violence against mother? How do we balance the rights of the family versus the rights of the individual? What are the legal rules governing such a situation in Hong Kong? At present, legal or professional guidelines on the covert administration of medication are almost non-existent. Discussion of these dilemmas can inform the debate and help us formulate some general principles for such guidelines.

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Current Issues for Mental Health Care in Australia


Dermot Casey, Mental Health Programs Branch, Commonwealth Dept. of Health

Australia is now entering its third 5-year period of national mental health reform, taking a path that is paralleled in many countries. Guided initially by the United Nations’ Declarations and Principles on the human rights of people with a mental illness, Australia’s early policy emphasis was on the reform of institutional care and protection of individual consumer rights. Much has been achieved over the past decade, with significant structural change in service delivery, legislative reform and promotion of consumers and carers as the central stakeholders. Australia’s progress in these areas is recognised internationally. Experience over the period has taught that, to achieve the aspirations embodied in the UN Declaration, mental health policy must evolve beyond an exclusive focus on the individual to a broader concern with the place of mental health in community life. Australian and international research has highlighted that mental disorders are prevalent, making up five of the top 10 diseases that cause the greatest disability, and have substantial economic impact. New developments are also pointing to the role played by mental health factors in physical health and disease. Policy responses to this new awareness need to be based on partnerships with the community that build public ownership, promote social inclusion and tackle the stigmatisation and marginalisation that act as obstacles to genuine change.

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Critical issues in Australian mental health care: Reviewing the impact of legislation and insurance

Grace Groom, Carmen Hinkley and Neil Wildman, Mental Health Council of Australia, Canberra

The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation established to represent and promote the Australian mental health sector. The main activities the MHCA undertakes are in the areas of national policy, national projects, and representation. Two particularly relevant projects the MHCA has undertaken relate to mental health legislation and insurance. Most recently, in 2002 the MHCA was contracted by the Commonwealth Government to undertake national consultation around the National Mental Health Strategy which has set the framework for the mental health care reform agenda over the past 5 years. One of the key findings of the consultation process was that mental health legislation was an area of major concern. In particular, respondents identified the need for national consistency in this area to allow people with mental illness to be provided treatment in the least restrictive environment within and across geographical boundaries. Another significant project of the MHCA undertaken since 2001 involves the MHCA and ‘Beyondblue: the national depression initiative’ entering into a partnership to address alleged discrimination against mental health consumers by the insurance industry. Through this partnership the MHCA and Beyondblue have been able to conduct an investigation into allegations that people with mental illness are being refused insurance industry products at the point of entry, and are being denied insurance policy claims on the grounds of non-disclosure of existing/previous mental illness at the time of submitting original insurance policy product application forms. The MHCA and Beyondblue have been working with peak insurance bodies to rectify this issue, and to ensure that equity exists among claimants. Reports indicate that mental illness accounts for 20–30% of current insurance claims and accounts for 50% of current insurance industry claim costs.

The national significance of this issue and the vast number of serious allegations being reported has prompted support of the Human Rights and Equal Opportunities Commissioner. The MHCA’s presentation will provide further detail regarding progress of Australia’s mental health reform agenda under a 3rd National Mental Health Plan, and within this context, progress of national legislation and insurance discrimination issues.

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Removing the barriers to cross-border mental health services

Bruce Paterson, Mental Health Branch, Dept. of Human Services, Victoria

The first National Mental Health Plan (1992) noted that differences between legislation in Australian jurisdictions created legal difficulties in delivering mental health services across borders. Ten years later, the first bilateral cross-border Ministerial Agreements relating to involuntary and forensic patients have commenced. This paper provides a summary of progress by jurisdictions regarding legislative amendments and agreements for cross-border services relating to involuntary and forensic patients, and outlines the work and issues remaining. Cross-border services range from admission and treatment of interstate involuntary patients to the apprehension and return of forensic patients who have absconded interstate.

More specifically, the Paper explains how the Agreement between NSW and Victoria relating to involuntary
patients was planned and implemented. The Agreement includes provision for (where the two States involved are
NSW and Victoria):

- involuntary admission of persons distant from hospitals in their own State to a nearby hospital in the other
  State;
- the apprehension and return of involuntary patients who abscond from one State to the other State; and
- the transfer of involuntary patients to their home State when they have been admitted to a hospital in the
  other State.

These developments have particularly benefited regional communities in border regions that previously had
difficulty accessing interstate (but nearby) inpatient mental health services.

The paper demonstrates how legal barriers to cross-border mental health services are being resolved, resulting in
concrete action and benefits to consumers, carers, and the community.

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Complaints Mechanisms – Where do I complain? Who will listen? Will they act?
Vivienne Topp, Mental Health Legal Centre, Victoria

We endorse the rights outlined by the UN – the right for “access to mechanisms for complaint and redress” – but
it must be elevated to a key priority if the crucial objective of adequate service quality and accountability is to be
met. Moreover, the establishment of an adequately empowered and independent national complaints and
accountability mechanism may well be the only way to address the serious deficiencies in terms of both ‘civil
libertarian’ and service access and quality rights which endure, Burdekin Report and National Mental Health
Strategy notwithstanding. Crucial to addressing underlying impediments to realization of these rights, such as
disproportionately low mental health service funding and priority from a whole-of-government perspective is the
development of a mechanism to ensure transparent service delivery and proper accountability of mental health
providers. Lack of accountability and secrecy systemically undermine the legitimacy of complaints of people who
have mental illness and the confidence the community can have in the complaints systems and services themselves.

We propose the establishment of an independent, permanent, adequately empowered accountability and
complaints handling body as a matter of priority. Serious consideration should be given to it being a national body.

In the tenth anniversary year of the Burdekin Report, as questions about just how much has changed in mental
health service delivery might be asked, such a proposal demands serious consideration. The context for this
proposal includes recommendations of the following: Victorian Auditor General’s Performance Audit, 2002 NSW
Mental Health Services Report, 2002 Mental Health Council of Australia Report – Out of Hospital Out of Mind,
2003 The aim of this presentation is to propose a realistic and responsive model, to be developed following
consultation with Victorian consumers of mental health services and review of existing mechanisms in Australia,
New Zealand and elsewhere. The establishment of such a body would address the concerns the Centre and others
have long had about the inadequacy of complaints and accountability mechanisms in Victoria.

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Mental Health Promotion

Community awareness, knowledge and attitudes about depression
Nicole Highet, Beyondblue, The national depression initiative, Melbourne

Background: Results from the beyondblue National telephone survey of 900 people in October 2001 showed that
Australians do not see common mental health disorders as a major health problem, although depression was
viewed as a major problem within the context of mental health specifically. Australians also had little knowledge
about depression (prevalence rates, signs and symptoms) its effective treatments (pharmacological and
psychological). There was also limited knowledge regarding behaviours that need to be implemented to obtain
effective treatment in the community. Australians also held negative attitudes towards people who experience
depression and its treatments. Methodology: One year on from this initial baseline study, the survey has been
repeated (and extended) in October 2002 with an increased sample of 2000 respondents across the Australia.
Results: In addition to evaluating the extent of change with respect to the areas of depression awareness,
knowledge and understanding, attitudes and behaviours, the potential role of media and community awareness
campaigns on depression literacy has been evaluated in detail. Furthermore, the present study assesses attitudes
of older and younger adults regarding health problems and treatments across the lifespan, as well as replicating
some measures used in international research to evaluate stigma with respect to depression in the wider
community. Conclusions: This presentation will outline the changes in depression literacy over the past 12
months and provide information on new areas assessed. In addition, the implications of these findings on media
activity, as well as current and future education and awareness campaigns will be discussed.

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An alternative way of thinking about and treating Borderline Personality Disorder patients
Melanie Higgins, Mark Swinton and Simon Bainbridge, Ashworth High Security Hospital, Liverpool, UK

Introduction. The Borderline Personality Disorder (BPD) concept is essentially one of an inability to regulate affect and exercise self control. This concept is popular with researchers with many papers published. However, BPD patients find it hard to access health care as they are often perceived as untreatable by clinicians. This paper describes an alternative approach that has been developed and implemented in practice. This alternative approach is based on giving primacy to the self-reported psychotic symptoms of patients; symptoms which are often not believed by clinicians. Method. A variety of clinical observational studies. Results. There is evidence that BPD patients show significant improvement on clozapine when they have not previous responded to other drugs. Previously published case series will be reviewed. Newly available is a review of outcome of 48 BPD patients treated with clozapine showing improvement for most patients. Also to be shown is evidence from neuroimaging that BPD patients have abnormalities in their parietal lobes. Discussion. The imaging findings can be plausibly related to psychopathology. These patients had hallucinations in multiple sensory modalities. These hallucinations are more likely to arise from deficits in the sensory association areas (the inferior and superior parietal lobes) than in the primary sensory receiving areas. It is suggested that – 1) an effective treatment model can be implemented by giving primacy to the psychotic symptoms of BPD patients. 2) the recurring and unresolvable argument about whether these patients have a mental illness or a personality disorder can be bypassed if patients are understood as having a developmental disorder centring on their parietal lobes. 3) This approach is welcomed by patients and their carers. There appears to be sufficient evidence to justify an randomized controlled trial of clozapine in BPD patients.

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Promoting the prospects for relatedness: How medico-legal decision making processes can contribute to connectedness (and don’t have to stipulate that each person must be an island!)
Brendan O’Hanlon and Mark Furlong, Faculty of Health Sciences, La Trobe University

Modern psychiatric practice, like western culture in general, tends to be premised on the assumption that individuals are sovereign, unitary subjects. In so far as the premise of the unitary self is accepted within Western culture, and is enacted within particular legal and health settings, it follows that mental health practitioners will tend to bifurcate the rights of ‘the patient’ with the interests and importance of that person’s ‘significant-other’ network. Informed by recent international research on social attachment and social capital that has examined ‘included’ as well as ‘marginal’ populations, this presentation will re-formulate what has often been described as the ‘needs of families’ within a broader conceptualisation of the risks of social exclusion to mental health consumers. These ideas will be discussed in relation to case studies addressing three key decision making processes in mental health services; confidentiality, involuntary treatment and guardianship. The conclusion drawn from this material is that the design of medico-legal decision-making processes, as much as the specific kinds of decisions, is central in defining the prospects for relatedness of mental health consumers in the medium to longer term. In so far as it is deemed desirable to strengthen, as opposed to inadvertently attenuate, the consumer’s location in supportive ‘significant-other’ networks, the design of decision making may need to be re-developed towards processes that are more inclusive.

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## Migration, Mental Health and Human Rights

*Convened jointly with the Faculty of Law, University of Sydney*

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<td>SESSION KEYNOTE – “Policy on asylum seekers: a threat to public mental health” Derrick Silove, School of Psychiatry, University of New South Wales</td>
<td><strong>Living in limbo: A personal account of the psycho-social effects of Australia’s detention and refugee policies</strong> Maqsood Alshams, Asylum seeker</td>
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<td>Immigration mindsets or national psychoses? – How our thinking has shaped our migration law Mary Crock, Faculty of Law, University of Sydney</td>
<td>Australia’s human rights obligations relating to the mental health of refugee children in detention Terry C. Hutchinson and Fiona Martin, Faculty of Law, Queensland University of Technology</td>
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<td>Alternative asylum mechanisms: The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment Jane McAdam, Lecturer in Law, Lincoln College, Oxford University</td>
<td>Forced medical treatment of asylum seekers on hunger strike in detention Mary A Kenny, School of Law, Murdoch University; Derrick Silove, School of Psychiatry, University of New South Wales</td>
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<td>Break 10:00–10:30</td>
<td>Views from the other side: ACM programs within Australia’s immigration detention facilities Janette Lippman, Health Worker, Villawood Detention Centre, Sydney</td>
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<td>Chair: Aamer Sultan, Iraqi Doctor and former detainee</td>
<td>Kate Durham, Founder of Spare Rooms for Refugees.com</td>
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<td>Closing the National Mind: The SIEV X tragedy and Australians’ thinking about Boat People Tony Kevin, Visiting Fellow, Research School of Pacific and Asian Studies, Australian National University, Canberra</td>
<td>Break 15:30–16:00</td>
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<td>Mental states: Negotiating the health rules in the migration process Jennifer Burn, Faculty of Law, University of Technology, Sydney</td>
<td><strong>Torture, Terror and the Migration Process</strong> 16:00–17:30</td>
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<td>Believable tales: Credibility and the burden of proof in refugee status determinations Susan Kneebone, Faculty of Law, Monash University</td>
<td>Chair: Lachlan Murdoch, Deputy Director, Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)</td>
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<td>To have and to hold: The importance of permanence in the (meaningful) protection of refugees Savitri Taylor, Faculty of Law and Business, LaTrobe University</td>
<td>SESSION KEYNOTE – Thinking about migration in a traumatised world: The impact of 9/11 on Canadian law and discourse on refugees and border control François Crépeau, Faculty of Law, Université de Montréal</td>
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<td>Being there: The importance of social support in restoring and maintaining the mental health of asylum seekers – The Story of the Tiger 11 Soccer Team Camilla Cowley, Member of Catholic Justice and Peace Commission - Brisbane</td>
<td>The aggressive ‘terroristic’ religious fundamentalists: Psychological analysis Inat Amidjaya, H. Douglas Singer Mental Health Centre, Rockford, IL, U.S.A.</td>
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<td>Torturing terrorists – Intersections with humanitarian law Ben Saul, DPhil Candidate, Oxford University</td>
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Migration, Mental Health and Human Rights

Abstracts

Migration and Human Rights

Policy on asylum seekers: A threat to public mental health

Derrick Silove, School of Psychiatry, University of New South Wales

Historically, it is unusual for the mental health consequences of state oppression and discrimination to be documented contemporaneously with the implementation of such policies. The asylum debacle in Australia differs in that mental health concerns about the detention and the treatment of asylum seekers in the community have been voiced early and repeatedly throughout the implementation period. In spite of efforts to prevent scrutiny, data have been collected that can be compared with research undertaken amongst refugees in a variety of settings worldwide. The inescapable conclusions are that detained asylum seekers report the same psychosocial risk factors and types of mental disturbances as refugees in other settings and that the experience of detention exacerbates these problems. Postmigration deprivations and threats of repatriation prevent asylum seekers in the community from adapting to their new circumstances. Promotion of psychosocial well-being and reduction of social risk factors that generate disability form the cornerstones of government mental health policy. It is paradoxical, therefore, that contemporary asylum policies fundamentally contradict these principles.

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Immigration mindsets or national psychoses? - How our thinking has shaped our migration law

Mary Crock, Faculty of Law, University of Sydney

This paper analyses the laws and policies governing immigration and refugees in Australia to determine the extent to which these reflect particular characterisations of problems or events. It explores a variety of perspectives or ‘frames of reference’ that can be taken or used to describe and deal with the matters in question. The author examines the extent to which ‘frames of reference’ operate to include or exclude issues such as human suffering, practical outcomes and fiscal cost. The objective is to identify the mindsets or understandings that appear to underpin current laws and policies. To the extent that these appear to have majoritarian support in the Australian community, the author reflects on how current practices might reflect shared perceptions or frames of reference. The paper argues that constriction of the community’s vision and understanding in the areas of immigration and refugees has wider ramifications which are not being articulated or discussed to the extent that they should be.

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Alternative asylum mechanisms: The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Jane McAdam, Lecturer in Law, Lincoln College, Oxford University

Over the past decade, a growing number of asylum seekers refused refugee status under article 1A(2) of the 1951 Convention Relating to the Status of Refugees (Refugee Convention) have resorted to the 1984 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) for protection. By bringing an individual complaint to the Committee against Torture (Committee) under article 22 of the CAT, successful claimants have been recognized under article 3 as requiring protection from refoulement to ‘another State where there are substantial grounds for believing that [they] would be in danger of being subjected to torture’.

This paper assesses the CAT as a complementary form of protection for asylum seekers. It reviews the scope and content of protection afforded by article 3 of the CAT by examining the procedures by which an individual can make a claim under article 3, the nature of claims which may be brought to the Committee for consideration, and the legal and practical effects of a finding by the Committee of a violation. In this analysis, the elements of the CAT’s definition of ‘torture’, the lack of enforceability of the Committee’s views, the uncertainty of the legal status and concomitant rights of a beneficiary of article 3 protection, and the various procedural requirements which the CAT imposes on an application to the Committee, are presented as limitations on the CAT’s effectiveness as an alternative protection mechanism. At the same time, however, it is argued that the extension of non-refoulement through the CAT and other human rights treaties ought to be welcomed and developed in the spirit of the Refugee Convention to ensure that it is given real meaning, beyond admission alone.

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The Migrating Mind

Closing the National Mind: The SIEV X tragedy and Australians’ thinking about Boat People

Tony Kevin, Visiting Fellow, Research School of Pacific and Asian Studies, Australian National University, Canberra

This paper examines in relation to the sabotage and sinking of SIEV X three propositions:

1. That in modern bureaucratic state systems, deeply criminal acts can be carried out without the necessity of evil intentions by individuals working in those systems (ref. Hannah Arendt, Zygmunt Bauman, Susan Neiman)
Mental States: Negotiating the Health Rules in the Migration Process

Jennifer Burn, University of Technology, Sydney

Health testing in Australian migration law is complex, simultaneously incorporating a codified legislative system with the exercise of discretion by specified decision-makers. All people seeking Australian visas are subject to health testing. Health testing has a multiple aims. It is designed to protect the Australian community from diseases that could represent a threat to public health, to protect the taxpayer from undue expenditure and, in an environment where resources are in short supply either because of cost or demand, to give preference to Australians over non-citizens. Health testing applies whether a person is in a refugee camp in Kenya, in the Australian community seeking asylum or a husband, wife or child of an Australian. This paper reviews the statutory scheme and identifies current issues in the application of the health test to mental health conditions.

Believable Tales: Credibility and The Burden Of Proof In Refugee Status Determinations

Susan Kneebone, Faculty of Law, Monash University, Melbourne

This paper examines the difficult task which an asylum seeker has to persuade a decision-maker that he / she is a genuine refugee in the light of the high standard of proof which is applied to a ‘well founded-fear of persecution’ test in refugee status determinations. It demonstrates how a large proportion of cases fail on the basis of the applicant’s credibility and comments upon the effectiveness of the procedures for extracting the applicant’s narrative.

To Have and to Hold: The importance of Permanence in the (meaningful) Protection of Refugees

Savitri Taylor, Faculty of Law and Business, LaTrobe University

Many refugees are allowed to enter or remain in Australia pursuant to temporary rather than permanent visas. Some of these refugees will never be eligible for permanent resident status in Australia. Instead, they face the prospect of having their refugee status periodically reviewed and hence have hanging over them the threat of possible repatriation. Temporary visa holders are also given lesser economic and social entitlements than permanent visa holders - the purpose being to impede their full integration into Australian society. It is argued in this paper that, in many cases, the grant to a refugee of temporary protection of this nature will not amount to ‘protection’ in any meaningful sense. It is further argued that the psychosocial harm which temporary status (and accompanying disadvantages) inflicts may in some cases be so great as to amount to ‘cruel, inhuman or degrading treatment’ within the meaning of article 7 of the International Covenant of Civil and Political Rights.

Being There: The importance of social support in restoring and maintaining the mental health of asylum seekers - The story of the Tiger 11 Soccer Team

Camilla Cowley, Member of Catholic Justice and Peace Commission - Brisbane

The Tiger 11 Refugee Soccer Club is ‘a team without borders’ in the club members’ mission statement which guides the continuing building of relationships within this unique environment. Membership is open to all refugees whatever their origin or visa status and it has brought together Hazara Afghans, Tajik Afghans, Pashtun Afghans, Christian and Muslim Sudanese, Eritrean, Sierra Leone, Iranian and Iraqi young refugees. The initial purpose of the club was to build a family, a community for the unaccompanied young Hazara refugees, who were suffering under their temporary status, the absence of family support, racial abuse following September 11 and lack of any real sense of belonging or acceptance in Brisbane. The restlessness and depression of these young refugees has found relief in the supportive family environment built around the soccer club by a team of volunteers and support from within the broader community. They have in a way, become a symbol of TPV refugees here in Australia and succeeded in humanising the issue of unauthorised arrivals in their reaching out to the wider community, as a group of vulnerable your refugees seeking only to belong and participate in this country they would love to call home. They have been able to reach across political, religious and ethnic boundaries, gathered support from within Local and State government bodies, faith communities across the Christian and broader spectrum and have achieved great things despite their precarious situation. They are an inspiration to all who travel with them and provide a blueprint for successful settlement and the importance of a community of belonging and acceptance in empowering the triumph of the human spirit against great odds.
Immigration, Detention and Mental Health

Australia’s human rights obligations relating to the mental health of refugee children in detention

Terry C. Hutchinson and Fiona Martin, Faculty of Law, Queensland University of Technology

In its submission to the Human Rights and Equal Opportunity Commission Inquiry into Children in Immigration Detention the Department of Immigration & Multicultural & Indigenous Affairs reported that as at 12 April 2002 there were 184 children in immigration detention centres in Australia. of these 163 were accompanied, 114 were male and 70 were female. The unaccompanied children were predominantly male and aged 16-17. In a report prepared in July 2002, it was concluded that the majority of children in detention centres in Australia displayed ‘high level emotional distress not accounted for by pre-migration trauma’. This paper seeks to analyse recent findings of mental illness of children in detention centres in the context of Australia’s human rights obligations under the UN Convention on the Rights of the Child. This paper discusses the principles under the Convention, and it examines to what extent Australia is adhering to its human rights obligations in regard to these children. It questions whether further harm is being inflicted on the children, and whether this situation is in the long-term interest of the Australian people.

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Forced medical treatment of asylum seekers on hunger strike in detention

Mary A Kenny, School of Law, Murdoch University; Derrick Silove, School of Psychiatry, University of New South Wales

This presentation considers hunger strikes as a form of protest by asylum seekers in Australia and examines the legality of force-feeding and other forced medical treatment of detainees against their will. The presentation will look at raises a number of questions about the lawfulness of the authority to force-feed under delegated migration legislation, not statute, for which no clear common law authority exists and which may be in breach of international law. The presentation will also consider the ethical position of medical practitioners when faced with such individuals. How do you balance the individual’s rights, with the medical practitioner’s ethical responsibility to keep people alive?

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The Pacific Solution

Kate Durham, Founder of Spare Rooms for Refugees.com

This presentation will take the audience through Ms Durham’s first-hand experience of The Pacific Solution gained through correspondence with asylum seekers detained on Nauru. The speaker will describe her visit to the detention facilities in 2002 which was the subject of a BBC documentary.

Torture, Terror and the Migration Process

Thinking about migration in a traumatised world: The impact of 9/11 on Canadian law and discourse on refugees and border control

François Crépeau, Faculty of Law, Université de Montréal

Canada has adopted a new Immigration and Refugee Protection Act in 2002 and has also adopted several controversial anti-terrorism legislations following the 9/11 events. Canada has also increased its cooperation with the American Administration regarding border controls, developing a “Smart Border Action Plan.” In December 2002, Canada and the US signed a new Safe Third Country Agreement, which parallels the European Dublin Convention and its coming into force is creating huge difficulties at the border, as it coincides with the American policy of registering all foreigners born in some countries. The paper will explore whether there is, from a legal point of view, a reconceptualization of immigration controls and refugee protection in Canada around security issues.

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The aggressive ‘terroristic’ religious fundamentalists: Psychological analysis

Imat Amidjaya, H. Douglas Singer Mental Health Centre, Rockford, IL, U.S.A.

The paper delineates the inter-relationships among fundamentalism, religion, militancy, and ‘terroristic’ personality. Aspects of mental health, law, culture, politics, psychology, and sociology are deeply involved and inter-mingled. However, the paper focuses mainly on the psychology of the religious fundamentalist who is both militant and ‘terroristic’; why does he believe in terror, how does he come to be pervasively hostile and brutal, what creates his ‘under siege mentality’, and a host of other questions. Although the writer describes and analyzes militant Islamic fundamentalists, the description and theoretical assertions apply to most militants or terrorists using any religion or religious ideology. Individuals who are nascent militant fundamentalists, or possess the psychological characteristics that predispose them to being militant, become terrorists only because they are recruited, trained, and sometimes exploited by a radical political group. This radical group capitalizes on, and exploits, the religious sentiments and loyalty of traditionally religious people. The presentation will describe the psychological aspects of the emergence or formation of such a radical climate and movements, which are
undoubtedly the outcomes of political and cultural factors. It is obvious that from the standpoint of clashing or conflicting political interests, the words ‘terrorism’ or ‘terrorists’ can be immediately controversial, because for every religious fundamentalist terrorist there may be millions of sympathizers who would quickly point out that these so-called terrorists are holy warriors who are fighting against the enemies of God. This fact does not invalidate a thorough study of the motivations, thoughts, feelings, and other aspects of the persons who conduct the acts of terror or the acts of holy war. It will be made clear that a fundamentalist is not necessarily religious (as, for example, the distinction between a fundamentalist constitutionalist vs. a liberal constitutionalist). A religious fundamentalist is not necessarily militant; and, a militant religious fundamentalist is not necessarily a terrorist. The militant fundamentalist believes in resorting to violence, while the terrorist fundamentalist deliberates and plans to launch a campaign of terror. However, it will be made clear that a militant religious fundamentalist can be reasonably expected to be a nascent terrorist or a good candidate for recruitment and training for acts of terrorism. The presentation deals with the practical questions such as: Why did young educated Muslim men, religiously devoted, bomb embassies and hijack commercial airplanes? Why were these young Muslim men personally committed to what they call the destruction and death of America? What motivated these Muslim men to assassinate their own Muslim government officials and plot to destroy their own governments in Saudi Arabia, Egypt, etc? Why did they kill the Egyptian President Anwar Sadat? What moved thousands of Pakistanis to go to Afghanistan-Pakistan borders to do jihad against the Americans? Why do some governments in the Arab world and wealthy Arab families spend millions of dollars a year to train young Muslim men in anti-Western and anti-American terrorist training camps in Iraq, Libya, Syria, Iran, Sudan, and Afghanistan? Are the motives or the underlying psychology behind all of these aggressive or violent acts the same as those behind the burning of the thousands of innocent people at the stake during the Spanish Inquisition? Did the perpetrators of the September 11, 2001 atrocities and destruction have the same motives and the same religious feelings as militant religious fanatics anywhere, regardless of religion? Do extremist right wing groups anywhere in the world harbor a highly emotionally charged view that their lives and survival are directly and physically threatened by modern society and governments, or that the world is so evil, that their sole mission is to destroy society and governments? How can one describe the personality of a terrorist?

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Torturing terrorists - Intersections with humanitarian law

Ben Saul, DPhil Candidate, Oxford University

The prohibition against torture ranks among the most fundamental norms of international human rights law and torture is also an international crime. However, there are periodic calls for terrorists to be tortured during interrogation, to obtain information considered vital to protect public safety. This paper argues that before torturing a suspect, it is impossible to know with any acceptable level of legal certainty that the suspect actually possesses the information or indeed is involved in terrorism. The very best judicial systems wrongly convict people even after final appeals have been exhausted. The margin for error radically multiplies in the pre-trial investigative phase where any available evidence is incomplete and untested, and urgent time pressures on the authorities encourage further mistakes. The individual and community consequences of forcibly violating the body or the mind are profound and signal a return to the blunt techniques of medieval justice. Torture is also ineffective, potentially leading to chronic disinformation and false confessions.

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# Ageing and the Future of Elder Care

Convened jointly with the Australian Association of Gerontology and with the support of the Commonwealth Office for an Ageing Australia


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<td>Anna Howe, Consultant Gerontologist, Melbourne; Judith Healy, National Centre for Epidemiology and Population Health, Australian National University</td>
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<td>Akira Homma, Dept. of Psychiatry, Tokyo Metropolitan Institute of Gerontology; M. Arai, Graduate School of Business Sciences, Tsukuba University</td>
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<td><strong>Advance Care Directives and End of Life Decision Making</strong></td>
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<td>Making decisions and advanced care planning: The Australian experience of advance directives and possible future directions</td>
<td>Cameron Stewart, Division of Law, Macquarie University</td>
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<td>Legislating and implementing psychiatric advance directives from a therapeutic jurisprudence perspective</td>
<td>Debra Srebnik, Department of Psychiatry and Behavioral Sciences, University of Washington</td>
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<td>The development of advance care directives in New South Wales</td>
<td>Barbara Squires, Director, Centre on Ageing, The Benevolent Society and National President, Australian Association of Gerontology</td>
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<td>Older people’s assets: A contested site</td>
<td>Cheryl Tils, Jill Wilson, Deborah Setterlund, School of Social Work and Applied Human Sciences, University of Queensland; Linda Rosenman, Dean, Faculty of Social and Behavioural Sciences, University of Queensland</td>
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Ageing and the Future of Elder Care

Abstracts

Who is responsible for care of the frail aged? International Perspectives

Gerdt Sundström, Institute of Gerontology, Jönköping, Sweden

The changing balance of government and family roles in caregiving in European countries

Patterns of care for the elderly have changed dramatically in Sweden in recent years. Fewer elderly are institutionalised or receive Home Help and more are supported by their family. It has mainly been spouses (as often men as women) and children (especially daughters), who have increased their help to frail elders. Also, more elders buy private help. The family structure of the Swedish elderly is more favourable today than before for providing help, and will improve further. More elders are married (or cohabit) and stay married longer, more have children and other kin than previously. Although old parents and their off-spring very seldom live together, they often do not live far apart. Social services increasingly target elders who lack close kin, are very frail and live alone. Adult children are not always satisfied with the public support, to the extent that it is forthcoming at all. Fewer carers get public support, be it direct or indirect. Patterns of care seem largely to be the same in the other Nordic countries, at least in Finland and Norway. Both carers and cared-for elderly persons want shared responsibility: that state and family together provide for frail elders. This is also what frequently happens, at the same time or – more often- in the long run. Paradoxically, more elders are cared for longer and more by their families, but eventually also a larger proportion of elders than before use public services. For example, more eventually enter institutional care than before. The dynamics of this process are not well captured by regular statistics, but are explored in this presentation that draws on evidence from fifty years of shifting patterns in Swedish old age care, under comparison with some other European countries.

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Consumer-directed home care in the Netherlands, England, Germany, and the United States

Jane Tilly, The Urban Institute, Washington, D.C.

This presentation will focus on a major innovation in long-term care in the United States and Europe – consumer-directed home care. Typically, consumer-directed programs allow the consumer to hire, train, supervise and fire the home care worker. Information for this study of consumer-directed care in the U.S., England, the Netherlands, and Germany was obtained from interviews with government officials, researchers, and representatives of provider and consumer groups during the fall of 2002. The interviews were supplemented by newspaper and journal articles, government documents, and provider, consumer, and research publications. The presentation will describe the consumer-directed programs in these four countries and key stakeholders’ views about the programs, with a focus on older person’s experiences. Issues the presentation will address include consumers’ competence to direct their services, quality assurance, and labor issues. The experiences of the Netherlands, the U.S., England, and Germany suggest that some countries are moving ahead in changing the nature of non-institutional services in a way that gives people with disabilities, including the frail older population, more control over the services that are so important in their lives.

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Intergenerational Rights and Responsibilities

The Intergenerational Report – Where is Australian policy heading?

Anna Howe, Consultant Gerontologist, Melbourne; Judith Healy, National Centre for Epidemiology and Population Health, Australian National University

The Intergenerational Report released as a Commonwealth Budget Paper in May 2002 added to a well-established history of research and policy development on the cost implications of population ageing in Australia. Its particular contribution was to sharpen the focus on shifts from inter-generational transfers to intra-generational self-sufficiency. Similar intergenerational issues were canvassed in the Royal Commission into Long Term Care in the UK which reported in 1999.

Our contention is that in the Australian case, shifting the social policy debate to the macro-economic context about the balance of public and private financing and state and family provision of care, signals a major potential shift from public to private transfers in financing aged care.

To assess explicit and implicit trends in intergenerational and public-private shifts in the two countries, this paper outlines policy measures implemented in four areas: containment of public expenditures on older age groups; promotion of informal care vis-à-vis formal community care; financing long term residential care aged; and access to health care, especially acute care for older people. Policy intentions, short term outcomes and longer term prospects are assessed to identify the extent of policy convergence and divergence between the two countries. Recognising the value of insights gained from comparative research, proposals for promoting more critical comparative analysis are presented.

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International issues in harmonizing caregiver research in dementia

Peter J. Whitehouse, Fairhill Center on Aging, Case Western Reserve University; Akira Homma, Dept. of Psychiatry, Tokyo Metropolitan Institute of Gerontology; Henry Brodaty, Dept. of Psychiatry, University of New South Wales

A global response to age-related cognitive challenges will be enhanced by sharing concepts and best practices across national boundaries and cultural divisions. Caregiving is a fertile area for such sharings just as efforts have emerged with regards to global collaboration about drug development. In fact the domination of world health by the medical/profit model is ultimately unhealthy. Age-related conditions like Alzheimer’s disease require biopsychosocial approaches. While not ignoring the biological aspects of disease and the potential importance of medications, we should also recognize that caring is ultimately dominant to curing. Normal age-related cognitive changes are the backdrop for all cognitive impairment due to disease in the elderly. The often politically motivated claim that Alzheimer’s disease is not normal aging masks intimate relationships between these age and disease-related processes. Even if we were to eradicate certain causes of dementia the brain as our most wonderful and yet vulnerable organ will likely to fail before the body as the disease of aging affect us all. Yet we can learn from the pharmaceutical industry the importance of international collaborative efforts to harmonize research methodologies. Such efforts as those of the International Working Group for the Harmonization of Dementia Drug Guidelines will be reviewed here. Recent efforts to extend harmonization approaches to caregiver research should be continued and will be reviewed in this presentation. Alzheimer’s Disease International under the leadership of Henry Brodaty have made some important initial attempts. Efforts to organize professional caregivers in Japan by Akira Homma will be reviewed. Programs from the Takeyama Foundation in Japan and the Carter Institute in the Unites States will be featured. Multinational caregiver intervention studies are underway. Assessment of both patients and caregiver quality of life are being seen as more important in intervention studies. However, the complexities of caregiver research are enormous. Ethical, economic, legal and cultural aspects play an even more important role in assessing carer interventions than in the process of developing more effective medications. In the short and long run however, improving quality of life through integrated biopsychosocial interventions remains an important goal. We need to expand the scope of our thinking about the range of interventions for people whose cognitive vitality is threatened. For example the use of computers and educational models may provide benefit. Hidden within the depths of the caregiver relationship can we not find positive aspects of aging? Do our processes of medical diagnosis and social labeling (we will consider the new label, Mild Cognitive Impairment) distort our views of cognitive aging? Can we even age successfully despite a loss of short-term memory and speed of processing? Can we not focus our attention on the potential positive contributions of older people whose experiences may provide us wisdom to preserve the health of our planet? Can we not study the benefits of caregiving as well as its burden? Should we celebrate caregiving around the world as an example of human beings at their diverse and challenged best?

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Protecting elders: Intergenerationally transmitted debt.

Fiona R Burns, Faculty of Law, University of Sydney

There has been considerable discussion about the enforceability of guarantees by financial institutions against wives who guarantee their husband’s liabilities. However, there have been a number of recent cases in Australia where very elderly parent/s (who are neither incapacitated nor dependent upon the adult child) have personally guaranteed or provided a mortgage to secure their child’s liabilities, unprepared for the consequences of default. Often the guarantee/mortgage has: Been given without a full disclosure of the financial status of the child; and/or Provided security the elder’s most valuable asset, such as the family home; and/or Contained an all monies clause. Such situations have not received the same level of publicity nor the same degree of academic interest as those concerning wives or defactos. At present, there are no significant barriers to financial institutions requesting or obtaining guarantees from elderly parents. The institutions are simply required to follow standard procedures mandated for all guarantors. Should an elder wish to have the guarantee set aside, he or she will have to prove breach of statutory requirements or some form of transactional wrongdoing or unfairness in which the financial institution was directly or indirectly involved. This paper examines: Whether the specific needs and vulnerabilities of elders with capacity have been adequately addressed by the general law and statutes based on transactional wrongdoing or unfairness; and whether pro-active steps need to be taken to protect elders (as has been the case in other jurisdictions). Such steps may preclude guarantees in some cases, whilst strictly regulating the requirements for an enforceable guarantee in others. Factors which could be taken into account include the existence of the parent-child relationship and the nature of the asset/s subject to the guarantee.

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The long-term care insurance in Japan: Its legal and social implications in connection with the demented elderly

Akira Homma, Dept. of Psychiatry, Tokyo Metropolitan Institute of Gerontology; M Arai, Graduate School of Business Sciences, Tsukuba University

The long-term care (LTC) insurance started in 2000 in Japan with a primary aim to achieve a democratic means of the burden sharing by distributing the financial burden of caregiving among the central and local governments...
and individuals aged 40 years and above. Services are provided to eligible elderly persons according to the degree of the care required based on the contract of the elderly him/herself and the service providers. After the implementation of the LTC insurance, two major problems have emerged. According to the results of the survey conducted by us before and after the implementation, the insurance was effective to reduce the burden of family caregivers for the elderly without dementia, while the burden was increased in the caregivers caring for the demented elderly probably due to the insufficient social resources, in particular, for the demented elderly with behavioral complications. The second problem was that a proportion of the family who used the legal guardianship was only 4% in the eligible people. The number of the eligible people was approximately 3,400,000 persons in 2002. It is estimated that more than half of them may be demented. In most cases, caregivers or families make a contract with the services providers with the name of the elderly persons. Legally speaking, when the elderly persons are demented, the contract of the elderly and the service providers are not valid. Legal guardianship, which was established also in 2000, must cover such issues. However, the system is not working well due to several reasons including the cost, low awareness, traditional relationship in the families, etc. Recently we organized some small working group including lawyers, psychiatrists, etc to promote the usage of the legal guardianship in Japan. In the presentation, we would like to discuss how to reduce the burden of caregivers for the demented elderly with some legal aspects.

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**Advance Care Directives and End of Life Decision Making**

**Making decisions and advanced care planning: the Australian experience of advance directives and possible future directions**

*Cameron Stewart, Division of Law, Macquarie University*

This paper will analyse the role that advance directives can play in the formation of advanced care planning. In particular the paper will review the legal history of advance directives in Australia including the common law and statutory regimes. The paper argues that schemes for advance directives have not yet proven to be successful. It is proposed that what is needed is a more integrated approach, whereby advance directives are but one mechanism used in a wider concept of advanced care planning. This integrated approach should employ a variety of mechanisms including proxy decision-making, structured concepts of best interests and clearly defined dispute resolution processes.

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**Legislating and implementing psychiatric advance directives from a therapeutic jurisprudence perspective**

*Debra Srebnik, Department of Psychiatry and Behavioral Sciences, University of Washington*

Created while competent, psychiatric advance directives (PADs) are legal documents that specify treatment preferences and may also include designation of a surrogate decision maker for use during later periods of acute illness in which competent decision-making is compromised. The presentation will first provide an overview of the potential therapeutic effects of PADs including increased choice over treatment, improved treatment relationships and engagement, reduced coercion, and the provision of important and otherwise unavailable treatment information (e.g., Winick, 1996; 2001; Srebnik & LaFond, 1998; Swanson, et al., 2000). The presentation will then focus on four areas in which legislation and methods of implementing PADs should consider therapeutic jurisprudence implications: (1) standards for competence to create PADs; (2) whether to ‘activate’ PADs prior to determination of incompetence; (3) whether revocation should be allowed during periods of incompetence, and if so, the standard for incompetence, how and by whom it should be determined, and the relationship of these issues to involuntary commitment; and (4) the circumstances under which PADs may not be honored such as if they are in conflict with practice standards or involuntary treatment, and implications of honoring PADs if specified treatment is not effective or is harmful. For each area, data from the author’s ongoing study of PADs, sponsored by the National Institute of Mental Health, will be presented to further describe key issues and support recommendations. Legal and therapeutic implications will also be discussed for each area, noting the values of autonomy, well-being, and care and protection that must be balanced.

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**The development of advance care directives in New South Wales**

*Barbara Squires, Director, Centre on Ageing, The Benevolent Society and National President, Australian Association of Gerontology*

Advance Care Directives (ACDs) are becoming an increasingly popular way for people to state their wishes about the treatment they do or do not want at the end of their lives. Their development in NSW needs to be understood in the context of Part V of the Guardianship Act 1987, which is the legislation relevant to medical treatment for adults who are unable to consent to their own treatment. Although it was proclaimed in 1989, its provisions are still not well understood by the medical profession, much less by the general public. Interest in Advance Care Directives (ACDs) grew after the visit to Sydney in 1993 by Prof Willie Molloy, of Toronto, Canada, author of “Let Me Decide.” Also in 1993, NSW Health published Dying with Dignity: Interim Guidelines on Management.
They mentioned Advance Directives, but not the Guardianship Act. Interest in ACDs continued among various
group, and in 1999, the discussion paper Taking Charge: Making Decisions for Later Life was published by the
NSW Committee on Ageing. At the same time, NSW Health was conducting consultations as part of the process
of revising the Dying with Dignity guidelines. To date, NSW has avoided going down the path of specific ACD
legislation, relying instead on the common law and the Guardianship Act, including the provisions by which a
competent person can appoint another to be their “enduring guardian.” NSW Health is expected to release
Guidelines for Decision Making at the End of Life in May 2003, which is likely to increase public awareness of
ACDs greatly and to add for pressure for a specific legislation.

The experience of the Victorian Civil and Administrative Tribunal in administering the Victorian
Medical Treatment Act
The Hon. Justice Stuart Ross Morris, President, Victorian Civil and Administrative Tribunal

An important jurisdiction of the Victorian Civil and Administration Tribunal (VCAT) is its responsibility for
guardianship and administration matters. Although most of these cases involve disputes about the administration of
estates or guardianship matters, a small number of important matters have arisen under Victoria’s Medical Treatment
Act. This Act sets out a regime whereby a patient, or the agent or guardian of the patient, may refuse medical
treatment, even if the consequence is that the patient will die. Although first passed in 1988, it was not until recently
that a case came before VCAT, and subsequently the Supreme Court of Victoria, requiring judicial determination of
the Act. The case – involving the artificial feeding of a senile woman known as BWV – required consideration of
key concepts in the Victorian Act, such as ‘medical treatment’, ‘palliative care’ and ‘the reasonable provision of food
and water’. This paper will explain concepts used in the Victorian Act and the manner in which these were
interpreted in the BWV case. Consideration will also be given to other cases which may have come before VCAT
which involve the making of decisions which may have the consequence of ending life.

When is old age a basis for special legal provision?
Older people’s assets: A contested site
Cheryl Tilse, Jill Wilson, Deborah Setterlund, School of Social Work and Applied Human Sciences,
University of Queensland; Linda Rosenman, Dean, Faculty of Social and Behavioural Sciences, University
of Queensland

Older people, their descendents, the State and the market all have stake in the use of the assets of older people.
Assets protect the independence of older people and provide for future health care and accommodation options;
family members expect to inherit these assets; the interest of the state is in older people using assets to self fund
retirement and pay user charges; and the private sector sees older people as an important market for leisure,
financial planning, health care and accommodation options. A change in accommodation such as entry into a
retirement village or residential facility raises issues of contested claims regarding the use of assets and the need
to protect vulnerable older people. Entry into a residential facility also engages family members who manage the
assets of older relatives in negotiating complex systems of pension and superannuation entitlements, user fees and
charges, and taxation. The current legal mechanisms designed to protect older people and their families in this
contested environment are not necessarily successful. This paper is based on a broad research program exploring
family asset management, financial abuse, decision making around entry to residential care, and the role of legal
and allied health practitioners in supporting and protecting the interests of older people and their families. It
critiques Enduring Powers of Attorney legislation and residential facility agreements in relation to their capacity
to protect the interests of older people and their family asset managers and the role of legal professionals and
service providers in providing information and advice. The argument is for more extensive community and
professional education, broader access to financial and legal advice at the point of entry to residential care or a
retirement village, increased support for family asset managers and approaches that monitor the use of current
protective mechanisms.

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Financial abuse of the elderly – A New South Wales perspective
Eleanor Barker, Office of the Protective Commissioner and Public Guardian, Sydney

This paper will investigate the themes of financial abuse and exploitation of the elderly with impaired decision-
making abilities as occurring in New South Wales. How and why does such financial abuse occur? What are the
possible causes of such abuse? Emerging relevant themes are explored. The paper will discuss abuse of enduring
powers of attorney particularly relating to the transfer or mortgage of the family home. Substitute decision-making
laws will be discussed. Appropriate legal remedies will be explored. Case studies cited. The principles of breach
of trust, particularly breach of fiduciary duty as well as other unconscionable conduct will be emphasised. The
Powers of Attorney Bill 2001 will also be discussed.

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Panellists will address the issues most pertinent to the national contexts.

Following an overview of the available empirical research on use of legal aid provision by older people in the Netherlands since the mid 1970s, this presentation will focus on two research projects. The first of these is effectively a replication of the ‘Paths to Justice’ study carried out in the UK (1999), and Scotland (2001) as well. They in turn were built on a 976 study in the Netherlands, and so enables both cross sectional and temporal comparative perspectives. The second is a study of the practice of advance directives in the Netherlands as far as the Dutch notaries are involved. These studies provide insights into how legal provisions achieve their intended objectives as they apply to older people, but show that there may also be unintended consequences in the way these provisions are put into practice.

Hong Kong has had no special legal protection for elders. The amended Mental Health Ordinance came into force in 1999 which established the Guardianship Board. It was given powers to make guardianship orders including emergency guardianship orders. An emergency guardianship order can be granted when the person with mental incapacity is in danger or is being, or likely to be, maltreated or exploited; and it is necessary to make immediate provision to protect that person. This power has been used by the Board to grant orders to prevent financial and other abuse of elders, and also to prevent them being taken by relatives from Hong Kong into Mainland China, where their best interests may not be met by the lower standard of living, including health care. Special health care provisions allow a doctor to treat a person with incapacity without consent, even without a guardianship order, there being no legal provision for family consenting to such treatment. The Domestic Violence Act does not protect the elder unless the abuser is the spouse or de facto.

The Australian panellist will sum up lessons that Australia might learn from the experience of other countries.
# Culpability, Capacity and Responsibility


**Brisbane Room (3rd Floor)**

## Registration

8:00–8:30

## Culpability, Responsibility and Mental Illness

8:30–12:30

**Chair:** The Hon. Justice Terry Buddin, Supreme Court of New South Wales

**The biology of choice: Perspectives on free will**

Laurence Tancredi, New York University School of Medicine, David N. Weisstub, Faculté de médecine, Université de Montréal

Reconceptualizing disorders of mood, thought and behavior as specific neurotransmitter dysfunctional states rather than as clinical syndromes

Andrew Slaby, New York University School of Medicine

Bergman’s, Through a Glass Darkly: Responsibility and mental state reconfigured

Leonard Kaplan, Faculty of Law, University of Wisconsin

**Break**

10:00–10:30

**Insanity, responsibility and identity**

Stephen Matthews, Centre for Applied Philosophy and Public Ethics, Charles Sturt University

**Moral responsibility: Learning from pathologies of agency**

Neil Levy, Centre for Applied Philosophy and Public Ethics, University of Melbourne; Tim Bayne, Department of Philosophy, Macquarie University

How should an incapacity to make the moral/conventional distinction affect legal responsibility?

Jeannette Kennett, School of Philosophy and Bioethics, Monash University

The neuroscience of cognition: Implications for legal competency

Laurence Tancredi, New York University School of Medicine

**Lunch**

12:30–13:30

## Mental Capacity

13:30–15:30

**Chair:** Alan Jager, Forensic Psychiatrist, Melbourne

Assessing capacities in individuals with mental impairments: Ethical considerations

Tracy Gunter, Roy J. and Lucille A. Carver College of Medicine, University of Iowa

Competency of impaired persons

Claudia Kachigian, Alton Mental Health Center, Southern Illinois University

Perps and vics: Contrasts and contradictions in how the torts system treats mentally impaired plaintiffs and defendants

Nicolas Terry, Center for Health Law Studies, Saint Louis University

Zacarias Moussaoui and the problem of marginally competent defendants representing themselves

Frank Herrmann, Boston College Law School

Mental illnesses as a bar to the death penalty in the United States

Mark E. Olive, Attorney-at-Law, Tallahassee, Fla, U.S.A.

**Break**

15:30–16:00

## Automatism

16:00–17:45

**Chair:** Mark Nolan, Faculty of Law, Australian National University

The right direction for automatism: A critical comparison of legal and scientific approaches

Simon Bronitt, Faculty of Law, Australian National University

Automatism and dissociation: Disturbances of consciousness and volition from a psychological perspective

Hamish J. McLeod, Mitchell K. Byrne and Rachel Aitken, Dept. of Psychology, University of Wollongong

Automatism, voluntariness and legal intention: R v Leonboyer

Steven Yannoulidis, Faculty of Law, Monash University

**Discussant:** Bernadette McSherry, Faculty of Law, Monash University
Culpability, Capacity and Responsibility

Abstracts

Culpability, Responsibility and Mental Illness

The biology of choice: Perspectives on free will
Laurence Tancredi, New York University School of Medicine; David N. Weisstub, Faculté de médecine, Université de Montréal

The issues surrounding freedom of choice go back to ancient times. The debate has always been between the position that man has the capacity for moral decision making, and that which claims that man is psychologically determined—perhaps through genetics, or early conditioning—to make certain decisions. This discussion will explore the historical roots of this debate and the corresponding issues related to the mind/brain relationship. The biological developments that call into question man’s capacity for free will and the implications of these developments on legal and social policy will be discussed.

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Reconceptualizing disorders of mood, thought and behavior as specific neurotransmitter dysfunctional states rather than as clinical syndromes
Andrew Slaby, New York University School of Medicine

Neurochemical and neurophysiological investigations have advanced our understanding of disorder of mood, thought and behavior far beyond that provided by clinical and epidemiological research. The presenters will discuss the re-evaluation of our understanding of how specific neurotransmitter dysfunction results in behavior aberration as grave as homicide and suicide, as well as the implications this understanding has for management of those with the disorders and public policy impacting those with the disorders. Self-destructive and other-destructive behavior will be discussed as examples.

Bergman’s, Through a Glass Darkly: Responsibility and mental state reconfigured
Leonard Kaplan, Faculty of Law, University of Wisconsin

Much has been written about the relationship between mental illness and notions of moral and legal responsibility. Thomas Szasz, e.g. notoriously argued with some influence that mental illness is mythological. Herbert Fingerette, Stephen Morse and Michael Moore ground the relationship of mental illness to legal responsibility in a notion of reason. If the rationality of the subject is eroded then and only then can one legitimately speak of a diminishment of criminal accountability. Ingmar Bergman, one of the greats of twentieth century cinema has delve into the problem of responsibility and agency through his life’s work. This paper will analyze some of that work, particularly his film Through a Glass Darkly to present a nuance representation of how a person may be significantly afflicted with a major mental disorder and yet be as or more responsible than others, ostensibly normal around her. The question then becomes can legal mechanisms fashion nuanced practice around Bergman’s compelling insights?

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Insanity, responsibility and identity
Stephen Matthews, Centre for Applied Philosophy and Public Ethics, Charles Sturt University

To establish responsibility it is usually thought we must establish (a) an identity of person, and (b) a level of competence. In cases of an insanity defence, establishing competence is central since a standard excusing condition is that the defendant lacked the capacity to recognize the criminality of the behaviour. However, it is sometimes thought that establishing personal identity in such cases takes on special significance because we are not merely interested in the philosophically uninteresting issue of avoiding a mistaken identity. We are, it is thought, interested in whether, having already established the bodily identity of the defendant with the crime-committing party, this individual has the psychological features sufficient for personal identity. In this paper, I argue that this is simply the wrong question. Having established the philosophically unimportant question of the bodily identity of the crime-committing party with the defendant, the only relevant question to ask is whether we have the same moral agent. That question invokes a set of presuppositions separate from the question of personal identity. In this paper the case is put for why the question of human agency, not personal identity, is the relevant question when considering the question of responsibility involving mental illness.

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Moral responsibility: Learning from pathologies of agency
Neil Levy, Centre for Applied Philosophy and Public Ethics, University of Melbourne; Tim Bayne, Department of Philosophy, Macquarie University

In some situations we ought to hold people morally (and legally) responsible for what they do, and in other situations we ought not. What distinguishes the former situations from the latter? That is, what distinguishes mere agency from moral agency? We approach this question by considering various pathologies of agency in which moral agency appears to have been lost or compromised. Such pathologies include non-insane automatism, anarchic hand
Culpability, Capacity and Responsibility

syndrome, post-hypnotic suggestion, the schizophrenia delusion of alien control, and obsessive-compulsive disorder. Although these disorders involve different breakdowns in agency, one thing that they appear to have in common is a disorder in the experience of agency. People suffering from these conditions engage in actions without experiencing themselves as the authors of their actions. This suggests that the experience of agency plays a crucial role in moral agency. Perhaps one needs to experience oneself as the doer of one’s deeds in order to be fully morally responsible for them. We explore this in connection with Daniel Wegner’s recent account of the experience of conscious will, and in connection with Fisher and Ravizza’s account of responsibility.

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How should an incapacity to make the moral/conventional distinction affect legal responsibility?

Jeanette Kennett, School of Philosophy and Bioethics, Monash University

The capacity to distinguish between what is morally wrong and what is merely conventionally wrong is acquired by normally developing children at around four years of age. Developmental psychopaths are unable to make this distinction and the evidence suggests that adult psychopaths are likewise impaired. This distinction however is essential to moral agency. Those unable to make it cannot make genuine moral judgments and so, it might be argued, cannot be held morally responsible for their actions. But does the argument rest there? Even if psychopaths and those with related disorders cannot be held morally responsible for what they do they might meet the standards for legal responsibility.

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The neuroscience of cognition: Implications for legal competency

Laurence Tancredi, New York University School of Medicine

For the most part the law assumes that functioning adults have the competency to fulfil many functions of everyday life from effecting a will, contract, informed consent for medical research and treatment to managing one’s affairs. However, developments in the neuroscience over the past ten or more years have revealed the neural circuitry involving much of cognition, its complexity, and the many possibilities for misperception of the competency of people to engage in ‘rational’ and ‘moral’ decisions. This discussion will explore the findings of neuroscience regarding cognition, speculate on the potential for more accurate assessments of competency in the near future and long term, and review what developments may lead to enhancement of the capacities.

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Mental Capacity

Assessing capacities in individuals with mental impairments: Ethical considerations

Tracy Gunter, Roy J. and Lucille A. Carver College of Medicine, University of Iowa

Competent individuals have the freedom to make decisions independently and the responsibility to function rationally in society. When an individual’s competence is questioned, the person’s capacity to responsibly self-direct is no longer implicit. Given the gravity of the issue, one must proceed with a full awareness of the ethical and practical issues involved at each level of the evaluation process. Before beginning an evaluation to ascertain an individual’s cognitive strengths and limitations, one must appreciate the context in which the question of competence has been raised, the standard for competence, and the particular decisions that are confronting the individual. This paper will focus on the ethical issues raised as the examiner approaches the matter of rendering an opinion on an individual’s rational ability to make decisions.

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Competency of impaired persons

Claudia Kachigian, Alton Mental Health Center, Southern Illinois University

Restoration of a patient’s competency to stand trial often involves a number of clinical, legal and ethical issues that can be difficult to balance. Active psychotic or other severe symptoms may render one incompetent to stand trial. Difficulties arise in a forensic setting in which the patient, or perhaps his lawyer, may not want treatment, for example, when the potential sentence if found guilty at trial may include life imprisonment without the possibility of parole or the death penalty. The psychiatrist may have an ethical dilemma in treating such a patient. The issue of whether one can be medicated against their will solely for the purpose of restoring competency has not been resolved in the United States, and the issues involved are somewhat different when a person is deemed competent to make such a decision as compared to the situation in which the person is not competent to consent to or refuse medications. My discussion will focus on competency to consent to treatment in mentally ill individuals in the pre-trial period with an update on the most recent cases, in the United States, on this issue.

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Perps and vic: Contrasts and contradictions in how the torts system treats mentally impaired plaintiffs and defendants

Nicolas Terry, Center for Health Law Studies, Saint Louis University

The common law torts system promotes an essentially simplified and homogenized view of mental illness and mental retardation. In contrast to criminal law models there has been little interest shown by the courts in
exploring more indeterminate issues such as intent, while compensation-based models such as those that apply to mentally ill drivers tend to favor efficiency approaches rather than clinically-derived analysis. Recent cases involving the potential liability of Alzheimer’s patients to their caregivers (for example, Creasy v. Rusk, 730 N.E.2d 659 (Ind. 2000)) and the mentally ill’s potential duties of self-care (triggered by a defense of contributory negligence in the case of a suicide) provide the background to explore the appropriate response of the torts system to mental illness and mental retardation.

Zacarias Moussaoui and the problem of marginally competent defendants representing themselves

Frank Herrmann, Boston College Law School

When a criminal defendant is marginally competent, his or her decision to waive counsel and act pro se presents courts with vexing problems endangering the fairness of the pending trial and the reliability of its outcome. The United States Supreme Court evaluates a criminal defendant’s competency to waive counsel and defend himself or herself by the same low standard it uses to evaluate a defendant’s competency to stand trial. A defendant is mentally competent to stand trial, so long as the defendant possesses a reasonable degree of rational understanding and a rational and factual grasp of the proceedings against him or her. Yet a defendant who is mentally competent to stand trial may be totally incompetent to defend himself. The decision to act pro se is far more complex and consequential than a determination by a court that a defendant is mentally well enough to stand trial. Zacarias Moussaoui’s pending case in a United States federal court in Virginia vividly illustrates the bind courts are placed in when they must measure a defendant’s mental competency to waive counsel by the same standard as mental competency to stand trial. Mr. Maussoui is the only person awaiting trial for the September 11 terrorist attacks. He has chosen to act pro se and a federal judge has deemed him mentally competent to do so despite evidence of Mr. Maussoui’s paranoid psychosis. Using the Maussoui case as a platform, Prof. Frank Herrmann will examine the conflicts between a defendant’s right to represent himself or herself and the needs for a fair and reliable trial.

Mental illnesses as a bar to the death penalty in the United States

Mark E. Olive, Attorney-at-Law, Tallahassee, Fla, U.S.A.

The death penalty in the United States is regulated primarily through the Eighth Amendment to the United States Constitution which prohibits punishments that are cruel and unusual. One of the tests for whether a punishment violates the 8th Amendment is whether it violates the ‘evolved standards of decency in a civilized society.’ Because this test is dynamic and not static, a punishment that has been accepted may become unacceptable as standards of decency evolve. For example, in 1989, the United States Supreme Court held that it did not violate the Eighth Amendment to execute persons who suffer from mental retardation. In 2002, the Court found that standards of decency had evolved and that such executions violated the current standards of decency. Does it violate the Eighth Amendment to execute persons who suffer from mental illness? Many of the considerations that led the Court to ban the execution of the mentally retarded also apply to the execution of persons who suffer from other diseases and defects. A successful challenge to the execution of the mentally ill would require, among other things: (1) a definition of mental illness that is sufficiently narrow (i.e., restricted to persons who dissociate or become psychotic); (2) a widely shared public understanding of and sympathy for the severe limitations and disadvantages shared by sufferers of mental illnesses; and (3) a recognition by juries, state legislators, persons who make charging decisions that the mentally ill should not face the ultimate punishment. This presentation will invite the mental health community to engage in a dialogue regarding how to: (1) narrow the number of persons who would fall within a ban on executing the mentally ill; (2) increase public understanding of the debilitating effects of mental illnesses; and (3) convince policy and decision-makers to support protecting the mentally ill.

Automatism

The right direction for automatism: A critical comparison of legal and scientific approaches

Simon Bronitt, Faculty of Law, Australian National University

Through a critical examination of several high profile cases in Australia, this paper will explore recent cases where criminal defendants have successfully raised (non-insane) involuntariness as a basis for an acquittal, including the case of R v Yildiz and Yilmaz [2002] ACTSC 41. The so-called legal defence of “automatism” has been modelled on a narrow construction of human thought and behaviour, which conflicts with some recent scientific thinking about impaired mental states. The paper will critique recent jury trial directions on automatism from wider socio-legal and scientific perspectives.

Automatism

The right direction for automatism: A critical comparison of legal and scientific approaches

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Automatism and dissociation: Disturbances of consciousness and volition from a psychological perspective

Hamish J. McLeod, Mitchell K. Byrne and Rachel Aitken, Dept. of Psychology, University of Wollongong

The capacity for an individual to exhibit involuntary but seemingly purposive behaviour is well recognised in the neuropsychological, neurological, and clinical psychiatric literature. Sample phenomena such as the alien hand syndrome, dissociative identity disorder (formerly multiple personality disorder), and dissociative fugue are broadly characterised by disturbances of the normal interplay between will, behaviour, and memory. Both internal (e.g. mental disease, central nervous system damage) and external factors (e.g. traumatic experiences) have been implicated in the provocation of dissociative states and impairments of the voluntary control of behaviour. This paper will provide an overview of some of these factors and describe the way that dissociation can be conceptualised and assessed from a psychological perspective. Empirical data on the rate and quality of dissociative experiences in a sample of Australian prisoners will also be presented. It will be argued that determining the intent component of an act may be informed by developing a more precise understanding of the circumstances (both internal and external) where disturbances of the normal processes of consciousness and volition can be suspected.

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Automatism, voluntariness and legal intention: R v Leonboyer

Steven Yannoulidis, Faculty of Law, Monash University

This paper argues for a reconceptualisation of the Automatism defence utilising philosophy of action. Through the study of the psychiatric evidence in the case of R v Leonboyer, the author begins with a brief overview of the various positions taken by psychiatrists in relation to dissociative states. The author then moves to a consideration of the seminal case of R v Hawkins in delineating the position at law. The main part of the paper seeks to utilise the insights of action theory in providing a more cogent understanding of the interrelationship between voluntary and intentional behaviour. The paper ends with the formulation of a defence which it is believed places the defence of Automatism on a more principled footing.

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Genetics, Health and Justice

Convened jointly with the Centre for Law and Genetics, University of Tasmania and Melbourne University

Thurs. Oct. 2, 2003 (9:00–16:30) James Cook Room (5th Floor)

Registration 8:00–9:00

Genetics and Public Policy 9:00–10:00

Chair: Loane Skene, Faculty of Law, University of Melbourne

Genetic research: Public trust and community expectations
Don Chalmers, Dean, Faculty of Law, University of Tasmania

Exploring genetic discrimination: Theoretical and empirical perspectives
Margaret Otlowski, Faculty of Law, University of Tasmania

Break 10:00–10:30

Genetic Research – Tissues, Consent and Testing 10:30–12:30

Chair: Don Chalmers, Dean, Faculty of Law, University of Tasmania

Social and emotional significance of human tissue and genetic material
Imogen Goold, Centre for Law and Genetics, University of Tasmania

Interests in unlawfully obtained excised tissue
Loane Skene and Brenda Masters, Faculty of Law, University of Melbourne

Brain tissue donation and DNA banking for schizophrenia research – It’s my body
Margaret Boyes, NISAD Schizophrenia Research; Carmel Loughland, Faculty of Medicine and Health Sciences, University of Newcastle; Philip Ward, Dept. of Psychiatry, University of New South Wales; Paul Tooney, School of Biomedical Sciences, University Of Melbourne

Lunch 12:30–13:30

Genetics, Health and Information 13:30–15:00

Chair: Margaret Otlowski, Faculty of Law, University of Tasmania

The law of consent in the genetic era
Timothy Caulfield, Canada Research Chair in Health Law and Policy, University of Alberta

Use of genetic information relating to mental illness
Loane Skene, Faculty of Law, University of Melbourne; Mark Walterfang, Dept. of Psychiatry, University of Melbourne

Genetics and depression: Policy and ethical issues
Wayne D. Hall, Lucy Carter and Katherine I. Morley, Office of Public Policy and Ethics, The University of Queensland

Break 15:00–15:30

Genetics and Social Values 15:30–16:30

Chair: George F. Tomossy, Faculty of Law, University of Sydney

A clash of relatives: The right to reticence and the right to know
Derek Morgan, Faculty of Law, Cardiff University

Barbara Ann Hocking and Vivienne Campion, Faculty of Law, Queensland University of Technology; Jennifer Fleming, Research Ethics Consultant, Brisbane

Abstracts

Genetics and Public Policy

Genetic research: Public trust and community expectations
Don Chalmers, Dean, Faculty of Law, University of Tasmania

Government policy is directed to biotechnology with the national Biotechnology Strategy setting out required safeguards for health and the environment.
The success of human genetic research in Australia will depend on high quality research and access to human tissue samples. This must all be done according to the highest ethical standards. The ALRC/AHEC report ‘Essentially Yours: The Protection of Human Genetic Information in Australia’ is a template for responsible genetic research and health applications. This report is the most comprehensive international report to date on the protection of human genetic information. The two volumes contain 144 recommendations spanning insurance, discrimination, law enforcement, clinical genetic services and, most relevantly to the conference, the ethical oversight of genetic research. It is recommended that the privacy legislation be extended to cover the collection, storage, use and transfer of tissue samples. Also, there are recommendations that the NHMRC update and review the reporting obligations in relation to human genetic research and generally strengthening the HREC system. Finally, the report recommends that the NHMRC should amend the National Statement to provide ethical guidance on genetic research data bases. The implementation of these recommendations will set a benchmark for best practice in this area. Equally important is the continued confidence and trust of the community in the research and researchers in human genetics. The paper will assess the ALRC/AHEC recommendations, their implementation and the critical issue of public trust.

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Exploring genetic discrimination: Theoretical and empirical perspectives

Margaret Otlowski, Faculty of Law, University of Tasmania

This paper seeks to explore the concept of genetic discrimination in both its theoretical and practical dimensions. The paper begins by examining what constitutes ‘genetic discrimination.’ In particular, it looks at discrimination on the basis of genetic risk (as distinct from existing disability) and evaluates the influence of the law in defining what is discriminatory. Whilst there has been much interest in the emerging phenomenon of genetic discrimination, which has also been the subject of recent inquiry by the Australian Law Reform Commission, there is presently a lack of research data addressing the incidence and implications of genetic discrimination in Australia. The paper outlines a major Australian Research Council funded empirical research initiative being undertaken by an interdisciplinary team that seeks to address this gap in the data. The team will, from the perspective of consumers and third parties, and through the legal system, explore the nature and extent of genetic discrimination in Australia, and address the legal and social implications of the phenomenon.

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Genetic Research – Tissues, Consent and Testing

Social and emotional significance of human tissue and genetic material

Imogen Goold, Centre for Law and Genetics, University of Tasmania

Over the past decade, most particularly since the highly publicised decision in Moore v Regents of California and the revelations of tissue retention in the United Kingdom, there has been considerable debate about the legal status of human tissue. In many cases, this discussion has centred on the appropriate consent that must be obtained for tissue to be used in research, medical treatment and forensic contexts, while the courts and academics have considered the possibility of according tissue property status. Underpinning these discussions and informing our perceptions of human tissue and its use are the emotional and social significance of tissue for both the individual and the community. This paper seeks to briefly explore this significance and how it has shaped the regulation of human tissue.

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Brain tissue donation and DNA banking for schizophrenia research – It’s my body

Margaret Boyes, NISAD Schizophrenia Research; Carmel Loughland, Faculty of Medicine and Health Sciences, University of Newcastle; Philip Ward, Dept. of Psychiatry, University of New South Wales; Paul Tooney, School of Biomedical Sciences, University of Melbourne

The Neuroscience Institute for Schizophrenia and Allied Disorders (NISAD) has recently established two new programs involving the collection of biological materials from volunteers with schizophrenia and their first-degree relatives: The Hunter DNA Bank for Mental Health Research is a collection and storage facility for DNA, RNA and lymphocytes from volunteers with and without a psychiatric illness history. The “Gift of Hope” Tissue Donor Program is for people who express a willingness to donate their brain when they die for neuroscience research into schizophrenia. Both these programs are linked to NISAD’s Schizophrenia Research Register, a volunteer medical research database of people with and without schizophrenia, who are willing to participate in research projects. All three programs have the strong support of the consumer and carer organizations in NSW. The collection and long-term storage of human tissue for use in biomedical and neuroscientific research is a relatively new and developing program around the world. The establishment of such facilities, while providing increased opportunities for scientists to investigate in new ways (i.e., genetics) some of the most distressing of all illnesses, including schizophrenia, also raises a number of questions about ownership of biological materials and ownership of information (including genetic information), sovereignty over one’s body, the meanings ascribed to body parts, and informed consent. The volunteers who participate in these programs sometimes hold strong views about ownership of biological materials and ownership of information. Legal wisdom and laws may conflict with these
views and the often-heard exclamation: “It’s my body.” The meanings ascribed to the brain as an organ of
donation and to blood as a source of DNA have special significance. For this reason, both the DNA Bank and Gift
of Hope programs have adopted the trust model for the collection, storage and use of human biological samples.
The trust model may be a helpful model for conceptualising and managing issues of privacy, autonomy, societal
claim and fiduciary relationship, particularly with regard to the specific issues surrounding mental illness research.

Loane Skene
Faculty of Law, University of Melbourne

Brenda Masters
Faculty of Law, University of Melbourne

Mark Walterfang
Department of Psychiatry, University of Melbourne

Loane Skene
Use of genetic information relating to mental illness
Mark Walterfang
Department of Psychiatry, University of Melbourne

The genetic underpinning of psychiatric disorders is extraordinarily complex, and for most major mental illnesses
(depression, bipolar disorder, schizophrenia) is likely to be oligogenic – that is, a combination of a number of
genes interacting, in the right environment, produces illness. There are rare disorders that have a single gene
abnormality – such as Huntington’s disease; but most psychiatric disorders do not involve a single gene
abnormality with a predictable causal relationship with the development of illness. With schizophrenia, for
example, if one of two genetically identical twins has schizophrenia, the other twin has only a 50% chance of
getting the disease – suggestive of a “two-hit” model whereby a number of genetic factors interact to produce a
vulnerable biological template upon which non-genetic factors impact. Research suggests these non-genetic
factors are likely to relate to the Individual’s environment, whether through stressful life experiences or birth
trauma, maternal or early childhood nutrition. Also, what we now call ‘schizophrenia’ is probably a group of
disorders, maybe a half dozen or so, which have different aetiologies biologically and whose expression is heavily
modified through the environment. Even though understanding the genetics of these disorders may go some way
to resolving the heterogeneity of these illness syndromes, the power to predict illness presence, course and
prognosis from genetic information alone is likely to be limited. There are no currently available genetic tests for
these illnesses, although in the next decade a number of susceptibility genes are likely to be uncovered by psycho
genomic research, which will have significant implications for sufferers and their families. The uncertainty of risk
prediction and prognosis in diagnosing mental illness raises particular difficulties in relation to its genetic aspects.
It may be necessary to contact the relatives of the patient (the inquirer) to assist in that person’s diagnosis. In
single-gene disorders, an ‘index case’ may be needed – a relative who has the mutation for the condition in that
family; that relative may then be asked to provide tissue or information to assist the diagnosis of the inquirer. And,
if one person in a family is found to have a relevant mutation, the doctor or counsellor may want to warn other
blood relatives about the mutation in their family so that they can initiate their own genetic testing if they choose
to do so. There may be concerns about the information being wrongfully used by third parties, such as insurers
and employers. However, in multiple gene disorders – where the interplay between different genes, and genome
and environment, is complex – it may be exceedingly difficult to give relatives useful information about the nature

The acquisition of property interests in unlawfully obtained excised tissue
Loane Skene and Brenda Masters, Faculty of Law, University of Melbourne

According to Lockean theory, a property interest may arise in an object by virtue of a person undertaking ‘work
and skill’ on it. This notion has been discussed in the fairly limited case law concerning property interests in
excised human tissue, for example in Doodeward v Spence (1908) 6 CLR 406 (HCA). Courts have accepted that
a person may acquire a property interest in excised human tissue by undertaking ‘work and skill’ on it, such as the
doctor preserving the malformed foetus in Doodeward. If the Lockean principles are the basis for such a legal
principle, it would seem that a property right could arise in human tissue only if it was lawfully acquired initially.
However, that seems inconsistent with the outcome of Moore v University of California 793 P 2d 479 Cal SC
(1990), in which the patent holder of the cell line was recognised as the ‘owner’ of it, despite having obtained the
cells without the consent of the ‘donor’, Mr Moore. The paper examines the law to date in relation to these issues.

Oversight of genetics research: Challenges for ethics review through the lens of genetics research
Jocelyn Downie, Director, Health Law Institute, Dalhousie University

When ethics review originated, genetics research was still in its early stages and its possibilities were the stuff of
science fiction. Today, mechanisms for ethics review, substantively unchanged in many parts of the world, are
confronted with challenges posed by genetics research. Some critics charge that Research Ethics Boards are
failing to meet these challenges and thus are failing to adequately protect the public from significant new risks. It
is claimed that REBs do not have the specialist expertise, time and resources to adequately review proposals and
monitor the research and that REBs are failing to manage many complex conflicts of interest. This paper explores
these claims using examples from genetics research into mental health. It concludes that there is an urgent need
for public policy reform for research oversight.

Genetics, Health and Information

Use of genetic information relating to mental illness
Loane Skene, Faculty of Law, University of Melbourne
Mark Walterfang, Department of Psychiatry, University of Melbourne

The genetic underpinning of psychiatric disorders is extraordinarily complex, and for most major mental illnesses
of their own genetic risk for future illness. These issues arise with any genetic testing since genetic information is, by nature, familial. However, with mental illness, the problems are compounded by the complexity of the diagnosis and the prediction of risk mentioned above, together with the fears and stigma associated with this type of condition. The authors explain the difficulties in diagnosis and in informing patients.

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Genetics and depression: Policy and ethical issues
Wayne D. Hall, Lucy Carter and Katherine I. Morley, Office of Public Policy and Ethics, University of Queensland

Recent findings from family, adoption and twin studies have strongly confirmed clinical experience that depressive disorders run in families. These findings suggest a genetic basis for susceptibility to depressive disorders such as bipolar and recurrent major depressive illness. Additional evidence for genetic susceptibility has been provided by the identification of candidate genes for depressive disorders. The identification of susceptibility alleles for depressive disorders promises to improve the identification of those at risk. We review the major findings from studies of susceptibility genes for depressive disorders and identify ethical and policy issues raised by proposals to screen and intervene with persons identified as at higher risk of developing depression, and to use genetic information in tailoring drug treatment to patients with depression (pharmacogenetics). We also suggest strategies that may be put in place to minimise the adverse effects and maximise the benefits of genetic screening, targeted interventions for at risk persons, and pharmacogenetics.

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The law of consent in the genetic era
Timothy Caulfield, Canada Research Chair in Health Law and Policy, University of Alberta

It has been recognized by numerous commentators that the genetic revolution has created unique consent dilemmas. It is the tension between the legal manifestation of the right to make autonomous decisions and the broader family, community and research interests unavoidably engaged by genetic technologies that is at the root of many of the emerging consent issues. In most common law jurisdictions, consent law has focussed on the right and necessity of individual consent prior to the provision of any health care procedure. The interests of third parties, even family members, are not considered. On the contrary, current Canadian consent law suggests that health care providers should follow the informed decision of the individual patient in spite of third party wishes to the contrary. Though exceptions to the need to get individual consent exist – such as in health care emergencies, threats to public health and when the decision maker is deemed mentally incompetent – there are no Canadian cases which have moved away from this autonomy centred model of decision making in health care. Using population genetics research and the creation of DNA databanks as the primary example, this paper will review the challenges created by the genetic revolution in the context of consent law. In particular, it will explore the consent dilemmas created by genetic research and DNA databanking and critique the suggested reforms (e.g., the use of “blanket consent,” waiver of consent or “anonymization”).

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Genetics and Social Values

A clash of relatives: The right to reticence and the right to know
Derek Morgan, Faculty of Law, Cardiff University

Dealing in genetic information discloses some of the sharpest examples of what John Harris has called the ‘new generation of acute and subtle dilemmas’ that human genetics will create in the millennium, dilemmas that will ‘transform the ways in which we think of ourselves and of society.’ Two contrasting examples of such dealings suggest what might be called a clash not of absolutes but of relatives; taken together they enable us to ask questions such as ‘what is genetic information?’ not in a descriptive, analytical sense but additionally in a normative and representational sense.

Recent reform proposals in the United Kingdom and in Australia for the creation of criminal offences – one very narrowly drawn and the other conceived more broadly – of wrongful dealing in genetic information underline the basis of genetic information to comprise an element of what sociologist Ervin Goffman once called ‘the right to reticence.’ Contrasted with this is the claim of people to establish the basis of their genetic identity, sometimes abbreviated as the ‘right to know’ the genetic ‘truth.’ One proposal seeks to protect genetic privacy, one to open it to others’ scrutiny. What can be understood from these contrasting approaches about the protection of genetic privacy and public policy?

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Genetics, Health and Justice


*Barbara Hocking and Vivienne Campion,* Faculty of Law, Queensland University of Technology; 
*Jennifer Fleming,* Research Ethics Consultant, Brisbane;

Current genetics research continues a long-standing scientific fascination with genes as the core of our destiny. Dorothy Nelkin has encapsulated the human genome project as offering the ‘essence of personal identity’— the ‘molecular vision of life’ and the ‘set of instructions for making a human being.’ Whether in relation to disability, disease, or behavioural ‘disorders’ we increasingly turn to our genes for explanation. As Michael Kirby has observed: ‘There are many practical implications which the unlocking of the mysteries of the genome will have for humanity. They include implications for medical therapies, criminal law, privacy and confidentiality, third party interests, intellectual property and human rights.’ Ways in which genetics will affect our legal identity are steadily unfolding but our genetic identity could be our clearest identity! In the future bio-utopia we will control our biological destiny! In this paper we will explore the increasing references to DNA as the projected cure for all. We will draw upon images in the media, particularly film media, to reveal the ways in which Hollywood is driving and reflecting our move towards bio-utopia. Our perusal of movies aims to amuse but the paper has a serious purpose: to reveal an intense social and cultural critique of issues of health care, sustainable futures, inter-generation equity, disempowerment of community and mind-brain interface. We look, through the lens of Hollywood, through films such as Gattaca, Blade Runner, Jurassic Park, The Nutty Professor, Minority Report and Artificial Intelligence, at ways in which we are learning of our genes and interpretations of the so-called ‘crime gene’. We turn by way of conclusion to the legal interpretations and ways to confront the complex interactions between genetics, society and the environment.

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<td>8:00–8:30</td>
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<td>8:30–10:00</td>
<td>Mental Health Nursing in the Forensic Setting</td>
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<td>Chair: Wendy Austin, Faculty of Nursing, University of Alberta</td>
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<td>Forensic mental health nursing in New South Wales, Australia: New developments in roles and responsibilities</td>
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<td>Forensic mental health nursing in New South Wales, Australia: New policy directions and implications for workforce planning, service development and research</td>
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<td>Managing Risk</td>
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<td>Chair: David M. Greenberg, Director of Community and Court Liaison Services for Corrections Health, NSW</td>
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<td>Achieving the balance: Ethical management of risk in forensic patients</td>
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<td>13:30–15:30</td>
<td>Patterns of Comorbidity</td>
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<td>Chair: Julio Arboleda-Florez, Dept. of Psychiatry, Queen’s University</td>
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<td>Post Traumatic Stress Disorder, personality and trauma in an Australian prisoner population</td>
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<td>Crime, Violence and Substance Abuse</td>
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Abstracts

Mental Health Nursing in the Forensic Setting

Forensic mental health nursing in New South Wales, Australia: New developments in roles and responsibilities

Ben Nielsen, New South Wales Corrections Health Service

The author will explore the evolution of the nurse’s role from its in-patient, secure-services origins to the emerging & diverse sub-specialism of mental health nursing that exists today in the forensic mental health system in New South Wales (NSW), Australia. Specific practice-based issues, such as the care and management of psychotic and personality disordered individuals, the role of the nurse within the multidisciplinary team, and inter-agency collaboration are addressed.

Other topics that will be discussed include the skills and knowledge base of forensic mental health nursing, professional standards, the development of the forensic nurse’s role and the challenges of community services provision, involving diversion from the criminal justice system.

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Forensic mental health nursing in New South Wales, Australia: New policy directions and implications for workforce planning, service development and research

Anne Doherty, New South Wales Corrections Health Service

Workforce attitudes, skills, learning and development are fundamental to forensic mental health nursing. There is a need to strengthen and support the ability of the forensic mental health nursing workforce to provide quality care and to build partnerships with consumers, carers, their families and community based mental health services at all stages of health care delivery.

Consideration is also given to the supply, deployment and retention of the forensic mental health nursing workforce, and their resulting impact on quality. Other topics that will be discussed include policy directions under the 3rd National Mental Health Plan and their implications for service development and research for this important subspecialty of nursing.

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Forensic mental health nursing in New Zealand: A vision realised?

Brian McKenna, School of Nursing, University of Auckland

Contemporary regional forensic mental health services in New Zealand have evolved following a Government inquiry in 1988 which highlighted gross inadequacies in the system at that time. The outcome of this enquiry was a new vision involving the restructuring of the forensic mental health framework, with specific implications for nursing practice. The nursing workforce was required to operate within a multi disciplinary framework; to undertake continuity of care in the least restrictive environment; to develop clinical expertise; and to be skilled in working with the cultural perspectives appropriate to the population being served.

Fifteen years on, this paper assesses the ability of the nursing profession to meet these requirements. The vision is alive and well, but within the context of a changing society new demands have evolved. These changes present challenges for nurses which will be outlined and discussed. Specific reference in this regard is made to the Auckland Regional Forensic Psychiatry Services which is the largest regional service in the country.

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Managing Forensic Clients

Achieving the balance: Ethical management of risk in forensic patients

Andrew Carroll, Forensic Psychiatrist, Victorian Institute of Forensic Mental Health & Monash University

This paper discusses the political and ethical pressures faced by forensic mental health systems when dealing with patients acquitted of serious crimes due to mental impairment (insanity) or unfitness to be tried. Although many still insist that the offence itself should not determine length of detention in hospital, such patients continue to be detained for far longer than recovery from their acute illness requires. This has been held by some legal and psychiatric authorities to amount to ‘punishment’. This paper suggests a way out of this moral and clinical dilemma by proposing that the seriousness of the index offence appropriately determines the level of uncertainty which can be tolerated when assessing future risk: more serious crimes require a high level of confidence in future risk assessment and management. Possible sources of uncertainty in assessing risk in forensic patients, both in hospital and in the community setting, will be discussed.

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Managing Risk & Mental Illness in Forensic Systems

Client centred care in a medium secure forensic unit – Can this model be achieved or is it really ‘client coercion in disguise’

Shirley Pullan and Jeffrey McMaster, Centre for Addiction & Mental Health, Toronto

The benefits of utilizing an example of model centred care are well accepted within the mental health field (Rowe, 1996). Working within a Centre that promotes this model of care as a strategic direction poses challenges for clinicians and administrators when applying this philosophy to a medium secure forensic setting. The authors will discuss the complexities involved in balancing the need for a client centred care approach with the need to protect the public and to provide a safe and secure environment for clients and staff. Strategies will be reviewed that have been effective in a medium secure forensic setting that attempt to involve clients in their care and rehabilitation, to the greatest extent possible, while maintaining the necessary legal, security and safety mandates of the program. Ethical dilemmas from a clinical and administrative perspective will also be addressed as they relate to the perceived incongruity of applying this model of care to clients with a medium secure detention order.

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Evaluating the normalization benefits of co-ed forensic mental health minimum secure units against the negative impact on successful rehabilitation, treatment and risk management

Shirley Pullan and Ian G. Swayze, Centre for Addiction & Mental Health, Toronto

It is commonplace to utilize a co-ed model in minimum secure rehabilitation units where male and female mentally disordered offenders are housed within the same program. The rationale for this practice is founded in trends that date back decades where the segregation of male and female mental health patients was abandoned, in most instances, to a model of ‘normalization’. In this framework, one of the desired outcomes is the provision of an environment that promotes the appropriate interaction of male and female patients as a component of community reintegration planning. Although this principle may be well intentioned, it poses numerous challenges and difficulties for both patients and clinical/management staff associated with co-ed forensic mental health minimum secure units. The authors will discuss the complexities involved in the clinical management of patients whose index offence, diagnosis and/or behavioural tendencies make adaption to this type of environment less than optimal. The ethical dilemmas from both a clinical and administrative perspective will be highlighted as they relate to the potential this model has for impeding progress for patients whose profiles are not congruent with this type of environment.

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Suicide in Queensland prisons 1991-2001

William John Kingswell and Terry Stedman, Park-Centre for Mental Health, Wacol, QLD; Anthony Cook, Oasis Specialist Centre, Sunnybank, QLD

Objective: To determine the suicide rate in Queensland prisons, identify possible risk factors for completed custodial suicides and determine whether the putative risk factors for prison suicide have clinical utility.

Subjects And Setting: All suicides in Queensland prisons between 15 April 1991 and 15 April 2001 were compared to a prison control group.

Design: Retrospective case control study.

Main Outcome Measures: Suicide rates are expressed as rates per 100,000 prisoners calculated on annual reception numbers (Reception numbers for years 1995-2001). Risk factors for completed suicide included remand status, psychiatric history, deliberate self-harm and suicide attempts, offence type and recent custody.

Results: In the period studied 57 prisoners committed suicide (54 male) in Queensland prisons. Suicide was by hanging (n=55) in 97%. Remandees constituted 18.7% of receptions but 53% (n=30) of suicides. Suicide was significantly more likely in remandees than serving prisoners (p<0.001). Reported stress (OR=8.4, CI: 3.2-22.1), a history of deliberate self harm (DSH) or suicide attempt (OR=3.7, CI: 1.4-9.9), violent crime or murder/attempt murder (OR=3.7, CI: 1.4-9.9 and OR 11.6, CI: 1.5-92.4 respectively) and recent detention (OR=5.7, CI: 2.0-16.4) were the only risk factors measured that were significantly associated with suicide.

For 15-24 year old males the average relative risk over the period 1995 to 1999 was 1.8 and for 25-44 year old males it was 2.8. 7% of suicides were committed by persons detained in relation to fine default alone.

Conclusions: Suicide rates in Queensland prisons are comparable with rates reported by Hurley for the 15 year period 1973-1987[1].

Exposure to custody is associated with an increased risk of suicide.

This study did not find that ethnicity, past psychiatric history or a history of drug or alcohol use was predictive of suicide in custody. We did find that remand status, past history of self-harm, recent admission, serious violent offending and the experience of stress were associated with increased risk.

There is potential to identify a group at elevated risk of suicide by combining a small number of risk factors. A potentially profitable strategy would be to lower the numbers exposed to custody as recommended by Justice Muirhead more than 10 years ago.

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Patterns of Comorbidity

Post Traumatic Stress Disorder, Personality and Trauma in an Australian Prisoner Population
Anna Egeressy, Tony Butler and Stephen Allnutt, Dept. of Psychiatry, University of New South Wales

In 2001 almost 1500 reception and sentenced prisoners in New South Wales (Australia) were screened using the Composite International Diagnostic Interview (CIDI), the 144 item version of Cloninger’s Temperament and Character Inventory (TCI) a psychobiologically based measure of personality. Twelve-month prevalence rates for PTSD in the reception and sentenced populations were significantly higher than the general Australian community (between 16% and 21% for males, and 43% for females compared with 1.2% for males and females 1.4%). The most frequently cited trauma experienced by male prisoners was that of witnessing someone being badly injured or killed. For female prisoners the most frequently cited trauma was being seriously physically attacked or assaulted. Violent and sexual traumas were significantly higher in the prisoner sample compared with the general population. PTSD was associated with higher TCI temperament scores on both harm avoidance and novelty seeking and low character scores on self-directedness. The high prevalence of PTSD among prisoners suggests that this population are not only ‘traumatisers’ but are also ‘traumatised’. These findings can be used to inform program development for the treatment of traumatised prisoners. Those with PTSD and high harm-avoidance may be assisted with strategies which focus on enhancing self-directedness.

Schizophrenia and Violence: an outcome study
Lindsay Thomson and Raj Darjee, Division of Psychiatry, University of Edinburgh: John Crichton and Jon Steele, Royal Edinburgh Hospital; Michelle Davidson, Clinical Psychology Course, University of Glasgow

Introduction: The association between schizophrenia and increased incidents of violence is now widely accepted. Strategies must be developed to allow for the safe management of these patients, particularly those who have been physically violent. This study examines the ten year outcome of a cohort of patients with schizophrenia initially resident in high security psychiatric care.

Method: Between 1992-3 all patients resident in high security psychiatric care were subject to a detailed study including case note examination, patient and staff interviews. Between 2000-2001 all 169 patients with schizophrenia were followed-up. Data were collected from case notes, criminal records, and interviews. Measures of risk assessment (PCL-R, VRAG and HCR-20 - historical only) were applied retrospectively.

Results: Results will be presented on the psychopathology, treatment, progress through rehabilitation, offending, violence, substance abuse and social functioning of the cohort in 2001. One-quarter remained in high secure psychiatric care, one-fifth moved to low/medium security, one-fifth to non-secure psychiatric wards, and one-quarter to the community. The usefulness of the risk assessment instruments will be discussed.

Conclusions: Data such as this is required for realistic assessments of prognosis and for the long-term planning of services.

ADHD and its comorbidity in an adult male forensic population – Consequences for diagnostic process and institutional policy
Marijke Drost, Forensic psychiatrist, Utrecht

It is estimated that in the general population about 1% of adults suffers from Attention Deficit Hyperactivity Disorder (ADHD). There are indications that in a forensic population even more ADHD is present. The results of a Dutch study of ADHD in a remand center and TBS hospitals will be presented, together with a discussion of comorbidity patterns and the consequences for prison or hospital policy.

Efficacy of medications in the treatment of delusional disorder
Angeline Stanislaus, Forensic Staff Psychiatrist, Chester Mental Health Center, Chester IL, USA

Delusional disorder is the least studied of all psychotic disorders. It is over represented in the Forensic population. Medication refusal among these patients is also common, resulting in judicial or administrative review of their refusal. Does the benefit of psychotropic medications outweigh the risks in these patients? Empirical research supporting efficacy and effectiveness of psychotropic medications in the treatment of delusional disorders is grossly deficient. This research project was initiated to analyze the effectiveness of psychotropic medications in delusional disorder patients. Clinical outcome was measured by days of hospitalization and episodes of readmission to the hospital. Comparison of the duration of hospitalization and number of episodes of hospitalizations between the treated and the untreated groups was made. Results showed that treatment of delusional disorders with psychotropic medications decrease the number of days of hospitalization, resulting in better clinical outcome. However, pharmacotherapy does not appear to decrease likelihood of re-hospitalization when treated patients are compared to untreated patients.
Psychiatric dilemmas of adolescence

Patricia White, Psychiatric Consultant, California Youth Authority

The diagnosis of mental disorders in a juvenile correctional population presents unique problems. This paper focuses in part on the diagnostic dilemma of differentiating between genuine psychiatric illness requiring treatment and adjustment disorders of adolescence that will subside of themselves with future growth and maturation. A second dilemma is also explored. Psychiatric conditions such as Bipolar Disorder, Posttraumatic Stress Disorder, Attention Hyperactivity Deficit Disorder, Impulsivity/Compulsivity Spectrum Disorder and Borderline Personality Disorder present with similar symptoms and are difficult to differentiate. A discussion of ways to improve the reliability of diagnostic judgments in this population concludes the presentation.

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Crime, Violence and Substance Abuse

The relationship between substance abuse and personality factors in a NSW prisoner population utilising the TCI

James Stallard, New South Wales Corrections Health Service; Stephen Allnutt and Tony Butler, Dept. of Psychiatry, University of New South Wales

Substance abuse is correlated with increased risk of criminal recidivism. It is a dynamic risk factor that if neutralised likely will have a significant impact on the rate of offending in the community. In any rehabilitation programme underlying personality factors play a role in motivation to engage in treatment, apply acquired skills and maintain abstinence. Utilising Cloningers Temperament Character Inventory (TCI), this paper examines the dimensional differences in temperament and character traits between prisoners who abuse and do not abuse substances. The paper also considers the possible relationships between personality and drug of choice

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Psychiatric morbidity in the Irish prisons population: Sentenced men

S. Linehan, D. Duffy, K. Curtain, B. Wright and D. Mohan, National Forensic Psychiatry Service, Dublin; H. Kennedy, Dept. of Psychiatry, University of Dublin

Objective: To find the prevalence of mental illness and substance abuse problems amongst sentenced men in prison in Ireland.

Methods: Stratified random sample of sentenced males (15% of 2320 fixed sentences, all of 126 life sentences), in the Irish prison population. The research ethics committee granted approval and informed written consent was given by all participants. The sample included all places of detention in the state, of those approached, 340 of 535 on fixed sentences and 98 of 120 serving life sentences were interviewed. The interview sample did not differ significantly from the full population in age or sentence length, or in the independent variable time served. Those who refused did not cause any detectable bias. We used the SADS-L, SODQ and a semi-structured standardised interview for further demographic and personal details.

Results: The life-sentenced prisoners differed from those on fixed sentence. Overall, the twelve-month prevalence of psychosis (ICD-10 F11.5-F34) was 2.4%, for major depression 13%, anxiety disorder 14%. Lifetime prevalence of harmful use or dependence on alcohol or drugs (ICD-10 Research Diagnostic Criteria F10.1-F19.2) was 86%. Only two of the 19 with a lifetime diagnosis of psychosis did not have a history of alcohol or drugs problems, but this did not differ significantly from the non-psychotic prisoners.

Conclusions: The prevalence of mental illness is very high, though no higher than in reports from other jurisdictions. Mentally ill prisoners have a very high prevalence of co-morbid drugs and alcohol problems. Substantial numbers would benefit from hospital treatment.

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Psychiatric morbidity in the Irish Prisons population: Remanded men

K Curtain, D Duffy, B Wright, S Linehan and H O’Neill, National Forensic Psychiatry Service, Dublin; H. Kennedy, Dept. of Psychiatry, University of Dublin

Objectives: To find the prevalence of mental illness and substance abuse problems amongst men remanded to prison (jail) in Ireland as these relate to service needs.

Methods: The research ethics committee granted approval and informed written consent was given by all participants. The remand population is in four places of detention in the state, 318 in one prison and 123 in the remaining three. We interviewed 103 of the 123, and 119 of the 318. Prevalence rates are corrected accordingly to represent the whole population. Those who refused did not cause any detectable bias. We used the SADS-L, SODQ and a semi-structured standardised interview for further demographic and personal details.

Results: Rates of psychosis and major depression were higher than in the sentenced population. Sixty four (29.1%) of 222 remand prisoners were seeing attending prison psychiatric clinics, 38 (17.2%) were attending prison drugs clinics and 32 (14.5%) were on methadone maintenance. However 17 (7.8%) needed referral to a
psychiatrist and 11 (5%) needed urgent transfer to hospital. One hundred and twenty three (55.7%) needed referral to a drugs clinic and 103 (46.6%) needed help with alcohol problems. Overall, 133 (60.2%) would benefit from referral to a psychiatric clinic on release from prison and 100 would benefit from referral to a drugs or alcohol service on release.

Conclusions: The demographic and social backgrounds of sentenced and remanded men are very similar. There is a higher prevalence of severe mental illness in the remand population, and a substantial unmet need for mental health services and for drugs and alcohol services.

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The incidence of aggression and crime among regular amphetamine users

Melissa Claire, Amanda Baker and Terry Lewin, Centre for Mental Health Studies, University of Newcastle; Nicole Lee, Turning Point Alcohol & Other Drug Centre, Fitzroy, Vic.; Sonja Pohlman, Prince Charles Hospital and District Health Service, Brisbane

The relationship between psychostimulant use and aggression is well documented in both the medical and social literature, describing how the potential combination of the psychoactive effects of psychostimulants - excessive confidence, energy and paranoia - can include dangerous and aggressive behaviour. Certainly the association between aggression and paranoid delusions is predictable since delusions of potential threat from others induce a combative response in many people. With reports of increasing use of amphetamine in Australia, there is a need to focus on the links between aggression and amphetamine use. This presentation will report on the incidence of anger and aggression among regular amphetamine users and discuss the outcomes of using cognitive behaviour therapy as an intervention for this group.

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When psychiatric evidence is presented in court for the purposes of mitigation it often constitutes a form of special pleading. This results, to a large extent, from the way in which the evidence is gathered, selectively assembled and presented. Complete objectivity is an admirable goal but impossible to achieve. The problem, however, is not entirely on the side of the psychiatrist. The courts also bear a responsibility in that they often fail to adequately assess the value of psychiatric evidence, partly because they do not always understand it, partly because it may be a convenient (and sometimes humanitarian) way of disposing of the case. These issues are explored in the context of the connection between depression and shoplifting. Depression is common. Shoplifting is common. A tiny proportion of people who shoplift are depressed. If a psychiatric report says that a person was depressed at the time they attempted to steal from a shop, this may be accepted by the court as a reason for mitigation. In doing so, courts may be making a fundamental logical flaw by equating coexistence and causality. The connection, if any, between mental disorder and criminality must be demonstrated, not simply assumed.

Serving Two Masters? Ethical Aspects of the Mental Health Professional Serving as Expert Witness and Clinician

Colin Holmes, School of Nursing Sciences, James Cook University

The Ethical Guidelines of the American Academy of Forensic Psychiatry state that ‘a treating psychiatrist should generally avoid agreeing to be an expert witness or perform an evaluation of his (sic) patient for legal purposes’. The theme was extended by Brodsky, of the Harvard Medical School, in his article in the American Journal of Psychiatry (April 1997) in which he pointed to inevitable role-conflicts for psychotherapists who attempt to wear the two hats of therapist and expert witness. In this paper I will review and assess the rationale for the separation of these roles as they concern any clinician called to provide expert testimony to criminal and mental health courts. The paper will concentrate on the ethical issues involved, and outline some of the implications for the ethical conduct of forensic psychiatric evaluations in Australia.

responsible treatment of psychotropic drug effects in criminal proceedings

Mark J. McMahon, Australian and New Zealand Coalition of Clubhouses


Colin.Holmes1@jcu.edu.au

Diminished responsibility in mitigation of sentence (akathisia by Sertraline ingestion). Defence produced a single expert witness from an overseas university; Prosecution declined to produce any contrary evidence, nor cross-examined expert. Judge did not critique any evidence. Zoloft manufacturer not heard. Lack of evidentiary process or balance. Consequent unchallenged statements like “suicidality/homicidiality can arise as a consequence of the drug…” approved by default in judgement.
Yet sertraline is common SSRI, prescribed for major depression. Media report: Royal Australian and New Zealand College of Psychiatrists worried that decision might cause panic in patients who were taking Zoloft or other anti-depressants and warned them against stopping their medication without first seeing their doctor.

Australian Department of Health and Aged Care maintains an Adverse Drug Reaction System. However, lack of legal obligation on medical practitioners, pharmacists or suppliers to advise Department of adverse reactions. Quality assurance of System?

How can this NOT be an area necessitating legal public policy rules to ensure congruence between just criminal proceedings on the one hand, and humane and effective mental health policy on the other? Appropriate evidentiary rules and practice, as well as public interest guidelines will be considered.

MarkMcMahon1@netscape.net
Break 10:00–10:30

**Young Offenders** 10:30–12:30

Chair: **Roger Dive**, Senior Children’s Magistrate, New South Wales

Psychopathology in female juvenile offenders – Untreated and underserved
**Angela Dixon** and **Jean Starling**, Department of Psychological Medicine, Children’s Hospital at Westmead; **Pauline Howie**, School of Psychology, University of Sydney

Caring for young offenders. A collaboration between NHS and Prisons

Creating space for young people, dialogue and decision making: A perspective on Youth Justice Conferencing in New South Wales, Australia
**Jane Bolitho**, School of Social Science and Policy, University of New South Wales

Multisystemic treatment of youth offenders in Australasia: Preliminary findings and future directions
**Nicola Curtis**, School of Psychology, Massey University; **Naamith Heiblum**, MST New Zealand, Christchurch

Outpatient treatment for young offenders with a psychiatric disorder: How to contribute through timely assessment and diagnosis, early help and prevention
**Jos Rietveld**, Board of Accare, Groningen; **Peter van der Noord**, Accare, Outpatient Clinic for Forensic Juveniles, Assen

Lunch 12:30–13:30

**Dangerousness and Risk Assessment** 13:30–15:30

Chair: **The Hon. Justice Virginia Margaret Bell**, Supreme Court of New South Wales

Capacity and confinement: Can we escape dangerousness?
**Peter Bartlett**, School of Law, University of Nottingham

Multi-agency public protection: A new approach to liaison between community forensic mental health and law enforcement – The UK experience
**R. Taylor**, Frank Farnham and **David James**, North London Forensic Service

The involvement of mental health service users considered to pose a risk to others in risk assessment and risk management
**Joan Langan** and **Vivien Lindow**, School for Policy Studies, University of Bristol

The impact of population attributable risk on mental health risk assessments in emergency department presentations
**Patrizia Fiorillo**, School of Public Health, University of Sydney

Break 15:30–16:00

**Patterns of Violence** 16:00–17:30

Chair: **Julio Arboleda-Florez**, Dept. of Psychiatry, Queen’s University

A national study of homicide in New Zealand: Incidence and time trends in mentally abnormal homicide 1970-2002
**Sandy Simpson**, Division of Psychiatry, University of Auckland; **Brian McKenna**, School of Nursing, University of Auckland; **Andrew Moskowitz**, Dept. of Psychology, University of Auckland; **Jeremy Skipworth** and **Justin Barr-Walsh**, Capital and Coast District Health Board, New Zealand

Towards identification of individuals with dangerously structured psychiatric disorder
**Antoine de Kom**, Forensic Psychiatrist, Pieter Baan Centre, Utrecht

Stalking and Erotomania (featuring the case report of a telephone stalker)?
**Thomas Knecht**, Munsterlingen Psychiatric Clinic

Conclusion 17:30
Young Offenders, Dangerousness & Violence

Abstracts

Young Offenders

Psychopathology in female juvenile offenders – Untreated and underserved
Angela Dixon and Jean Starling, Department of Psychological Medicine, Children’s Hospital at Westmead; Pauline Howie, School of Psychology, University of Sydney

Objective: While it is well established that psychopathology is common among male juveniles in custody, relatively little is known about the mental health needs of young female offenders. This study documents the spectrum of present and lifetime psychological disorders in female juvenile offenders and examines the relations between mental health status and sociodemographic, family and trauma variables. Method: One hundred juvenile offenders were matched with 100 female controls on age and socioeconomic status (SES). Psychological profiles and trauma histories of both groups were assessed using the K-SADS-PL semi-structured interview. A self-report measure was used to assess family functioning. Results: Rates of trauma and psychopathology were higher for offenders than controls (p < .001), with particularly high levels of conduct disorder (91% v. 1%, p < .001), substance abuse disorders (85% v. 5%, p < .001), depression (55% v. 25%, p < .001) and posttraumatic stress disorder (37% v. 4%, p < .001). In the offenders, 78% met the criteria for three or more diagnoses. The number of psychiatric diagnoses was the most significant factor associated with offender status (OR = 21.26, p < .001). Conclusions: There is a high prevalence of psychological disorder in females in juvenile justice custody and this has a very strong association with offender status. Because these co-morbid disorders are treatable, there is a clear opportunity to intervene to decrease psychological distress. Primary and secondary preventative efforts targeting associated risk factors are also crucial to reduce the long-term outcomes of psychiatric disturbance in these young women.

Caring for Young offenders. A collaboration between NHS and Prisons
Kevin Cleary, Forensic Psychiatrist, London; Azer Mohammed, Senior Registrar in Child Psychiatry, London

Feltham Young Offenders Institute is the prison service institution caring for young offenders in the London and South East of England Regions. Holding young offenders between the ages of 16 and 21 years it has a maximum capacity of 800 young people. For the last two years the provision of healthcare has been managed by the National Health Service (NHS) with almost all clinical care provided by the local NHS Trust. This unique model of care for a young offenders institute in England has led to a significant alteration in the focus of healthcare provision in Feltham. An extensive structured health needs assessment was undertaken in late 2002 using the Salfords Needs Assessment Schedule for Adolescents. For the purpose of the needs assessment three groups were considered: Juveniles (age 15-17), Young Adults (age 18-20) and those young people who were resident in the inpatient healthcare centre (age 15-20). There were significant differences between three groups with a trend to increasing mental health needs with age. The mental health needs of the inpatient group were markedly greater on almost all indicators of need. All three groups had problems with substance abuse.

Creating space for young people, dialogue and decision making: A perspective on Youth Justice Conferencing in New South Wales, Australia
Jane Bolitho, School of Social Science and Policy, University of New South Wales

This paper reports on initial results of an empirical study of Youth Justice Conferencing, a diversionary program for young offenders in New South Wales, Australia. The field research involved the observation of 85 Youth Justice Conferences, and a survey completed by 140 Youth Justice Conference practitioners: Police Officers, Convenors, and Managers. These results will be used to highlight some psychological, social, structural, and practical challenges facing participants and practitioners. In particular it will reflect on the social psychological nature of decision making and group dynamics, the expression and regulation of emotion, adolescent emotional, cognitive and moral development, social demographic characteristics, and the nature and consequences of support networks particularly where victims and young offenders are also coping with specific mental health, social, and physical impairments. Thus it will focus on the intra and inter personal processes that influence the potential for serious adolescent offenders to actively participate in, and benefit from, the dialogue and decision making unique to Conferencing.

Multisystemic treatment of youth offenders in Australasia: Preliminary findings and future directions
Nicola Curtis, School of Psychology, Massey University; Naamith Heiblum, MST New Zealand, Christchurch

MST is a time-limited, intensive and individualised home-based treatment model that effectively reduces youth offending by targeting the multiple risk and protective factors associated with serious antisocial behaviour in youth. Using an ecologically valid, strength-based approach, MST empowers caregivers and other informal supports (e.g., extended family, teachers, community organisations) to develop the necessary skills and
Young Offenders, Dangerousness & Violence

competencies to achieve positive, sustainable changes in the youth’s behaviour. Over 25 years of rigorous research, MST has demonstrated such long-term outcomes as reduced recidivism, drug use, and days in out-of-home placement for youth, as well as improved school attendance, pro-social peer relationships, and adaptive family functioning. Moreover, MST has been shown to effectively reduce youth antisocial behaviour across multiple replications and over a broad range of clinical presentations, service providers, and community settings. Given these results, MST has been widely acknowledged as an effective therapeutic programme with the potential to bring about significant changes in the care and treatment of antisocial youth, both in Australasia (e.g., McLaren, 2000; Ministry of Justice, 1999) and overseas (Kazdin & Weisz, 1998; McLaren, 2000; Stanton & Shadish, 1997).

Outpatient treatment for young offenders with a psychiatric disorder: How to contribute through timely assessment and diagnosis, early help and prevention
Jos Rietveld, Board of Accare, Groningen; Peter van der Noord, Accare, Outpatient Clinic for Forensic Juveniles, Assen

The question which we as Forensic Outpatient Department for young people address is how to avoid the continuation or start of delinquent behaviour through timely assessment & diagnosis, early offered therapeutic help and prevention. Additionally how can developmental stagnation be quickly righted enabling young people to learn, internalise and go on to display socially acceptable behaviour. How we currently approach these questions and our thoughts for the future concerning further developments, necessary for an appropriate service provision and effective interventions in our region and for our target group, these are the points that we will cover in this contribution.

The focus of our attention, the formulated goals, developments in the field of group therapy, possibilities for treatment and for scientific research, these will be addressed.

Important in the mandate that we were given and directly to the fore in daily practice is the intensive collaboration with other care providers, especially those in the judicial circuit.

Since the opening of our outpatient department one and a half years ago, it has become more than clear to us that we are working in a relatively uncultivated new area, with a difficult and often unmotivated target group, but on the other hand with many possibilities. Possibilities especially regarding the collaboration, scientific research and joint approaches to treatment of young people who frequently wish that it could be different but for whom it continues to go wrong.

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Dangerousness and Risk Assessment

Capacity and confinement: Can we escape dangerousness?
Peter Bartlett, School of Law, University of Nottingham

The amendments proposed by the government to the Mental Health Act 1983 in England and Wales have been universally unpopular. Much of the resistance has centred on an increased emphasis on risk as the justification for the imposition of mandatory powers. This has proven particularly controversial regarding persons with personality disorders, who under the 1983 could not be subjected to mandatory powers unless they were treatable. While the critics of the proposed amendments speak with one voice as to what they oppose, there is no consensus as to what the criteria for intervention ought to be. In a world where we favour non-discrimination on the basis of mental disability as a principle, capacity would seem at least in theory to be the obvious choice.

This paper will examine how far this approach can be used as a criterion for the exercise of mandatory powers. It accepts that such an approach is practical and desirable for treatment decisions, but it argues that capacity should not be the guide for decisions regarding confinement. The difficulty is how capacity in such a context is to be defined: it seems for confinement decisions, an understanding of one’s level of dangerousness if left in the community must be a part of the calculation. If that is correct, then both an individual’s actual dangerousness and their understanding of their dangerousness enter the equation through the back door. We cannot in the end escape dangerousness, and the appropriate approach is therefore to face the issue head on, through the articulation of a clear test of dangerousness, rather than to bury the assessment in the more abstract criteria relating to capacity. Sadly, the criteria in the most recent (June 2002) draft bill published by the government do not meet even rudimentary standards of legislative clarity. We should be pressing for better drafting rather than a different standard.
peter.bartlett@nottingham.ac.uk

Multi-agency public protection: A new approach to liaison between community forensic mental health and law enforcement – The UK experience
R. Taylor, F. Farnham and D. James, North London Forensic Service

Against a background of increasing international concern about public protection and an impetus to manage more closely those perceived to be high risk of serious offending, there has been a series of new laws in the UK aimed at improving public protection. A description of the legislative changes and of newly-established ‘multi-agency public protection panels’ will be given. The contrast between the public protection agenda and patient care in
Young Offenders, Dangerousness & Violence

forensic community outreach work will be set out. Research data on the first twenty-five “public protection” referrals dealt with by a forensic community outreach service in central north London will be presented. Serious concerns about confidentiality issues will be discussed, as well as possible conflicts with European human rights legislation, now incorporated into English law.

david.james5@ntlworld.com

The involvement of mental health service users considered to pose a risk to others in risk assessment and risk management

Joan Langan and Vivien Lindow, School for Policy Studies, University of Bristol

Mental health policy and practice in the United Kingdom is being driven by two contradictory impulses. Moral panic about the perceived dangerousness of people defined as mentally ill is leading to the development of increasingly coercive mental health services at the same time as service users’ views about the components of a supportive mental health services is given greater credence. Little is known about the views and perspectives of the individuals most likely to be subject to coercion – those who are considered to pose a potential risk to other people. There is also little guidance available to mental health professionals on how to involve people who are considered to pose a potential risk to others in risk assessment and management. The presentation will use findings from a qualitative research study that explored the extent to which mental health service users considered to pose a potential risk to others were involved in risk assessment and risk management. The research is based upon interviews with service users, professionals involved in their care and relatives or friends. Interviews took place as service users were being discharged from psychiatric hospital into the community and six months later. The presentation will consider how the topic of risk was discussed with service users; the extent to which service users, professionals and relative or friends agreed about the level and nature of any risk; factors influencing agreement; the implications of inaccurate information and gaps in information exchange about risk for service users and professionals; the extent of service user involvement in risk management plans; dilemmas and concerns for mental health professionals seeking to involve service users; how helpful service users found the support offered in terms of managing risk Recommendations for good practice informed by the research will also be discussed.

j.langan@bris.ac.uk

The impact of population attributable risk on mental health risk assessments in emergency department presentations

Patrizia Fiorillo, School of Public Health, University of Sydney

Violence, to self or others, has been viewed by society as an inherent consequence of mental illness. This assumed risk has led to people with a mental illness being assessed with Occupational Health & Safety or with professional and/or service liability in mind. Assessing risk according to a category denies the person presenting with mental health problems the ethical right to be assessed, and treated, as an individual. Data gathered from mental health presentations to a busy Emergency Department on the use of mental health legislation and Security Officers has led to the development of a research study to explore the use of clinical, rather than category, risk assessment in practice. The data collected and the study proposed will be presented.

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Patterns of Violence

Towards identification of individuals with dangerously structured psychiatric disorder

Antoine de Kom, Forensic Psychiatrist, Pieter Baan Centre, Utrecht

This theoretical paper presentation aims to introduce the development of a method designed to appraise evidence of psychopathological causation in forensic psychiatric assessments. The background situation is that psychiatric disorders are traditionally examined for statistical associations with offences in samples rather than among individual persons. Proving that a disorder has really caused a person to offend violently might have received too little methodical attention. As a Dutch forensic psychiatrist, I have been following the British debate about Dangerous Severe Personality Disorder, thinking: how could it be proven that ‘severity’ leads to ‘dangerousness’ in the individual? Shouldn’t we try to discover to what extent it can be proven that a disorder causes a person to become dangerous? In our psychiatric observation clinic, the Pieter Baan Centre, we search for robustness of evidence whenever a disorder of any severity may have been a causative factor at the time of the offence. I would like to explain the idea of Structural Causative Evidence Mapping (SCEM). This approach requires formulation of general forensic causation criteria such as pre-conditional psychopathological necessity, sufficiency, and the presence of precipitating events. SCEM is my attempt to superimpose a person’s structural crime characteristics on his mental disorder to reveal inherent specific traits common to both disorder and offence. Once general causation criteria are found to have been met, the robustness of proof of a specific causative link between disorder and offence increases when this structural link proves to be manifold, repetitive or actualized. The application of SCEM will be illustrated in a number of case vignettes.

a.dekom@pbc.dji.minjus.nl
A national study of homicide in New Zealand: Incidence and time trends in mentally abnormal homicide 1970-2002

Sandy Simpson, Division of Psychiatry, University of Auckland; Brian McKenna, School of Nursing, University of Auckland; Andrew Moskowitz, Dept. of Psychology, University of Auckland; Jeremy Skipworth and Justin Barr-Walsh, Capital and Coast District Health Board, New Zealand

Public perception is that mentally ill people are causing increasing public harm, generating increased stigma against those who suffer mental illness. Taylor and Gunn (1999) demonstrated that in relation to homicide in England and Wales, such a perception was inaccurate. They found that post deinstitutionalisation the absolute numbers of such events had changed little and their proportion of total homicide had declined. We are studying the same issue in New Zealand. We will present the results of a similar study looking at all homicides [including murder, manslaughter, infanticide, and murder suicide] over a 32 year period, and present the absolute rate and time trends of offences attributable to mental illness on the part of the perpetrator. Implications for service delivery, and media depictions of such issues will be discussed.

sandy.simpson@waitematadhb.govt.nz

Stalking and Erotomania (featuring the case report of a telephone stalker)?

Thomas Knecht, Munsterlingen Psychiatric Clinic

Stalking can be defined as an excessive and often offensive striving for personal contact with a target person mainly of the opposite sex which in many cases happens to be a celebrity. In single cases, this persecutory behavior can lead to violent assaults and bodily harm or even death of the stalker’s victim. In many respects, this phenomenon resembles a mental disorder named erotomania, which has been described by several authors since antiquity. The lecturer presents a case report of a young man with minimal mental retardation stalking a woman in the neighborhood exclusively by telephone. Further, he provides an historical and clinical overview of the subject.

thomas.knecht@kttg.ch
**Parallel Sessions and Themes of the 28th International Congress on Law and Mental Health**

### Friday, Oct. 3, 2003

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<td><strong>Perth Room (3rd Floor)</strong></td>
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<td><strong>Mental Illness and Intellectual Disability in the Criminal Justice System</strong> (p. 103)</td>
<td>Mental Illness and the Criminal Justice System</td>
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<td>Closing Session Keynote and Panel</td>
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<td>Mental Illness and Intellectual Disability in the Criminal Justice System</td>
<td>The New Zealand Experience</td>
<td>Legal, Ethical &amp; Financial Issues in Community Psychiatry</td>
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<td><strong>Caring for the Mentally Ill</strong> (p. 107)</td>
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<td><strong>Current Issues in Corrections</strong> (p. 113)</td>
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<td>Workshop: Predicting Recidivism</td>
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<td>Children’s Rights – New Issues, New Challenges</td>
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<td>Human Rights and Mental Health</td>
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<td>Choosing Death: Euthanasia &amp; Suicide</td>
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<td>Globalisation, Health and Human Rights</td>
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**Evening Events:**

Annual General Meeting of the International Academy of Law & Mental Health  
*Brisbane Room (3rd Floor)* 17:45-18:15

CONGRESS SOCIAL EVENT – Closing Banquet
## Mental Illness & Intellectual Disability in the Criminal Justice System

### Oct. 3, 2003 (8:30–12:30)  
Perth Room (3rd Floor)

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<tr>
<td>8:00–8:30</td>
<td>Registration</td>
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<tr>
<td>8:30–12:30</td>
<td><strong>Mental Illness and the Criminal Justice System</strong></td>
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<td>Chair: John Feneley, Assistant Director General, New South Wales</td>
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<td><strong>Protecting the human rights of the mentally ill:</strong></td>
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<td><strong>Contemporary Challenges for the Australian Criminal Justice System</strong></td>
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<td>Duncan Chappell, President, Mental Health Review Tribunal of New South</td>
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<td>Wales</td>
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<td><strong>Asperger’s disorder meets Mr. Potato Head</strong></td>
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<td>Dan Howard, Office of the Department of Public Prosecutions of New</td>
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<td><strong>The unimportance of M’Naghten’s</strong></td>
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<td>Jonathan Carne, Forensic Psychiatrist, Sydney</td>
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<td>10:00–10:30</td>
<td><strong>Break</strong></td>
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<td><strong>“Folie a deux” as a psychiatric defence to intra-familial homicide</strong></td>
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<td>Stephen Allnutt, Dept. of Psychiatry, University of New South Wales</td>
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<td><strong>Understanding the 1995 amendment to the Israel penal law:</strong></td>
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<td>A challenge for psychiatrists</td>
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<td>Roberto Mester, Sackler Medical School, Tel Aviv University; Yuval</td>
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<td>Melamed, Lev-Hasharon Mental Health Center, Tel Aviv</td>
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<td>**Differences in psychopathology associated with prior criminal</td>
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<td>behaviour among first-episode psychosis patients**</td>
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<td>Runa Munkner, Glostrup University Hospital, Copenhagen</td>
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<td>**Developmental disability and mental illness in the criminal</td>
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<td>justice system**</td>
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<td>Trevor Parmenter, Vivienne Riches and Roger Stancliffe, Centre for</td>
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<td>Developmental Disability Studies, Faculty of Medicine, University of</td>
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<td>12:30–13:30</td>
<td><strong>Lunch</strong></td>
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### Intellectual Disability and the Criminal Justice System  
13:30–15:30

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<td><strong>Chair:</strong> Phillip French, CEO, People With Disabilities NSW</td>
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<td><strong>Representation of the mentally ill and developmentally disabled</strong></td>
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<td>Doug Humphreys, Director Criminal Law, Legal Aid Commission of NSW</td>
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<td><strong>Intelectually disabled offenders and trial competence:</strong></td>
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<td>The novel New Zealand approach</td>
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<td>Warren Brookbanks, Faculty of Law, University of Auckland</td>
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<td><strong>The defendant/offender within the criminal justice system:</strong></td>
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<td>A therapeutic jurisprudence approach to those with intellectual</td>
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<td>Astrid Birgden, Psychology Dept, Charles Sturt University</td>
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<td>15:30–16:00</td>
<td><strong>Prisoners with a disability: What’s the problem?</strong></td>
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<td>Melissa O’Brien, School of Social Policy, University of Melbourne;</td>
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<td>David Sykes, Office of the Public Advocate of Victoria; Sarah Oliver,</td>
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<td>School of Social Work, University of Tasmania</td>
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<td>Ian Freckelton, Barrister-at-Law, Vic.</td>
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<td><strong>PANEL DISCUSSION</strong></td>
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<td>Nick Cowdery, Director of Public Prosecutions, New South Wales</td>
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<td>Sandra Egger, Faculty of Law, University of New South Wales</td>
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<td>Phillip French, CEO, People With Disabilities NSW</td>
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<td>Andrew Haesler, Public Defender, New South Wales</td>
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<td>Her Honour Judge Megan Latham, District Court of New South Wales</td>
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<td>Beverly Raphael, Director, Centre for Mental Health, New South</td>
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<td>South Wales Dept. of Health</td>
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Abstracts

Mental Illness and the Criminal Justice System

Protecting the human rights of the mentally ill: Contemporary challenges for the Australian criminal justice system

Duncan Chappell, President, Mental Health Review Tribunal of New South Wales

In 1993 the Australian Human Rights and Equal Opportunity Commission (HREOC) published a landmark report on the findings of a notable inquiry into the human rights of people with a mental illness. The inquiry included a review of issues affecting mentally ill people who committed criminal offences, and those brought into the custody of police or correctional services. The HREOC report concluded that mentally ill people detained by the criminal justice system were frequently denied the health care and human rights protections to which they were entitled.

In the present paper, a broad appraisal is made of the progress made since the release of the HREOC report to redress this situation, focusing in particular upon policing issues, and the rights of persons found unfit to be tried, or not guilty on the grounds of mental illness.

Asperger's disorder meets Mr. Potato Head

Dan Howard, Office of the Department of Public Prosecutions of New South Wales

The Law’s response to cases involving mental illness and/or intellectual disability has evolved in so piece-meal a fashion that what should be its cutting edge is at times, in truth, a blunt instrument. This paper examines a recent criminal trial by jury in New South Wales of a man accused of indecently assaulting a young woman under his care who suffered from Asperger’s Disorder and schizophrenia. The question of whether or not she consented or was even capable of consenting, and whether or not he believed that she was consenting, exposed some serious anachronisms in the Law’s processes. The jury’s task became all the more complex when the accused raised in his defence his own depression.

The unimportance of M’Naghten’s

Jonathan Carne, Forensic Psychiatrist, Sydney

This paper examines some factors affecting the sentencing of mentally ill offenders in New South Wales. The author draws attention to the way these factors may lead to different sentences for the same crime. The paper examines the clinical consequences of this ambiguity.

“Folie a deux” as a psychiatric defence to intra-familial homicide

Stephen Allnutt, Dept. of Psychiatry, University of New South Wales

This paper discusses the application the various psychiatric defences (insanity, automatism, substantial impairment) that may be available to defendants who commit homicide in the context of shared delusional disorder (folie a deux). Shared Delusional Disorder is not uncommon among members of the same family. Homicides perpetrated by those suffering from mental illness commonly involve family members. This paper will utilise a recent case of intra-familial homicide involving a “folie a trios” to illustrate the applications of the various defences.

Understanding the 1995 amendment to the Israel penal law: A challenge for psychiatrists

Roberto Mester, Sackler Medical School, Tel Aviv University; Yuval Melamed, Lev-Hasharon Mental Health Center, Tel Aviv

In 1995 an amendment was introduced to the Israel Penal Law. The main core of the amendment grants the judge the capacity to decide upon diminished punishment in cases where, previously, there had been a statutory life sentence. One of the sections of this amendment, subsection 300/a/a, deals with the concept of severe mental disorder, short of full insanity, as one of the conditions required for the application of this subsection. The challenges for the psychiatrist relate to the determination of the type of mental disorder and the degree of severity relevant for the application of this subsection and of the causality link. As part of this lecture short cases will be presented summarily and discussed. A critical analysis of the present version of subsection 300/a/a/ will also be included. The guidelines recently set out by the Israel Psychiatric Association for the preparation of a medical report for the court in cases of diminished punishment pleas will also be presented and discussed.

Differences in psychopathology associated with prior criminal behaviour among first-episode psychosis patients

Runa Munkner, Glostrup University Hospital, Copenhagen

Background: Since many schizophrenia patients have committed crimes prior to their first contact with the psychiatric hospital system, a possibility is offered for early detection in the judicial system.
Aim of the study: To analyse the temporal relationship between the first psychotic symptoms and first contact to the judicial system and the psychiatric hospital system respectively among individuals with a disorder in the schizophrenia spectrum. To determine which psychopathological features characterise the patients who begin a criminal or a violently criminal career before their admission with first-episode-psychosis and which psychopathological features separate them from the schizophrenia patients who have not committed any registered crime previously.

Population: In Denmark the opportunities for register-based studies are as good as can be owing to thorough, comprehensive and accurate registers and the fact that all Danes have a civil registration number, making linkage across time and registers very accurate. Data concerning psychiatric hospital admittance and criminality were linked to data from the Danish National Schizophrenia Project, in which psychopathology, duration of untreated psychosis (DUP) and premorbid function was rated at admission for first-episode psychosis.

Results: The differences in psychopathology associated with prior criminal behaviour among first-episode will be presented and discussed.

Developmental disability and mental illness in the criminal justice system
Trevor Parmenter, Vivienne Riches and Roger Stancliffe, Centre for Developmental Disability Studies, Faculty of Medicine, The University of Sydney

There has been increasing international, national and local recognition of the need for more appropriate responses and services for individuals who come in contact with the criminal justice system and who have an intellectual disability and mental health issues. This paper will provide an overview of prevalence data that indicates a significant over representation of people with intellectual disabilities in correctional facilities and review the problems facing this population. Findings from two specific evaluation studies undertaken by the Centre for Developmental Disability Studies will also be presented, along with recommendations for future provision based on these results. One of these projects trialled a case management approach to supporting offenders with an intellectual disability upon their release from prison. The twenty month follow along found that a number of serious barriers were encountered within the overall system of provision for this population, the most serious of which related to lack of adequate accommodation upon release. The second project involved a two stage evaluation of one model of provision for individuals with intellectual disabilities who are sex offenders, only some of whom were on parole. This service provided both residential and therapy services in a small group home located in the community. Residents were found to have high levels of emotional and behavioural difficulties, in addition to offending behaviour, that continue to require support and supervision. Critical issues, including guardianship involvement, restrictive practices and retrieval, therapy provision, and risk management issues will be discussed in relation to overall clinical and lifestyle outcomes.

Intellectual Disability and the Criminal Justice System

Representation of the mentally ill and developmentally disabled in criminal trials
Douglas Humphreys, Director Criminal Law, Legal Aid Commission of NSW

Representation of the mentally ill and developmentally disabled poses special problems to counsel. Questions include the model of representation to adopt where the client is unable to give instructions due to their disability through to situations where the client may not wish to rely upon a mental illness defence that is available. The courts expect much greater assistance from counsel where the client is unfit to be tried yet some case law creates a very real tension for the ethical lawyer.

Intellectually disabled offenders and trial competence: The novel New Zealand approach
Warren Brookbanks, Faculty of Law, University of Auckland

In the English common law tradition, the rules governing trial competence have always had a special impact on offenders suffering from intellectual impairment. Arguably, the existence of such a condition, which endures over a lifespan and is largely unamenable to treatment or change, disadvantages those so affected in the trial process because once found to be relevantly impaired they are unlikely to recover the measure of competence sufficient to justify return to trial, and possible acquittal. Yet lengthy psychiatric detention of persons with learning difficulties found to be permanently unfit for trial is inappropriate and may lead to unnecessary stigmatization and isolation of those affected. Nevertheless, legislation in many jurisdictions does not differentiate, for purposes of assessment and disposition, between offenders with mental illness and those with an intellectual disability. This often means that the latter are inappropriately detained in psychiatric hospitals where treatment is neither possible nor necessary. New Zealand is currently in the process of enacting legislation that will provide a separate management "track" for intellectually disabled offenders, including new provisions governing the assessment of trial competence and the disposition of those found to be unfit to stand trial. The paper will examine current law and practice for assessing the trial competency of developmentally impaired offenders and will offer a critique of the proposed New Zealand legislation. It will be argued that in order to properly assess trial competence in
developmentally impaired persons, appropriate support services, including advocacy services, need to be made available and professionals adequately trained to understand the distinct and complex needs of the target group. Failure to do so may compromise just legal outcomes and result in the undesirable incarceration of intellectually impaired offenders.

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The defendant/offender within the criminal justice system: A therapeutic jurisprudence approach to those with intellectual disability
Astrid Birgden, Psychology Dept, Charles Sturt University

Therapeutic jurisprudence is a framework that views legal rules, procedures and the role of legal actors as potential therapeutic agents. Therapeutic jurisprudence is a legal theory that utilises psychological and other social science knowledge to determine ways in which the law can enhance psychological well-being. The good lives model for the rehabilitation of offenders is also designed to enhance psychological well-being. A humanistic approach to the management of defendants and offenders with an intellectual disability at court and in corrections will be outlined. When charged with an offence at court, and when offered rehabilitation programs in corrections, the client with an intellectual disability has to make decisions. The approach will explicate how legal actors should harness the ‘teachable moment’ to increase the autonomy of legal decision-making in clients within the criminal justice system.

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Prisoners with a disability: What’s the problem?
Melissa O’Brien, School of Social Policy, University of Melbourne; David Sykes, Office of the Public Advocate of Victoria; Sarah Oliver, School of Social Work, University of Tasmania

Whilst a number of studies have highlighted the disproportionate number of people with cognitive disabilities ending up in our prison systems, the issue of effective identification, management and rehabilitation of these prisoners fail to be adequately addressed. The Victorian prison system has a variety of programs designed to meet the specific needs of this group. However these programs are often very poorly co-ordinated and under resourced. In the current climate where there is a record number of people being incarcerated which has resulted in the building of more prisons, there seems to be a surprisingly low level commitment by correction authorities to more effectively address the needs of this group. This paper seeks to highlight key aspects of the problem, together with exploring why there has not been a more planned response to the needs of these prisoners. A proposal outlining the key elements of an approach to this issue is advanced, as well as what needs to be emphasised if correctional authorities are going to be persuaded to act more decisively on this issue.

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Session Keynote

Offenders with Mental Illnesses and Intellectual Disabilities: Participation Capacity, Culpability Estimation and Risk Evaluation
Ian Freckelton, Barrister-at-Law, Vic.

The criminal law has traditionally made assumptions about accused persons’ capacity, sanity and competence. It has formulated fall-back positions where accused persons/offenders have conditions that limit their ability to participate “satisfactorily” in the legal system. Further dilemmas are encountered where the levels of blameworthiness for such offenders’ actions are equivocal and the risk that they pose, if released back into the community, is not easily quantified.

Conceptualising the trial process, the sentencing process and the reintegration process of offenders with mental illnesses and intellectual disabilities as an exercise constructed to achieve a compromise between accurate fact-finding and minimising counter-therapeutic outcomes for all participants (and potential participants) in the criminal justice process is a constructive step. However, more by way of hard data are necessary to enable courts to make empirically and conceptually legitimate decisions. For instance, more sophisticated understanding of the interplay between mental illness and intellectual disability, on the one hand, and decision-making capacity, competence to understand and risk, on the other hand, is another important objective of research.

Challenges for the IALMH include educating the judiciary about the subtleties of the impact or non-impact of mental illnesses and intellectual disabilities, as well as refining conceptually the ways in which court processes and decision-making can be adjusted to bridge accurate fact-finding and sensitivity to the special needs of accused persons and offenders with disability.

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Fri. Oct. 3, 2003 (8:30–17:45)  Sydney Room (3rd Floor)

Registration 8:00–8:30

The New Zealand Experience 8:30–10:00

Chair: John Dawson, Faculty of Law, Otago University

Investigating the quality of psychiatric care: The New Zealand experience
Ron Paterson, New Zealand Health and Disability Commissioner

Is New Zealand’s Health and Disability Commissioner legislation an example of therapeutic jurisprudence?
Rosemary Godbold, National Centre for Health and Social Ethics, Auckland University of Technology

Some issues arising from New Zealand mental health legislation for mental health nurses
Anthony O’Brien, School of Nursing, University of Auckland

Break 10:00–10:30

Legal, Ethical & Financial Issues in Community Psychiatry 10:00–12:30

Chair: Jagannathan Srinivasaraghavan, Department of Psychiatry, Southern Illinois University School of Medicine

An international perspective
Jagannathan Srinivasaraghavan, Department of Psychiatry, Southern Illinois University School of Medicine

The concept of Community Psychiatry – Did it prevail?
Veena Garyali, State of New York Dept. of Mental Health

An Australian Perspective
Elsa Bernardi, New South Wales Dept. of Health

India, the United Kingdom and New Zealand – A comparison
Mina Bobdey, Waitemata District Health Board, Auckland

A Canadian perspective
Varadarajan Raghuraman and Anusha Raghuraman, Dept. of Psychiatry, North York General Hospital, Toronto, Canada

Break 10:00–10:30

Involuntary Treatment 13:30–17:30

Chair: Virginia Aldigé Hiday, Department of Sociology and Anthropology, North Carolina State University

Conceptions of liberty in compulsory community care
John Dawson, Faculty of Law, Otago University

Involuntary treatment in the community: defining good practice in the use of Community Treatment Orders (CTOs)
Lisa Brophy, North West Area Mental Health Service, Melbourne

Outpatient commitment in New Zealand: A comparison study
Brian McKenna, School of Nursing, University of Auckland; Sandy Simpson, Division of Psychiatry, University of Auckland; John Coverdale, Waitemata District Health Board, Auckland

Community Treatment Orders: A study from the experiential viewpoint of consumers
Rowan Davidson and Tim Rolfe, Office of the Chief Psychiatrist, Dept. of Health of Western Australia

A nine year population experience with outpatient commitment
Steven P. Segal, School of Social Welfare, University of California; Philip Burgess, Mental Health Research Institute, University of Melbourne

Break 15:30–16:00

Psychosis and involuntary hospitalisation in Victoria: A pilot study on family perspectives within the debate
Annemarie Skegg, Alfred Mental Health Service, University of Melbourne

Reframing consent: Capacity to refuse treatment
Cath Roper, School of Postgraduate Nursing, University of Melbourne

Discussant: John Grigor, School of Medicine and Health Sciences, University of Otago

End of Congress 17:30
Mental Health Care – The New Zealand Experience

Investigating the quality of psychiatric care: The New Zealand experience

Ron Paterson, New Zealand Health and Disability Commissioner

In New Zealand, mental health services must be provided in accordance with the Code of Health and Disability Services Consumers’ Rights. In particular, mental health consumers have the right to have services provided with reasonable care and skill, and in compliance with legal, professional, ethical, and other relevant standards. Any person can complain to the Health and Disability Commissioner about an alleged breach of the Code of Rights. The Commissioner’s focus is on protecting and promoting consumers’ rights through complaint resolution, not retribution. Complaint resolution strategies include referral to an independent advocate, liaison with another agency, referral to a mediator, and investigation of more serious allegations. Several case studies from the Commissioner’s Office illustrate the role of expert advisors during the investigation process, the use of mental health standards in determining the appropriate standard of care, and the concept of “reasonable actions in the circumstances”.

Is New Zealand’s Health and Disability Commissioner legislating an example of therapeutic jurisprudence?

Rosemary Godbold, National Centre for Health and Social Ethics, Auckland University of Technology

This research critiques New Zealand’s unique Health and disability Commissioner Act by applying the lens of therapeutic jurisprudence. The Health and Disability Commissioner (HDC) is the ultimate arbiter in complaints of breaches of the Code of Health and Disability Services Consumers’ Rights (the Code). The Code provides the legal framework under which providers must plan and provide health and disability services (Townshend and Sellman, 2002). The purpose of the complaints procedure is to promote and protect the rights of all health and disability service consumers, and to secure the fair, simple, speedy and efficient resolution of complaints relating to infringement of those rights (Section 6). The emphasis of the complaints process is on dispute resolution and recommendations to prevent reoccurrence. Selected opinions are published on the publicly accessible HDC web site to fulfill the educational imperative of the legislation. Examination of published opinions is revealing, and suggests answers to the following questions:

- How effective is the complaints process at upholding the rights of consumers?
- How do the recommendations resulting from the investigative process exemplify therapeutic jurisprudence?
- Does this unique legislation offer a therapeutic jurisprudential framework for resolution of health and disability service consumers complaints?

This presentation aims to explore answers to these questions through examination of the Code and a selection of published HDC opinions.

Some issues arising from New Zealand mental health legislation for mental health nurses

Anthony O’Brien, School of Nursing, University of Auckland

The 1992 New Zealand Mental Health (Compulsory Assessment and Treatment) Act was introduced at a time when number of significant changes to mental health service provision were underway. In addition, changes in the preparation of nurses for practice in mental health had seen the closure of hospital based specialist psychiatric nursing programs, and the replacement of psychiatric nurses with generically prepared comprehensive nurses. The new legislation created new roles for nurses at a time when their education and introduction to practice were problematic, to say the least. It also created new expectations of nurses to formally participate in legal processes, and to honour the intent of the legislation to provide mental health care to the least restrictive standard. This presentation will review issues arising for nurses from changes to the legislation. Specific issues covered are: participation in judicial reviews of committal decisions, power to detain patients, surreptitious use of legal processes to pre-empt decisions to detain, and the roles of Duly Authorised Officer and Responsible Clinician. The paper will use a framework of ‘least coercive care’, which recognises an ethical obligation to act against consumers’ autonomy at times, but to limit any coercive actions to the minimum necessary to prevent harm.

Legal, ethical & financial issues in Community Psychiatry

Legal, ethical and financial issues in community psychiatry: International perspectives

Jagannathan Srinivasaraghavan, Department of Psychiatry, Southern Illinois University School of Medicine

This paper from the United States of America will approach the following aspects of Community Psychiatry: 1) Continuity of Care 2) Levels of Care 3) Criteria for Civil Commitment 4) Outpatient Commitment 5) Specialized Services. An excellent aspect of Community Psychiatry in some states is the continuity of care between hospitals and community mental health centers that every patient needing hospitalization is screened; a case worker from the community follows patient recovery through discharge and the discharged patient is seen in the community within a week following discharge. The biggest challenge is developing all appropriate levels of care such as group homes, nursing homes, halfway houses, assisted living and assertive community treatment, so patients do not use the hospital following maximum hospital benefit and the society is not burdened with dangerous patients.
roaming the streets. The criteria for civil commitment changed from ‘need for treatment’ to ‘dangerous to self or others’ resulting in patients getting hospitalized, yet refusing treatment. Overturning the refusal of medications is handled either by an administrative review process or a judicial review process, each with their own advantages and disadvantages. While outpatient commitment is on the statutes of many states, this has not been utilized well due to lack of good mechanism of enforcement. Specialized services such as Substance Abuse treatment, Child and Adolescent services and Geriatric services are highly variable from one state to another and from urban to rural within each state as well. Finally without adequate funding for education, training and setting up appropriate levels of care, community psychiatry has not lived up to its expectations.

The concept of Community Psychiatry – Did it prevail?
Veena Garyali, State of New York Dept. of Mental Health

I wonder what Philippe Pinel or Benjamin Rush would think of the state of community psychiatry if they were alive today. We have come a long way in terms of providing humane and moral treatment for the mentally ill but a lot still remains to be done. The public health models of prevention conceptualized their role in the community as the reduction of disease and its sequelae. In the ‘1950s’ and ‘1960s’ we hoped that metal illness could be prevented from happening. With the advances in biological psychiatry we realized that it was too much to hope for. Different models have been suggested and tried in various settings and forms. The major push for community psychiatry in USA came in the 60s with the idea of opening community mental health centers so that the patients could be served in their neighborhood and could avoid the trauma of dislocation. Lot of money was allocated by the federal government for this cause and Community Mental Health Centers mushroomed all over the country. The republican government which came the 70s and 80s changed the funding source to block grants to the state governments to be phased out over three years. However many factors – the most important being funding – worked against this concept coming to full realization. The presenter aims to present the history of the evolution of community psychiatry in the USA, where it is now, approaches which have furthered the cause, and what have been the main obstacles. The purpose of this presentation is to learn from the past and an attempt at figuring out a model that would serve the mentally ill better.

An Australian perspective
Elsa Bernardi, New South Wales Dept. of Health

The Australian Community Mental Health system is influenced by Federal and State policies and complex funding arrangements. Australia is about to launch its Third National Health Strategy (2003-2008). Its implementation will continue to influence community psychiatry. Ethical issues include conflicts of duty between perceived community needs, those of the carers and consumers.

Of importance in the Australian context at a National level:
• Medicare as a universal provider of health care services – the impact of recent restrictions of Medicare services and GP Shared Care item numbers
• The Pharmaceutical Benefit Scheme – the rationing of expensive medicines according to diagnostic groupings and the ethical dilemmas faced by prescribing doctors
• The National Mental Health Strategy – transfer from psychiatric institution to community and general hospital services, emphasis on promotion, early intervention, consumer involvement and the linkage of outcome measures to funding.
• Crisis in psychiatric nursing and psychiatrists in the public sector.
• A mal-distribution of psychiatric workforce across Australia

At a State level:
• Mental health services are provided through a mixture of public and private delivery. Hospitals and community services are State funded with some funding from Federal coffers. office based (private services) are partly reimbursed by Medicare. The gap between Medicare and real fees has led to more pressure on state funded community services.
• There is a lack of uniform Mental Health Act legislation across States.
• The partial closure of State mental hospitals and the mainstreaming of mental health, including community teams to local area health services, have left a mixed system of care.
• Budgetary restraints have affected Community teams as they compete with general medical services and acute beds.

Models of service include:
• Crisis teams have altered from original models to meet needs eg rural.
• Assertive (or intensive case-management) teams targeting those with serious disability and providing small caseloads.
• Administrative measures such as sectors and integration of services.
I have worked in the field of psychiatry in India, United Kingdom and now New Zealand. Hence I will try to provide perspectives on the subject from my experience from these three countries.

Mental Health services have been separated from the general health sector in organisational, administrative, financial and even professional terms.

However community attitudes are changing. Scientific understanding and treatments of Mental illnesses are improving. As a result the delivery of mental health care is changing. It has shifted from institutional to community based care.

India: India is a large developing country with the second largest population in the world. Health care is provided by government and private sector. Mental health care is both hospital and community based. In some states and metropolitan cities health care system is better than small villages where still mental health care is virtually not existing.

UK: NHS (National Health Service) is the sole provider of the health care. Every patient in UK is entitled to free health care apart from prescription charges. Community psychiatry has taken over the institutional care in last 20-25 years. Primary care trusts are currently developing. The services are very much same in all parts of the country with some differences in delivery of care.

NZ: District Health Boards are the health care providers. Secondary care is free to all NZ residents. A critical part of the mental health services in NZ resides within the hospital and community mental health teams. Mental health commission’s strategy is to assist with the implementation of there ‘Blue print for mental Health services in NZ’, which was published in Nov’98 by sharing the information of services recognised as potential ‘best practice’ models.

Mental health act(MHA) and various other acts used in delivery of mental health care and implementation of it in the community will be discussed. Special features of the MHA regarding community treatment will be highlighted.

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A Canadian perspective

Varadarajan Raghuraman and Anusha Raghuraman, Dept. of Psychiatry, North York General Hospital, Toronto, Canada

It is a general consensus that the best place for a mentally ill person to receive psychiatric care is in his or her own community, closer to his or her natural support network, unless his or her illness behaviour is a threat to his or her physical or mental condition or to others. Developed countries such as Canada have gone a long way in this direction in the past 20 years, yet there is some more distance to be covered. Canada, the second largest country on the earth with its relatively small population of 30 million, consisting of people of varied linguistic and cultural background, faces unique challenges. The Government being the sole provider of the health care, the Federal, Provincial conflict forms the first level of challenge. Health care delivery and Mental Health Act falls in provincial jurisdiction though the funding of the health care is the responsibility of the Federal Government. Maintaining uniformity in the quality of psychiatric care in the community between provinces becomes more problematic in this setting. In Ontario, the most prosperous and populous province of Canada, in patient beds in psychiatric units had been reduced by over 10% in the last 10 years despite an increase in population. Starting Assertive Community Treatment Teams and Court Support systems to serve the seriously mentally ill in the community and to prevent them from falling in the hands of criminal justice system had strengthened the community care. A new legislation was introduced in the year 2000 under the Mental Health Act (COMMUNITY TREATMENT ORDER) to prevent the delay of admitting a non-compliant patient in the community, to the hospital. This created a significant amount of debate in the public and polarized the stake holders. Despite various attempts made by the Government, a substantial number of mentally ill people end up in jail, the ACT teams are bursting at their seams and the welfare of the people belonging to ethnic and linguistic minority groups are still missed out. The validity of the Community Treatment Order is constantly being challenged. there are ways these problems can be addressed and a comprehensive psychiatric care in the community can be realized.

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Conceptions of liberty in compulsory community care

John Dawson, Faculty of Law, Otago University

This paper concerns how patients under Community Treatment Orders conceptualise their own liberty and coercion; and the manner in which compulsory community care can both advance and limit a person’s freedom in different ways and at different points in their life. It is based on qualitative interviews with 42 patients under Community Treatment Orders in Otago, New Zealand; and the wider academic literature.

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Involuntary treatment in the community: Defining good practice in the use of Community Treatment Orders (CTOs)

Lisa Brophy, North West Area Mental Health Service, Melbourne

This paper will begin by discussing national and international literature on community based involuntary treatment of people with psychiatric disorders. It is apparent that the use of CTOs, or variations of them, has increased in the last few decades, despite the fact that there remains considerable opposition to them, in terms of concerns about possible human rights abuses and challenges to professional ethics. Given that CTOs are now commonplace within many mental health systems, questions remain about how critical voices can be both heard and acknowledged so that those working in the field can act with professional integrity and with reference to evidence based practice. The second part of the paper will explore the current legal and professional knowledge base used in the process of applying for and administering CTOs before reporting on the author's own small-scale research into this topic. This involved a case study approach with professionals and service users in Victoria, Australia. This revealed aspects of the decision-making processes, for example in terms of who was most likely to be on a CTO, for which reasons and for how long. The author is also particularly interested in what needs are met and the 'lived experience' of those placed on a CTO. The paper concludes by arguing that good practice should be broadly interpreted to include not only aspects of direct service to these consumers, but also a critical understanding of the impact of policy and legislation. For example, in terms of the optimum length of a CTO and the way that external review processes might be used to enhance positive outcomes.

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Community Treatment Orders: A study from the experiential viewpoint of consumers

Rowan Davidson, Tim Rolfe, Theresa Marshall and Duane Pennebaker, Office of the Chief Psychiatrist, Dept. of Health of Western Australia

CTOs were introduced to Western Australia within the WA Mental Health Act 1996 to articulate a legal process which ensures that patients with a mental illness may receive treatment while living in the community. This is a less restrictive environment than hospital care.

One perspective of this form of compulsory treatment is that it attempts to stop the ‘revolving door’ of admission, discharge and readmission that had become so common for many people with a mental illness. An alternative viewpoint is that CTOs are an infringement of personal liberty and an extension of a psychiatrist’s power, which are contrary to human rights.

Research in the field has primarily been quantitative, evaluating the proposed goals of CTOs such as a reduction of the relapse rate and reduced re-admissions. Research targeted at eliciting the experience of consumers or carers is limited. McDonnell and Bartholomew (1997) reported on consumers who responded to a questionnaire: Carne (1993) reported on the views of carers; Thompson (1993, unpublished) canvassed the views of some consumers in Victoria and Dawson and his colleagues considered the consumers perspective in New Zealand (2002).

Using a Therapeutic Jurisprudence framework the authors consider whether interventions within a legal framework can be perceived as therapeutic for the individual. In addition the result for clinician-consumer relationships in the community when there is the element of compulsion is considered and whether the intervention of a legal process results in a better therapeutic service from the consumer perspective. The authors conducted a series of focus groups with consumers who are on or have been on a CTO as well as eliciting feedback via written submissions and phone calls. The resulting information will be analysed using qualitative research tools to obtain qualitative outcomes.

The results of this research will be presented together with the background issues in the presentation to the IALMH Congress.

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Outpatient commitment in New Zealand: A comparison study

Brian McKenna, School of Nursing, University of Auckland; Sandy Simpson, Division of Psychiatry, University of Auckland; John Coverdale, Waitemata District Health Board, Auckland

In New Zealand, the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 is a significant treatment option for people with long term mental illness. The Act legitimises the use of coercion in long term care through Community Treatment Orders. The legislation also attempts to ameliorate perceptions of coercion by placing obligations on health professionals to include patients in fair decision making processes (‘procedural justice’). We have previously found that there is a strong relationship between legal status and patients’ perceptions of coercion on admission to inpatient services in New Zealand. In this context health professional application of procedural justice principles acts as a buffer against patients’ perceptions of coercion. However patient perceptions of the provision of treatment in the ‘least restrictive environment, using Community Treatment Orders, is not known. Such information is crucial both for clinicians and those involved in the development of health policy. This paper presents the findings of a cross sectional quasi-experimental study designed to research these issues. Reliable and validated psychometric measures of coercion and procedural justice were used to compare the perceptions of outpatients under Community Treatment Orders (n = 70) with voluntary outpatients (n = 70) controlled for by severity of illness.

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A nine year population experience with outpatient commitment

**Steven P. Segal,** School of Social Welfare, University of California; **Philip Burgess,** Mental Health Research Institute, University of Melbourne

Involuntary outpatient commitment (IOPC) is one of the most controversial interventions in the mental health field. It offers the promise of helping individuals with serious mental illness believed to be unable to appreciate their need for mental health services. Alternatively, consumer groups view it as a significant abridgement of patient rights without first offering adequate services. There is a paucity of IOPC research considering how alternative IOPC schemes are used to meet differing clinical needs and what types of services individuals placed on IOPCs actually use. This paper takes the opportunity to consider nine years experience with outpatient commitment in Victoria, Australia. In a system designed on PACT program principles, we look at the clinical patterns of care for the entire state population with IOPC experience. We outline patterns of service utilization of the Victoria population placed on IOPCs between 11/11/1990 & 30/06/2000 (N = 9695). We move beyond previous research in our investigation of a population’s experience over an extended period of time and our explorations of significant differences in patterns of care within the population of those placed on outpatient commitment orders. More importantly, we add some empirical information on how an IOPC policy is actually used for different patients at different points in their treatment careers.

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Psychosis and involuntary hospitalisation in Victoria: A pilot study on family perspectives within the debate

**Annemarie Skegg,** Alfred Mental Health Service, University of Melbourne

**Objective:** This pilot study explores the ethical, legal and practical dilemma of involuntary psychiatric hospitalisation in Victoria today.

**Method:** First it analyses the concerns of key experts in psychiatry, the consumer movement, and family carer movement. Secondly, it analyses the opinions of a sample of family carers in light of their personal experiences. An interpretive qualitative methodology was used.

**Results:** Results indicate many families and their advocates regard the wording of the Mental Health Act 1986 (Vic) positively, but hold significant concerns regarding clinician’s interpretation of ‘the Act’. These results demonstrate the considerable frustration of some at the difficulties of obtaining help when a relative is reluctant to engage with mental health services. Results also indicated families may prefer a model of care emphasising relapse prevention/early intervention through increasing proactive outreach services for those who are difficult to engage in treatment. The insufficient level of federal and state funding of Mental Health Services was a predominant theme. Another prominent theme was the need to reconceptualise the two categories of ‘voluntary’ and ‘involuntary’ treatment more in terms of a continuum.

**Conclusion:** Policy implications are discussed together with the need for further empirical investigation.

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Reframing consent: Capacity to refuse treatment

**Cath Roper,** School of Postgraduate Nursing, University of Melbourne

Current mental health legislation in Australia allows for involuntary detention in a mental health facility, and for the giving of treatment deemed necessary even if it is against expressed preference. This is based upon a notion of perceived capacity to consent. Here’s the rub. The law is saying that a particular person is not capable, does not have the ability or capacity to consent because if it doesn’t say that, we will have to start thinking about unwillingness to consent, or ability to refuse. How does one test for this? Having one’s ability to say no removed is an extremely serious matter. It does not take much to imagine what our communities would be like if refusal was emptied of realisation and meaning. As is often the case amongst those of us who come to the attention of mental health services, our lives have sometimes satellited around repeated experience of having our will over ridden. The combination of having the power to say no removed, being exposed to force or coercion in attempts to implement treatment, and not having preferences respected can be a dangerous product of being ‘helped’ by mental health service use. This paper poses three related questions.

1. What would we do if we did not have a mental health act?
2. Can we assess for capacity to refuse?
3. Can we redefine notions of insight and risk?

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### Current Issues in Corrections

**Fri. Oct. 3, 2003 (8:30–17:30)**

**Melbourne Room (3rd Floor)**

<table>
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<tr>
<th>Time</th>
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<tr>
<td>8:00–8:30</td>
<td>Registration</td>
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<tr>
<td>8:30–10:00</td>
<td><strong>Workshop: Predicting Recidivism</strong></td>
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<td>The process of predicting violent and non-violent offender’s recidivism</td>
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<td>Julio Arboleda-Florez, Dept. of Psychiatry, Queen’s University; Wagdy Loza, Kingston Penitentiary, Canada</td>
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<td>10:00–10:30</td>
<td>Break</td>
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<td>10:30–12:00</td>
<td><strong>Reintegration and Reducing Recidivism: Families, Prisoners and Communities</strong></td>
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<td>Chair: Julio Arboleda-Florez, Dept. of Psychiatry, Queen’s University</td>
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<td>Prisoner social capital and community re-entry: Ties that bind or binds that tie?</td>
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<td>Nancy L. Wolff, School of Planning and Policy, Rutgers University; Jeffrey Draine, School of Social Welfare, University of Pennsylvania</td>
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<td>Reintegrating long term forensic patients back into the community: Rehabilitation and managing risk within a Victorian legislative framework Catherine Dwyer and Jessica Creamer, Thomas Embling Hospital, Melbourne</td>
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<td>Working with angry HIV+ ex-inmates: How to defuse their anger before it becomes violent</td>
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<td>Kevin Fauteux, Clinical Supervisor, Continuum’s Forensics Programs San Francisco</td>
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<td>Pre-release prison humanities programs and prisoner re-entry strategies vs. The United States post-release revolving-door recidivism trap Richard Rabson, Faculty of Law, University of Wisconsin-Madison</td>
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<td>12:30–13:30</td>
<td>Lunch</td>
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<td>13:30–15:30</td>
<td><strong>Treatment &amp; Rehabilitation</strong></td>
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<td>Chair: David M. Greenberg, Director of Community and Court Liaison Services for Corrections Health, NSW</td>
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<td>Mental health screening in prisons – A review</td>
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<td>Phil Brinded, Medlicott Academic Unit, Christchurch, New Zealand</td>
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<td>15:30–16:00</td>
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<td>16:00–17:30</td>
<td><strong>Sex Offenders</strong></td>
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<td>Chair: Hjalmar van Marle, Erasmus University Medical Centre, Rotterdam</td>
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<td>Bruno Gravier, Belinda Mezzo, Corinne Devaud, Jessica Waeny, Service de Médecine et de Psychiatrie Pénitentiaires, Lausanne, Switzerland</td>
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<td>M. Osterheider, Clinical Director, Westphalina Center for Forensik Psychiatri, Lippstadt, Germany; Th. Mueller, Chief ot the Criminal Psychology Service, Federal Ministry of Interior, Republic of Austria; R.K. Ressler, Director, Forensic Behavioral Services International, Spotsylvania, Virginia</td>
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Current Issues in Corrections

Abstracts

Workshop: Predicting Recidivism

The process of predicting violent and non-violent offender’s recidivism

Julio Arboleda-Florez, Dept. of Psychiatry, Queen’s University; Wagdy Loza, Kingston Penitentiary, Canada

During this workshop the following areas will be covered:

a) Brief review of the history of predictions and ethical issues related to these predictions;
b) Problems affecting the accurate prediction of offender’s recidivism;
c) Variables associated with the prediction of recidivism;
d) Brief descriptions of five actuarial measurements;
e) The process of completing and communicating prediction reports.
f) Suggestions for making accurate predictions

g) A review of the commonly used components of prediction reports.

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Reintegration: Families, Prisoners and Communities

Prisoner social capital and community re-entry: Ties that bind or binds that tie?

Nancy L Wolff, School of Planning and Policy, Rutgers University; Jeffrey Draine, School of Social Welfare, University of Pennsylvania

Prisoners often draw upon their social relations to help them reintegrate into the community after years of incarceration. Through social relations, individuals have opportunities to ‘stake claims’ to resources that help them to function independently. The research literature shows conclusively that the health, well being, and service utilization behavior of those with impaired health are improved by emotional and material support provided by their social relations. Research also shows that social support may reduce criminal behavior and protect society against crime. But there is also evidence showing that the size, strength, and resource potential of social networks and the support embedded in them vary among individuals. People with poorer social networks can be expected to have worse health and justice outcomes, everything else equal. The asset value associated with social relations is referred to as social capital. This paper focuses on the social capital of prisoners and the impact of criminal behavior and incarceration on its formation and mobilization. Social capital, as an asset, changes over time and with social context. Our focus is on the time-varying nature of four attributes of social capital: the strength of connections, the ability to mobilize them, the endowment of resources within these relationships, and their social context. We argue that the incarceration experience has the potential to alter the characteristics, potential, and mobilization of social capital in ways that reduce its ability to produce improved health and justice outcomes for ex-offenders. To offset this depreciation effect, we recommend a set of investment strategies that could have a positive impact on the prisoner’s social capital and prospects for successful re-entry. But success is likely only if investment occurs continuously over the prison sentence. Building sturdy ‘social’ bridges between prisoners and the community takes more than a day to build but if built may lead to a road worth travelling.

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Reintegrating long term forensic patients back into the community: Rehabilitation and managing risk within a Victorian legislative framework

Catherine Dwyer and Jessica Creamer, Thomas Embling Hospital, Melbourne

The presence of mentally ill offenders in the community has raised many fears and anxieties about public safety, and is a highly sensitive political issue. In Victoria, new legislation governing the treatment and release of this type of offender was enacted in 1997, and Forensicare’s Thomas Embling Hospital was given the role of reintegrating many serious mentally ill offenders back into the community. Within the hospital Daintree Unit has the chief responsibility for repatriating Forensic Patients back into the community with the aims of managing risk whilst balancing the achievement of rehabilitation goals, to ensure safe re-integration into the community and an improved quality of life. The Unit’s therapeutic philosophy revolves around providing opportunities for in-patients to develop and achieve biopsychosocial goals in order to optimise their level of functioning in the community. This paper will outline the legislation governing Forensic Patients and discuss the effect that the new process has had on treatment and risk management strategies implemented in the process of release to the community. These include the modification of internal psychological factors relating to increased risk; a graduated community leave system; a dual case management system; and ongoing monitoring and supervision.

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Working with angry HIV+ ex-inmates: How to defuse their anger before it becomes violent

Kevin Fauteux, Clinical Supervisor, Continuum’s Forensics Programs San Francisco

Issue: HIV+ inmates often return to the community with significant anger and potential for violence, and those who work with them—social workers, nurses, doctors—need to be able to defuse their anger in order to provide needed services and to ensure their own safety.
Setting: Homebase works with HIV+ inmates both within San Francisco jails and once released at our housing/office site in San Francisco’s inner city. Project Homebase provides social services, HIV prevention intervention, housing and primary care for HIV+ inmates transitioning out of the San Francisco jail system and back into the community. Common to these men and women—and to many people with low income, HIV, mental health and substance abuse issues—is anger and potential violence. Case managers, nurses and doctors frequently are confronted and even threatened with this anger. Homebase’s task is twofold: how to ensure caseworkers’ ability to manage clients’ anger so as to prevent it from disrupting delivery of services and how to do so ensuring their own personal safety.

Results: Homebase case managers have learned how to approach angry clients with sensitivity and professionalism, and how anger is escalated when they do not. Through training and supervision they learn 1) how to identify the nature of a client’s anger (healthy, dangerous, defensive, etc.); 2) the skills to deescalate angry clients and to intervene with violent clients, 3) understanding how their own issues around anger affect their work with angry clients; and 4) how to work with anger in substance abusers, borderline personalities, schizophrenics and socio-path.

Lessons Learned: Homebase case managers have learned the insights and appropriate intervention tools to help a client who becomes defensively hostile when they talk to him about HIV prevention, or who is angry because her dementia makes it difficult to remember when to take her numerous anti-virals, or who becomes threatening when he is off his psychiatric meds. So too participants at this conference presentation will be able to return to their clinics and offices applying their newly learned skills to defuse angry clients and deescalate violence. As a result they will feel more physically secure and less stressed in their work, while the HIV+ men and women with whom they work will feel that their anger is better understood and treated professionally.

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Pre-release prison humanities programs and prisoner re-entry strategies vs. The United States post-release revolving-door recidivism trap
Richard Ralston, Faculty of Law, University of Wisconsin-Madison

This paper asserts that prospects of affecting the diminished life chances for ex-convicts and, therefore, the security of society is a critical but unjoined debate. It is a discourse constructed along dichotomous but mutually reinforcing pathways: the termination or absence of pre-release programs for inmates about to re-enter the Free World and the emergence of security-propelled policies that effectively ensure recidivism. The consequence of the increasingly bleak prospects for ex-convicts, on the one hand, and a failure to join a debate about the adequacy/inadequacy of pre-release and post-release policies and programs, on the other, threatens to make of us all passive witnesses to American prisons being turned into what Foucault predicted prisons would be years ago – effective producers of a recycling criminal class. Observations of recent pre-release humanities programs in Wisconsin and some discussion of relevant best practices will be offered.

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Mental Illness in Corrections – Treatment and Rehabilitation

Mental health screening in prisons – A review
Phil Brinded, Medicott Academic Unit, Christchurch, New Zealand

Epidemiology studies in prisons worldwide have highlighted the increased prevalence rates of mental disorder in prison compared to the general community. It is also evident that much of the pathology in the prison setting remains undetected. Whilst there are a number of examples of ‘gold standard’ mental health screening projects cited in the literature, screening of new prison receptions for mental illness remains a resource intensive exercise that many prison systems are ill resourced to perform adequately. Less resource intensive methods that still retain adequate sensitivity and specificity must be developed where mental health services operate in a setting of financial restraint and ‘rationing’. This paper reviews the international literature on mental health screening in prisons and attempts to indicate future directions for screening programmes.

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The prevelence of mental illness among NSW reception and sentenced prisoners
Tony Butler and Stephen Allnutt, Dept. of Psychiatry, University of New South Wales

Abstract: Providing appropriate mental health services for prisoners is difficult without reliable epidemiological data of the prevalence of psychiatric morbidity. The limited of information available on mental illness among NSW prisoners prompted the two projects to be conducted: (1) an assessment of mental illness among new receptions to the correctional system; and (2) a cross sectional random sample of prisoners who had participated in the 2001 Inmate Health Survey. We adopted the same screening instrument as used in the National Survey of Mental Health and Wellbeing (NSMHWB) to enable community comparisons. This generates both ICD-10 and DSM-IV diagnoses for a range of psychiatric conditions. This instrument also includes screeners for disability and suicidal thoughts. Over 900 reception and approximately 600 sentenced prisoners were screened. High levels of mental illness were detected in both groups, particularly among females. Findings from both studies and implications for planning forensic mental health services in NSW will also be discussed.

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Turning 180 degrees: Developing offence-specific programs that meet the rehabilitation needs of offenders

Zoey Doueal and Astrid Birgden, Corrections Victoria

The assessment, treatment and management of offenders to reduce recidivism must recognise that offenders are heterogeneous, have multiple needs, and require interventions based on theory and research. On an international basis to date, offence-specific programs have largely focussed on offence type and provided homogeneous programs of varied intensity to encompass all offence-specific needs. Historically this ‘one size fits all approach’ has poorly targeted offender needs. Current initiatives in the Victorian correctional system are based on the principles of risk, need and responsivity. Rehabilitation programs have refocused on individual offender needs and balanced a case formulation approach with group manual based interventions tailored to sexual and violent offending behaviour. This approach draws upon a risk-needs approach, good lives model and therapeutic jurisprudence. Multisystemic therapy concepts serve to support the offender through the entirety of their contact with the correctional system. The paper will present a model that offers higher risk offenders offence-specific programs designed to provide community protection as well as address individual offender needs.

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When and if should offending behaviour be the target for rehabilitation? An approach to offenders with mental disorder

Peter Persson and Astrid Birgden, Corrections Victoria

The question is no longer about the right of access to rehabilitation programs for mentally disordered offenders, but rather, the types and timing of programs being offered. Though ‘right of access’ has largely been accepted, the translation of the concept into practice means that significant systemic and therapeutic challenges remain. Current initiatives in the Victorian correctional system are based on the principles of risk, need and responsibility. A model of service delivery has been developed in collaboration with forensic mental health and disability services. Some of the issues that have been addressed are: the systematic definition and identification of mentally disordered offenders, designing programs to address disability while meeting rehabilitation needs, translating responsivity into meaningful and effective programs, and ensuring adequate transitional support. This paper will outline the management of disability while addressing offending behaviour utilising a continuum of care model between corrections and disability services.

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Sex Offenders

An Australian recidivism study of convicted sex offenders

David M Greenberg, Dept. of Psychiatry, University of Western Australia; Julia-Ann Da Silva, Dept. of Psychiatry, University of New South Wales

Objective: This is landmark Australian study examines the descriptive and criminal profiles, the recidivism rates and variables predictive of sexual, violent and criminal re-offences of a sample of 2,165 convicted sex offenders in Western Australia. A survival analysis of subgroups of sex offenders such as treated and untreated child molesters, rapists and intra-familial groups has been conducted. A logistic regression model based on the variables found to distinguish between recidivists and non-recidivists was developed to determine how reliably these factors determined recidivism.

Method: The sample population consisted of 2,165 convicted sex offenders referred to a sex offender treatment unit in WA between 1987 and 2000. Subjects were assessed for treatment programs based both in prison and in community and entered into treatment programs. Most of these offenders were eventually released back into the community. This database was subsequently linked to the state police arrest database to provide a follow up arrest records over a 12-year period. Survival analyses and a Cox regression model were used to determine treatment effects.

Results: Results of research will be presented.

Conclusions: Sex offenders form a ‘special group’ of patients who require specialised forensic psychiatric/psychological services. Evidenced based initiatives to examine the descriptive characteristics, criminal histories, and re-offence data should form the basis of psychiatric assessment and treatment programs for these offenders.

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Clinical approaches to sexual offenders: Developing an interview framework

Bruno Gravier, Belinda Mezzo, Corinne Devaud, Jessica Waeny, Service de Médecine et de Psychiatrie Pénitentiaires, Lausanne, Switzerland

Many epidemiological studies have, until now, been able to collect a number of relevant elements on various aspects of biography, socio-professional history, criminological evolution, and psychological profile of sexual offenders.

On the other hand, we have only a few instruments allowing us to explore satisfactorily the central clinical aspects of the psychical life of these patients and, in particular, the way in which they have integrated or elaborated
childhood traumas, how they have dealt with sexual encounters or how they perceive their emotional life. Therapists who work with sexual abusers have, most of the time, some difficulties in approaching these kinds of problems because of, among others things, the inadequacy of these subjects’ ability to express and recognise their emotions and those of the others. Their difficulty in discussing their intimacy or what was of a particular importance in their history creates many obstacles to the creation of a therapeutic and secure setting. As a consequence, they have to face an important period of confusion when structuring their points of reference and, consequently, have great difficulty in making psychic links and identifying the significant elements of their psychic life.

Several authors underlined the way in which certain questionnaires can function as tools to establish the therapeutic relationship. The questionnaire that we developed addresses this objective by providing the therapist with a framework that makes it possible to highlight these aspects and take into account the particular cognitive functioning of these patients.

In our paper we will present some aspects of this questionnaire and will indicate how it accounts for the specific pathological character of the way in which these patients think.

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Crime Scene Analysis (CSA) in an institutional psychiatric setting – The cross-over-study at the Westphalian Center for Forensich Psychiatry (WCFP)

M. Osterheider, Clinical Director, Westphalia Center for Forensik Psychiatry, Lippstadt, Germany; Th. Mueller, Chief of the Criminal Psychology Service, Federal Ministry of Interior, Republic of Austria; R.K. Ressler, Director, Forensic Behavioral Services International, Spotsylvania, Virginia

The WCFP is located in the Midwest of Germany. It is the largest Forensic Clinic in Europe (about 360 pat.) and preferred a highly security standard. When patients were admitted to the clinic by the judges the following situation is given normally: There is no detailed information about crime scene and autopsy files in patients with sexual offenses and homicide. There is no standardised cooperation between forensic psychiatrists and criminologists or investigators. Because of the given lack of knowledge in criminal psychology there is – of course – no analysis of crime scene and crime situation which results in the fact that there is no standard integration of CSA in making forensic prognosis. In the relevant literature decisive dimensions for recidivism prognosis have been reported by several authors (e.g. NEDOPIL, 2000). Statistic and dynamic factors in different fields of assessment (e.g.: dimensions of sexual deviance, psychosocial malfunctioning) are given which give a lot of information about the patients risk for recidivism. Not all of the used information is given in the patients files. A detailed analysis therefore has to be done.

To optimize forensic psychiatric diagnoses and assessment – especially in the research of sexual homicide – a collaboration study has started in early 2001 focussing on crime scene analysis in an institutional forensic clinical setting. The WCFP collaborates with Bob Ressler, former FBI agent, and Thomas Mueller, Vienna. In the workshop (14 days) general information about sexual offences, sexual homicide and methods of crime scene analysis is also given as preparing case reports and studying video tapes in a team work setting. Also forensic inpatients have been interviewed in the WCFP. A special ‘cross over design’ has been established in which two different study groups have different informations about patients history (with and without crime scene data).

The results within the CSA-group showed that they obtained more information about the patients psychopathology, that there is a more clear and detailed insight and understanding of the patients sexual imagination and fantasies and that it is possible to explain especially statistic and dimensional factors to reassure the recidivism and prognosis. We can conclude that detailed information about crime scene – which is sexual behavior and fantasies of the patient – is indispensable to receive maximum information, for understanding the patient (re-interpretation of the crime), for treatment planning (objective basis) and especially for making a better prognosis.

The risk factors for decision making will be received especially by CSA: The existence of high violence in sexual offenders, planned and pre-imagined crime and sadistic practices as well as internalization of deviant sexual practices and its progression is developed by detailed CSA. The collaboration is now ongoing in the 3rd year. Further scientific evaluation is strongly needed so that a German multicentre approach will start in 2003. In the WCFP the CSA is operationalised in the clinical setting by using a standardised questionnaire which will be presented as well as data about the mentioned ‘cross over design’.

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Fri. Oct. 3, 2003 (8:30–17:30)  

**Families, Justice and the Courts**

**Brisbane Room (3rd Floor)**

### Registration
8:00–8:30

### Children’s Rights – New Issues, New Challenges  
8:30–10:00

**Chair:** Patrick Parkinson, Faculty of Law, University of Sydney

- **Birthrights, self-determination and veracity:** The rights of donor-conceived children to information about donors  
  *Kerry Petersen, Law School, La Trobe University*
- **Children’s rights for safety and security:** Child protection in an age of terror  
  *Louise Newman, New South Wales Institute of Psychiatry*
- **Making meaning of children’s rights – The role of the Commission for Children and Young People**  
  *Robin Sullivan, Queensland Commissioner for Children and Young People*

**Break**  
10:00–10:30

### Responding to Child Abuse  
10:30–12:00

**Chair:** Her Honour Judge Penny J. Hock, District Court of New South Wales

- **Child Abuse Cases in the Family Court**  
  *The Hon. Justice Jennifer Boland, Family Court of Australia*
- **Child abuse and neglect**  
  *Bhagirathy Sahasranaman, Henderson Mental Health Center, Fort Lauderdale, Florida*
- **The long term psychiatric sequelae of childhood abuse and neglect**  
  *Louise Newman, New South Wales Institute of Psychiatry; Carolyn Quadrio, Dept. of Psychiatry, University of New South Wales*
- **Towards better institutional processes for dealing with sexual abuse allegations**  
  *Tom Allobelli, Faculty of Law, University of Western Sydney*
- **Confabulation: But is it evidence?**  
  *Yolande Lucire, Forensic Psychiatrist, Sydney*

**Lunch**  
12:30–13:30

### Families, Mental Illness and the Courts  
13:30–15:30

**Chair:** Judy Cashmore, Faculty of Law, University of Sydney

- **An examination of how courts exercising family law jurisdiction decide parenting cases that involve parents and/or children who have a mental illness**  
  *Federal Magistrate Judy Ryan, Federal Magistrates Court of Australia*
- **Court responses to children living with parental mental illness: A study of child protection matters that present to the Melbourne Children’s Court**  
  *Gregory Levine and Rosemary Sheehan, Children’s Court of Victoria*
- **Contact between a child and their family following care and protection proceedings**  
  *Roderick Best, Department of Community Services, Sydney*
- **Family Court and Youth Court (Criminal) in Ontario: The ability to assess and intervene when mental health is an issue**  
  *The Hon. Justice Brian Weagant, Ontario Court of Justice, Toronto*

**Break**  
15:30–16:00

### Domestic Violence  
16:00–17:30

**Chair:** The Hon. Justice Jennifer Boland, Family Court of Australia

- **Prioritising safety or contact? Domestic violence, family breakdown and family law**  
  *Lesley Laing, School of Social Work and Policy Studies, Faculty of Education, University of Sydney*
- **Beyond Battered Women Syndrome?**  
  *Julie Stubbs, Faculty of Law, University of Sydney; Julia Tolmie, Faculty of Law, University of Auckland*
- **Current UK knowledge of criminogenic need, mental health and addictions in domestic violence offenders: Implications for criminal justice responses**  
  *Elizabeth Gilchrist, School of Health and Social Sciences, Coventry University; Rebecca Johnson, Rachel Takriti and Anthony Beech, School of Psychology, University of Birmingham*

**End of Congress**  
17:30
Children’s Rights – New Issues, New Challenges

Birthrights, self-determination and veracity: The rights of donor-conceived children to information about donors

Kerry Petersen, Law School, La Trobe University

ART is a rapidly developing field of medicine which raises some complex issues about the rights of donor-conceived children. In families where the family members are related through marriage and biology, the legal and social status of children is an assumed right. However, in families where there are donor-conceived children, in Australia these rights are constructed by a legal fiction which creates new legal relationships and severs biological ones. Very few jurisdictions have made provision for donor-conceived children to have access to identifying information about donors. Sweden was the first country to permit ‘mature offspring’ to obtain identifying information about donors in 1984. Few other jurisdictions have followed suit. The state of Victoria conferred a statutory right on donor-conceived children to receive identifying information in 1998. This paper will examine some of the laws and policies governing the right of donor-conceived offspring to have access to identifying information and will also discuss human rights and ethical principles which can inform this debate on birthrights.

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Children’s rights for safety and security: Child protection in an age of terror

Louise Newman, New South Wales Institute of Psychiatry

Protecting children from harm and provision of security and opportunities for development is a fundamental motivation for many parents seeking asylum. Yet the reality of the asylum experience has been the prolonged detention of families in environments which mitigate against child protection and are traumatising and depriving. The policy of mandatory detention of unauthorised asylum seekers in Australia and the creation of offshore detention centres highlight significant tensions in the political rhetoric of child protection and Australia’s relationship to international children’s rights conventions. This paper will review the evidence of Psychological harm of detention on children and the questions this raises about the commitment to the welfare of the children.

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Making meaning of children’s rights – The role of the Commission for Children and Young People

Robin Sullivan, Queensland Commissioner for Children and Young People

This presentation makes meaning of children’s rights as set down in the Convention on the Rights of the Child 1990 (CROC). CROC was adopted in 1989 and entered into international law in 1990. However, the history of the rights of children can be traced as far back as 1853. Some would say it evolved earlier, during the 18th century, with the ‘transformation from a purely power oriented interest in education towards an interest in the development of the entire human being’ (Nyssen & Bornhoff 1988).

CROC articles can be categorised into three groups, or what is known as ‘The Three P’s’ (United Nations, The future United Nations Convention on the Rights of the Child: Briefing Kit, 1989). These categories are: provision, protection and participation.

The Children’s Commission of Queensland was established in 1996 and was the first independent commission for children in Australia. In the wake of the Briton Review (1999) and the Forde Report (1999), recommendations were made to expand the Commission’s powers. This lead to the introduction of the Commission for Children and Young People Act 2000 which reflects CROC and embeds its principles into the Commission’s practice framework.

As such ‘The Three P’s’ are a useful vehicle to encapsulate the role of the Commission for Children and Young People and move it from legislation to implementation. Exemplars of how the Commission interprets its role are provided.

Responding to Child Abuse

Child Abuse Cases in the Family Court

The Hon. Justice Jennifer Boland, Family Court of Australia

A significant percentage of cases requiring determination by a Judge involve allegations of physical, psychological or sexual abuse of children. Often one or both of the parents are not legally represented. This paper examines the role of the Child Representative in such cases, the interface with state welfare departments and state legislation, the presenting of evidence to the Court, and an examination of the type of orders the Court can make. It also examines the Court’s pilot project to specially managing serious abuse cases with a multi-disciplinary approach involving not only the Court by the relevant state welfare body. It also considers whether a departure from the standard adversarial procedure of the Court is appropriate in these cases.
Child abuse and neglect
Bhagirathy Sahasranaman, Henderson Mental Health Center, Fort Lauderdale, Florida

The World Health Organization defines child abuse or maltreatment as “all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power.” Child neglect is the failure or omission by a caretaker to provide the care, supervision, services or protection necessary to maintain the child’s physical and mental health and could include abandonment, failure to seek necessary health care, failure in ensuring that the child attends school, etc. One could also consider a child to be in a situation of threatened harm, if, for example, he or she is allowed to witness adult substance abuse or is living in a household with significant domestic violence. Victims of child abuse and neglect span all ages, races, religions, and socioeconomic backgrounds, and there are countless victims all over the world. In the United States alone, child abuse reports have maintained a steady growth for the past ten years, and in 1999, an estimated 1400 child abuse and neglect related fatalities were confirmed by child protective agencies. Interviews of children or young adults in Finland, the United States and Korea have indicated that from five to ten percent of all children experience physical violence in childhood. The cost of child abuse and neglect is extremely high. It can cause significant emotional suffering of children and contribute to a host of other serious problems such as youth violence, delinquency, alcohol and substance abuse, teen pregnancy and chronic mental illness. Increasing public awareness, identifying risk factors and having prevention programs in communities are of paramount importance to help reduce the incidence of child abuse and neglect.

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The long term psychiatric sequelae of childhood abuse and neglect
Louise Newman, New South Wales Institute of Psychiatry; Carolyn Quadrio, Dept. of Psychiatry, University of New South Wales

CSA affects 1 in 3 female and 1 in 4 male children and as such constitutes one of the most serious public health risks to children. The long-term effects of CSA are pervasive and protean, and the psychiatric sequelae cover the entire spectrum of disorders. While PTSD is an appealing concept forensically, it is by no means the commonest outcome. The author has many years experience in assessing adults and children who have experienced childhood abuse, in preparing family assessments for the Family Court, and giving expert witness testimony to the Family Court and in criminal and civil courts. The author has previously presented data relating to False Allegations of Childhood Sexual Abuse. In this paper the author will review issues of prevalence, detection, outcomes of abuse and resilience in children, whether there is a specific sex abuse syndrome in adults or in children, the biopsychological basis of posttraumatic personality disorganisation and the issue of false allegations.

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Towards better institutional processes for dealing with sexual abuse allegations
Tom Altobelli, Faculty of Law, University of Western Sydney

Institutional processes for dealing with allegations of child sexual abuse, such as those used by churches, educational and other governmental organisations fail to recognize that the public has a legitimate interest in ensuring that the processes used to investigate and resolve complaints and offer assistance to victims are transparent, rigorous and accountable. They generally also fail to understand the unique perspective of the now-adult but who was a child-victim of sexual abuse. These institutional processes inadequately balance the public interest with the private interests belonging to the stakeholders in these claims. The need for confidentiality that is invoked in seeking to protect private interests directly undermines public confidence in the process. Greater recognition needs to be given by institutions to the legitimacy of the public interest, and this legitimacy needs to be reflected in the processes used. The role of such processes in educating the public and thus having a preventative function needs also to be recognized. At the same time the public needs to recognize the legitimacy of claims by stakeholders to use confidential processes until clear findings have been made in relation to allegations. The paper will suggest a new model for dealing with claims within institutions arising out of allegations of sexual abuse, that moves closer to finding that elusive balance between the public and private interests.

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Confabulation: But is it evidence?
Yolande Lucire, Forensic Psychiatrist, Sydney

No one knows what happened between two people a long time ago (the ‘truth’) but is a confabulation legitimately admissible ‘evidence’? For 150 years, psychiatrists, Kraepelin, Jaspers, Fish have recognized confabulation (Pseudologia fantastica) as a hysterical phenomenon. Themes for confabulators change with cultural preoccupations. For 300 years young women denounced innocents as witches, for half of their property. This has recently given way to epidemic allegations of satanic, sexual and other abuses with variable levels of plausibility. The success of a confabulation depends on the availability of a credulous listener, doctor, therapist, counsellor, social worker, lawyer or politician. Psychiatrists recognize confabulations in a clinical setting as they differ from memories of real events in the same way as a novel about an event differs from an observer’s account. The author
argues (with real examples) that confabulated allegations should not be allowed as evidence as they are contaminated beyond repair, that the text of such an allegation should be treated like a forensic sample from a crime scene which, rather than being placed into a sealed bag by gloved hands, was thrown onto the back seat of a car, handled by several unknown persons, soiled by animal and vegetable matter to the extent that the core cannot be distinguished by rational means, as opposed to blind prejudice. A report of sexual abuse should be treated with the same level of care to safeguard it from pseudo-memories that we know are instilled by books counselling, therapies, friends, police and victims services.

Families, Mental Illness and the Courts

An examination of how courts exercising family law jurisdiction decide parenting cases that involve parents and/or children who have a mental illness

Federal Magistrate Judy Ryan, Federal Magistrates Court of Australia

This paper will examine the way in which courts exercising jurisdiction under the Family Law Act decide residence and contact cases. How do courts decide whether a person has a mental illness? Who is qualified to express an opinion about mental illness and its ramifications for the family? Do child protection agencies shy away from private family law disputes and is there a need for a Federal Child Protection Agency that will investigate and report upon risk issues to Federal Courts? These issues will be discussed by reference to the legislative framework, case studies and the Family Law Council’s Report “A Federal Child Protection Agency.”

Court responses to children living with parental mental illness: A study of child protection matters that present to the Melbourne Children’s Court.

Gregory Levine and Rosemary Sheehan, Children’s Court of Victoria

Mental illness is an issue for a number of families reported to child protection agencies. Parents with mental health problems are more vulnerable, as are their children, to having parenting and child welfare concerns. Studies undertaken in the Melbourne Children’s Court (Victoria), in 1998 and 2001, found that the children of parents with mental health problems comprised just under thirty percent of all new child protection applications brought to the Court, and referred to alternative dispute resolution. This paper reports on the study findings, which are drawn from a descriptive survey of Children’s Court Pre-Hearing Conferences. Information was gathered about the child welfare concerns, the parents’ problems, including mental health problems, and the contribution by mental health professionals to resolving child welfare concerns. The issues that bring children of parents with a psychiatric disorder to the attention of the Children’s Court are particularly challenging. The lack of involvement by mental health professionals in the child protection system has meant that the Court is given little appreciation of either a child’s emotional or a parent’s mental health functioning. Information about mental illness and psychological disorder, about what responds to treatment, what programmes work and what do not, is essential, yet is frequently unavailable to the court. It is clear that there must be effective co-operation between the adult mental health and child protection services so that the Court has all necessary information about the needs and the likely outcomes for these children and their parents. This ensures decisions that meet both the needs of children and respects their individual rights, and the rights of their families.

Contact between a child and their family following care and protection proceedings

Roderick Best, Department of Community Services, Sydney

A significant proportion of proceedings for the care and protection of children involve family members with a mental illness. A significant proportion of these proceedings also result in the separation of the child from the family. This paper will examine the criteria used by the courts to determine when, and to what extent, a child will continue to have contact with the child’s family following court ordered removal.

Family Court and Youth Court (Criminal) in Ontario: The ability to assess and intervene when mental health is an issue

The Hon. Justice Brian Weagant, Ontario Court of Justice, Toronto

Ontario is a jurisdiction that is wealthy in civil and criminal procedure. However, often the procedures themselves are an impediment to timely assessment and intervention in cases involving mental health issues. This is very apparent in the juvenile justice system, where many community service providers ultimately turn to the criminal justice system as the most efficient tool to match young persons to services.

This presentation will explore the ability of the court in Canada’s largest city, Toronto, to effectively assess and intervene in family and youth court when mental health is relevant to the issues.
Domestic Violence

Prioritising safety or contact? Domestic violence, family breakdown and family law
Lesley Laing, School of Social Work and Policy Studies, Faculty of Education, University of Sydney

For over 20 years the focus of domestic violence policy has been on bringing violence perpetrated within the home into the domain of the criminal justice system. However, many women who never use the criminal justice system and who seek safety for themselves and their children by ending a relationship in which they are being abused, find themselves re-victimised by the civil Family law system whose culture increasingly favours contact with both parents following parental separation. This paper explores the challenge for the Family Court in responding to the accumulating research evidence about the impact of domestic violence on children and young people, the evidence of the frequent co-existence of child abuse and domestic violence and the risk to women of post-separation violence during contact.

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Beyond Battered Women Syndrome?
Julie Stubbs, Faculty of Law, University of Sydney; Julia Tolmie, Faculty of Law, University of Auckland

This paper will build on the authors’ previous work on battered women syndrome by considering recent decisions in cases in which battered women have been charged as a consequence of killing their abuser. In previous papers we have examined the manner in which the use of expert evidence concerning ‘battered woman syndrome’ commonly had contributed to the construction of the defendant as irrational or suffering some psychological deficit. Current practice seems to rely less on the explicit use of battered woman syndrome evidence but nonetheless replicates some of the features of BWS cases. In some of the recent cases, particularly those involving Indigenous women, structural disadvantage seems to be readily translated into individual pathology. This may reflect both dominant (mis)understandings of domestic violence and the tension courts experience in trying to give recognition to structural disadvantage in a forum that typical conceptualises issues in individualistic terms. The connection between domestic violence and gender inequality is lost. Despite some compassionate sentences, individual women continue to be denied recognition that they acted in self-defence.

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Current UK knowledge of criminogenic need, mental health and addictions in domestic violence offenders: Implications for criminal justice responses
Elizabeth Gilchrist, School of Health and Social Sciences, Coventry University; Rebecca Johnson, Rachel Takriti and Anthony Beech; School of Psychology, University of Birmingham

Data from a U.K. Home Office funded study of criminogenic need in Domestic Violence offenders is reported. The main aims of this project were to identify which factors contribute to the occurrence of Domestic Violence which would in turn inform the development of new programmes (or enhance existing programmes) to address these needs, based around the concept of ‘what works’ and informed by an evidence based model of change. The study accessed a sample of over 300 men mandated to community intervention following a conviction related to Domestic Violence with a view to establishing appropriate foci and formats for intervention in the UK. Information was collected on psychological, social, demographic and mental health factors, using a range of tools, from the MCMI–III and a Hypermasculinity Inventory (HI) to measures such as Rosenberg Self-Esteem and assessments of attachment, for example, Relationship Questionnaire (RQ).

This data has been analysed to explore whether these men form a homogenous group or whether, similar to research in the US, we can identify different sub-groups of domestic violence offender who evidence different needs. A selection of these results are presented and discussed in relation to international work on domestic violence, risk, screening and intervention, particularly suggestions for multi-agency involvement in screening.

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<td>Fri. Oct. 3, 2003 (8:30–17:30)</td>
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<td>Registration</td>
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<td><strong>Mental Health and Human Rights</strong></td>
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<td>Chair: Melinda Jones, School of Law, University of New South Wales</td>
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<td>Help-seeking and Complex PTSD in survivors of the siege of Sarajevo Thomas Wenzel, University Hospital for Psychiatry, Vienna</td>
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<td>Fighting impunity, the work of the Inter-American Court of Human Rights Ana Deutsch, Clinical Director, Program for Torture Victims, Los Angeles, California</td>
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<td>The right to obtain or refuse psychiatric treatment: What is the role of the courts? Amita Dhanda, Faculty of Law, University of Law Hyderabad, India</td>
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<td>Outcomes of Patients discharged from detention under the Mental Health Act (1983) Elizabeth Perkins, Director, Health and Community Care Research Unit, University of Liverpool</td>
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<td>Legal and Ethical Issues Associated with the Practice of Seclusion Eimear Muir-Cochrane, School of Nursing and Midwifery University of South Australia</td>
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<td>Japanese mental health law David N. Weisstub, Université de Montréal, Montreal; Tsunemi Hasegawa, Hasegawa Hospital, Tokyo</td>
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<td>Disclosure of information about psychiatric hospitals Hiromi Shiraishi, Department of mental Health Services, Tokyo Institute of Psychiatry; Tetuhiro Ito, Hokkaido Mental health and Welfare Center, Sapporo</td>
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<td>Auditing mental health human rights Helen Watchirs, Regulatory Institutions Network, Australian National University</td>
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<td>Legislating Human rights in mental health in England and Wales: Working with the European Convention Genevra Richardson, Queen Mary &amp; Westfield College, University of London</td>
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<td>A comparative survey of mental health law and practice in Pacific Island nations Philip W. Bates, School of Medical Practice and Population Health, University of Newcastle</td>
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<td>Balancing rights and risks: The Mental Health Act 1983, the ECHR and the Draft Mental Health Bill Judy Laing, Law School, Cardiff University</td>
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<td>What does the ‘Right to Health’ mean for people with mental illness? Sylvia Bell, Human Rights Commission, Auckland</td>
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<td>Can international law improve mental health? A look at the proposed Convention on the Rights of People with Disabilities Melinda Jones, School of Law, University of New South Wales</td>
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<td>The mental health impact of human rights violations: Responses in international law Barbara Von Tigerstrom, School of Law, University of Canterbury</td>
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Mental Health Law and Human Rights

Help-seeking and Complex PTSD in survivors of the siege of Sarajevo

**Thomas Wenzel, University Hospital for Psychiatry, Vienna**

In Sarajevo and most areas of Bosnia-Herzegovina, the war has left a legacy that is characterized by psychological, physical and economical long term sequels but also recent injuries caused by land mines. While international attention and support is shifting to different geographical situations, data on the post war situation are rarely published outside of the region with only few exceptions. In our study we explored the psychological sequels in a sample of 60 consecutive patients in a community oriented health care centre, specialising in treatment and occupational rehabilitation for war victims. The Harvard Trauma Questionnaire (HTQ) and the Impact of Events Scale (IOES) were used to evaluate the war and post-war experience of serious stressors and psychological sequels. The sample consisted of 13 female and 47 male patients. The mean age was 36.03 years (SD 13.29, range 17-68 years). 7 (53.8 %) of the female patients were in the help seeking group, 6 (46.1 %) in the non-help seeking group. The mean number of trauma items directly experienced by the patients according to the Harvard Trauma Questionnaire was 6.5 (mean, SD, range 1-13), 5.73 in the help-seeking and rather unexpectedly - 7.33 in the control group, a difference significant at the p > 0.05 level (Mann-Whitney U-test). Sex distribution was not significantly different between groups (Chi-quadrat test). 17 patients (28.3 %) in the complete sample fulfilled the criteria for a clinical diagnosis of Posttraumatic stress disorder (PTSD) in the HTQ, while basic PTSD symptoms were present in all patients. Symptoms of complex emotional sequels were also high, and characterized patients that had been exposed to rape as part of ethnic cleansing, while PTSD and other events were not more frequent in this group. The data in our study reflect the importance of a broader understanding of war time stressors and sequels in the community. Rape and Complex PTSD are problems that must be considered for a forensic evaluation of war sequels, but also for community mental health planning.

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Fighting impunity, the work of the Inter-American Court of Human Rights

**Ana Deutsch, Clinical Director, Program for Torture Victims, Los Angeles, California**

International attention has in recent years focused on finding ways of combating impunity for violation of human rights. Seemingly, there is an increased interest in exploring the psychological impact of impunity at the individual level as well as the social level. The inter-American community counts on powerful mechanisms and instruments to protect human rights and to fight impunity. The Inter-American Commission of Human Rights and the Center for Justice and International Law have the mission of ensuring compliance with the American Convention on Human Rights “Pact of San Jose of Costa Rica.” Violations of human rights imputed to states that have signed the Pact are brought in front of the Inter-American Court of Human Rights (ICHR). This paper presents a case study showing how the ICHR operates. This case study involves the torture and murder of four children and the ordeal of their families seeking justice. This study includes a discussion of the legal aspects of the proceedings and the psychological effects on the family members of the victims. The crimes were committed in 1991, and submitted to the ICHR in 1996. The final judgment was delivered on May of 2001 granting reparation for the families of the victims.

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The right to obtain or refuse psychiatric treatment: What is the role of the courts?

**Amita Dhanda, Faculty of Law, University of Law Hyderabad, India**

In recent years Indian Courts have been required to deal with the following kind of issues in the realm of mental health treatment: firstly those in which courts have been required to ensure minimum treatment facilities in State mental hospitals; secondly, where the legality of providing treatment to persons with psychiatric illness at religious, faith healing and other unlicensed sites have been interrogated; and lastly, petitions, which seek the prohibition of unmodified ECT and regulation of, modified ECT. These petitions have brought to the fore the following kind of questions. How should competing claims of autonomy and protection be dealt with? What weight should be accorded to patient interrogation of psychiatric treatment? How should professional opinion on utility and safety of treatment be evaluated? How should non-modern facilities of mental health care be dealt with? Should such facilities be entirely ousted? Or should only the inhuman practices at such facilities be prohibited? What is the responsibility of the State towards persons with psychiatric illness? What do the Bill of Rights in the Indian Constitution and international human rights instruments guarantee to persons with psychiatric illness? Do these instruments mandate a minimum treatment regimen?

The paper begins by elaborating on the circumstances, which have necessitated Indian courts to consider the above issues. It next generally assesses the competencies of Courts to deal with such like questions and lastly evaluates the manner in which the Indian courts have dealt with them.

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Case Studies in Mental Health Law Reform

Outcomes of patients discharged from detention under the Mental Health Act (1983)
Elizabeth Perkins, Director, Health and Community Care Research Unit, University of Liverpool

In the last ten years, despite a reduction in psychiatric beds, there has been an increase in England in the detention of patients in hospital under the Mental Health Act (1983). This study was funded by the Department of Health to examine what happened to patients once they had been discharged from detention under the Mental Health Act (1983) and in particular how patients negotiated everyday living. It is recognised that people with mental health problems may require care, support and assistance to live at home in the community. The Care Programme Approach (Department of Health, 1995) requires that each patient discharged from hospital receives an individually tailored care programme and a named key worker. The study was based on a study of 44 patients discharged from hospital in two regions of England. All patients had been detained in hospital under section prior to their discharge. Patients were interviewed twice following their discharge: on the first occasion between three and six months of discharge and again nine months after discharge. The accounts of patients sit alongside those of family members and the patient’s RMO and reveal how differently events are viewed by those involved. The paper explores the patient’s view of their admission to hospital; their experience of receiving care while under section; the arrangements made for their discharge; and their subsequent experience of life in the community. The paper highlights the difficulties of living with a mental illness and the constraints within which psychiatry is currently operating.

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Japanese mental health law
David N. Weisstub, Université de Montréal, Montreal; Tsunemi Hasegawa, Hasegawa Hospital, Tokyo

Foreign critiques of the Japanese mental health system have had a major impact on the process of legislative reform in Japan since the Second World War. Although there have been significant landmarks in laws pertaining to involuntary hospitalization and patients’ rights culminating in the reforms of 1988, the overall application of the governing principles has been hampered by intervening social factors. The accreditation of mental health specialists, the nature of Japanese government bureaucracy, the private/public ownership of Japanese mental health facilities, culturally specific stigmatization and Japanese family structures are all factors deserving of in-depth analysis. Constructive influences on the reform process will be cited as well as policy suggestions made for improving the quality of care for mental health patients and protection of their human rights.

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Disclosure of information about psychiatric hospitals
Hiromi Shiraishi, Department of mental Health Services, Tokyo Institute of Psychiatry; Tetuhiro Ito, Hokkaido Mental health and Welfare Center, Sapporo

Within the stream for hospital reform, to establish a rule for disclosure of information about the hospital is one of the urgent issues in Japan. Because psychiatric treatment not rarely involves treatment without full consent of the patient, it requires more ‘transparency’ as to the organization and functions and so forth of the treatment facility than other medical disciplines. There are ways to disclose hospital information by the hospital itself. Among them advertisement, the homepage on the internet and the report of the assessment by the third party. Some of the hospitals are preparing to establish a intramural committee to deal with the press release of its medical accident. For information about the psychiatric hospitals retained in local and national governments, we can access to at least some pieces of information through application. But many concerned still insist that there should be more disclosure. We made a survey on this issue to the members of the Psychiatric Review Board. We will report the result of it and discuss how information about psychiatric hospitals should be disclosed.

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Legal and ethical issues associated with the practice of seclusion
Eimear Muir-Cochrane, School of Nursing and Midwifery University of South Australia

The debate about the appropriateness of seclusion as a nursing practice in in-patient settings in the twenty first century continues, with powerful and often emotive arguments from those who view it as an anachronistic and punitive form of ward management, and from others who see it as a useful emergency measure to protect individuals from imminent harm. This paper focuses on the legal and ethical issues in relation to the use of seclusion, with policies and practices in Australian and New Zealand psychiatric institutions viewed within the context of worldwide trends. The interplay of ethical principles and international mental health law has encouraged a move towards the provision of care and treatment of the disturbed psychiatric patient within the least restrictive environment, supposedly reducing the potential for the inappropriate use of control mechanisms. Nevertheless, current legislation can be seen to preserve the status quo because it legitimates seclusion as an acceptable nursing practice, albeit within given parameters, thereby defusing the imperative to promote the reduction and abolition of psychiatric control mechanisms and seek new possibilities in mental health care.

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Legislating Human Rights in Mental Health

Legislating human rights in mental health in England and Wales: Working with the European Convention

Genevra Richardson, Queen Mary & Westfield College, University of London

Following the implementation of the Human Rights Act 1998 the European Convention of Human Rights has been incorporated into UK law. Thus both current and any future mental health legislation must comply with the requirements of the ECHR. This paper will consider the extent of the challenge already faced by the current Mental Health Act in England and Wales and will examine the ECHR implications for the proposed new legislation. A distinction will be drawn between those human rights obligations which impose essentially procedural requirements on state authorities and those which have more substantive implications for the nature of mental health law. Traditionally the ECHR has been seen as more concerned with the former than the latter. However, in recent years more thought has been given to matters of substance including, for example, the assertion of entitlements to care and treatment, the grounds on which detention and compulsory treatment can be imposed, the conditions and location of detention and the question of discrimination against those with mental disorder. This paper will discuss these questions and will consider how far human rights instruments can affect the substance of mental health legislation.

Balancing rights and risks: The Mental Health Act 1983, the ECHR and the Draft Mental Health Bill

Judy Laing, Law School, Cardiff University

This paper will assess aspects of the Mental Health Act 1983 in the context of the European Convention on Human Rights (ECHR) and the Human Rights Act 1998, and analyse to what extent the 1983 Act has been effective in safeguarding patients’ fundamental human rights. The article will focus on areas where there have been human rights concerns and, in particular, will consider some important recent court decisions in the UK where ECHR breaches have been found. The decisions will be analysed and judicial attitudes towards the ECHR will be explored. The paper concludes with a brief account of some of the proposals in the Draft Mental Health Bill and considers to what extent they will remedy some of the deficiencies by providing adequate human rights protection.

A comparative survey of mental health law and practice in Pacific Island nations

Philip W. Bates, School of Medical Practice and Population Health, The University of Newcastle

The Author was project director for a comparative survey of mental health law and practice in 13 pacific island nations conducted in 1997-98 through the School of Law at the University of Newcastle which was supported in part by WHO (Western Pacific Region) funding. A survey instrument was developed and trialled in one of the island nations based on a series of scenarios. After some modifications, the scenarios were then presented in each of the other nations to discussion groups of multidisciplinary senior informants by trained facilitators. The discussion groups typically included medical, nursing, law enforcement, religious, community and legal participants. The scenarios and the discussion groups identified and recorded typical actual practices in each of the participating nations. These were subsequently compared by the project team with ‘official’ sources of law and practice. There were striking, and significant, similarities in the actual practices of most of the participating nations, consistent with shared ‘pacific nation’ values of Melanesian and/or Polynesian cultures, but also reflecting the lack throughout the Pacific of trained personnel and resources, and the dispersed island populations over many sub-islands. Actual practices were not generally congruent with the ‘official’ sources of law in each of the participating nations. The ‘official’ laws in a number of nations reflected colonial eras or influences, or had been adapted from Western models which did not have the same cultural base or presumed greater availability of resources and personnel.

Auditing mental health human rights

Helen Watchirs, Regulatory Institutions Network, Australian National University

Auditing human rights in the mental health area is a new model of human rights monitoring, and ideally it should be conducted as a tripartite process involving community, government and expert representatives. The audit attempts to increase accountability and legal compliance with the UN Principles for the Protection of and for the Improvement of Mental Health Care – the benchmark used for audit indicators. The object of the audit is to highlight areas of best practice as well as legislative gaps in mental health (and other) laws. It recognises that law is a necessary, but alone not a sufficient, method of implementation. The audit is an evaluation device designed to raise public rights consciousness, understanding and debate, and to serve as an advocacy tool for law reform by testing the extent of legal implementation of international norms at the domestic level. In Australia the audit (originally called a ‘Rights Analysis Instrument’) was performed in six States and Territories in 1998-99 and in Queensland in 2002. The process was government-driven and not fully tripartite or transparent in all jurisdictions, which adversely affected community participation and ownership of the results. However, a national multi-disciplinary panel was convened to promote consistency and validity of results between jurisdictions. The main deficiency identified by the audit was in relation to informed consent for treatment. The greatest impact of the audit was in being used as
drafting instructions for new laws in some jurisdictions. A similar audit methodology is being conducted in the HIV/AIDS area, but the views of external (community) and internal (government) members are more balanced by the presence of an independent human rights expert performing the main evidence gathering and analytical work in preparation for the consultation process. A broader anticipated use of the audit is to focus the dialogue in the under-resourced UN treaty monitoring system. Providing comparative data on whether formal laws comply with human rights norms enables internal tracking over time to see whether the situation has improved or deteriorated, and external comparison with other jurisdictions. The narrow dimension being measured by the audit is formal law, which gives it greater objectivity and specificity, but is also a limitation in terms of reliability because of the gap between law and practice. A second stage audit could be designed to attempt to capture other broader dimensions such as administrative practices. There is also scope for updating the UN Principles, particularly in relation to community treatment rights, and incorporating these revised standards into the audit.

**Human Rights, International Law and Mental Health**

**What does the ‘Right to Health’ mean for people with mental illness?**

*Sylvia Bell, Human Rights Commission, Auckland*

Under the International Covenant on Economic, Cultural and Social Rights everyone is theoretically entitled to the highest standard of health but how relevant is this for people with mental illness? The concept of progressive realisation and the acceptance that available resources are likely to limit the rate at which the right is realised have been used to excuse the extent of compliance. In addition, traditionally many of the rights in the Covenant have not been considered justiciable. However, the position is slowly changing as signatories explicitly include socio-economic rights in their Constitutions and Courts become more proactive. While the rights in ICESCR are particularly relevant for people with mental illness, it can be unclear to what extent they can be enforced. This paper will examine the relationship of a number of the rights in ICESCR, human rights legislation and mental health law -with reference to some relevant case law and developments in the application of the international instruments – in order to determine whether people with mental illness can claim to benefit from the right to health.

**Can international law improve mental health? A look at the proposed Convention on the Rights of People with Disabilities**

*Melinda Jones, School of Law, University of New South Wales*

The disability community holds out great hope for significant improvement to the lives of its members through a dedicated Convention on the Rights of People with Disabilities. The third attempt to get such a convention on the agenda of the United Nations succeeded in 2000, and momentum for grass roots support for the convention has been growing since that time. It is considered to be the most important legal development since the Declaration on the Rights of People with Disabilities, the real effect of which was to begin the process of giving recognition to the entitlement of all people with disabilities to be included as full members of the community. But can international law do anything to improve the position of people with psychiatric disabilities and mental illness? Anti-discrimination laws have had some impact on the lives of people with disabilities, but the benefits have not always flowed to people with mental illness. It is hoped that the proposed Convention will adopt an human rights approach, and that this may give it significantly more force than an anti-discrimination law. But will the process of developing the law result in a strong or a weak law? Will it have any teeth to ensure that it does not become a paper tiger? Will all disability groups be equally empowered? And what real benefit can flow from international law? This paper will consider these and other issues for people with mental illness and for societies concerned to take the right to (mental) health seriously.

**The mental health impact of human rights violations: Responses in international law**

*Barbara Von Tigerstrom, School of Law, University of Canterbury*

An individual who is the victim of a human rights violation will often suffer mental trauma and distress, to a greater or lesser degree depending on the nature and severity of the violation. This traumatic effect – of which there is increasing awareness and understanding among mental health professionals and others – plays an important role in the rationale for preventing and punishing human rights violations. This paper approaches the issue from a different angle, examining some of the ways in which international legal instruments and institutions have explicitly recognized and responded to the impact on mental health of traumatic events such as human rights violations. The recognition in the International Covenant on Economic, Social and Cultural Rights of “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” provides the basis for a general obligation to provide appropriate mental health services for individuals, including victims of abuses. An alternative basis is the right to an effective remedy for human rights violations, which may include the right to “rehabilitation” where required. These are further articulated in the substantive obligations of states in relevant instruments, as well as reporting obligations, implementation of obligations, and remedies for victims of violations. Examples of these and some of the issues they raise are examined in the paper.

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Fri. Oct. 3, 2003 (8:30–17:40)  Boardroom 1 (Ground Floor)

Registration  8:00–8:30

Choosing Death: Euthanasia and Suicide  8:30–10:00

Chair:  Margaret O’tlowski,  Faculty of Law, University of Tasmania

Attitudes to euthanasia of Queensland doctors, nurses and community members: Reasons behind the attitudes, and changes between 1995 and 2000
Colleen Cartwright and Gail Williams,  School of Population Health, University of Queensland; Margaret Steinberg,  Centre for Philanthropic & Non-Profit Studies, Qld University of Technology

The Dutch experiment in regulating euthanasia: Some lessons to learn
Albert Klijn,  Department of Legal Theory, University of Groningen

Ethical issues in suicide research
Brian Mishara,  Département de psychologie, Université du Québec à Montréal; David N. Weisstub,  Faculté de médecine, Université de Montréal

Break  10:00–10:30

Anorexia Nervosa  10:30–12:30

Chair:  Diane Robinson,  Deputy President,  Mental Health Tribunal of New South Wales

Therapeutic pathways in treatment of severe Anorexia Nervosa?
Terry Carney,  Faculty of Law,  University of Sydney; David Tait,  Dept. of Sociology,  University of Canberra; Dominique Saunders,  Research Associate,  University of Sydney; Stephen Touyz,  School of Psychology,  University of Sydney; Alison Wakefield,  Dietician,  RPA, Sydney; Pierre Beumont,  Dept. of Psychological Medicine, University of Sydney

Can psychiatric terminology be translated into legal regulation: The anorexia example
Pierre Beumont,  Dept. of Psychological Medicine, University of Sydney; Terry Carney,  Faculty of Law, University of Sydney

Understandings of coercion in the treatment of patients with anorexia nervosa
Stephen Touyz,  School of Psychology,  University of Sydney; Miriam Ingvarson,  Dept. of Criminology,  University of Melbourne; David Tait,  Dept. of Sociology,  University of Canberra

Lunch  12:30–13:30

Law, Equity and Mental Health  13:30–17:30

Chair:  Belinda Bennett,  Faculty of Law, University of Sydney

International law, reparations and racial health: Global problems and remedies
Alfreda Robinson,  George Washington University Law School

The (US) ‘justice’ system: A view from the street
Krista Ralston,  Law School,  University of Wisconsin-Madison

A dangerous intersection: Assessing the interplay of race and (mental) disability
Camille Nelson,  Saint Louis University School of Law

Nigger and the economy of citizenship, race epithets as proxy in law & society
Michele Goodwin,  School of Law,  DePaul University

Break  15:30–16:00

Restricting abortion in the name of mental health: Data and implications
Nada Stotland,  Dept. of Psychiatry,  Rush Medical College, Chicago

Sexual identity and marriage
Iyla Davies,  Faculty of Law,  Queensland University of Technology

Undue influence: What’s psych got to do with it?
Patricia Recupero, Alison Heru, and Marilyn Price,  Brown University School of Medicine

End of Congress  17:30
Abstracts

Choosing Death: Euthanasia and Suicide

Attitudes to euthanasia of Queensland doctors, nurses and community members: Reasons behind the attitudes, and changes between 1995 and 2000

Colleen Cartwright and Gail Williams, School of Population Health, University of Queensland; Margaret Steinberg, Centre for Philanthropic & Non-Profit Studies, Qld University of Technology

Introduction: In 1995 researchers from the University of Queensland published results of a study into attitudes of doctors, nurses and community members to euthanasia and other end-of-life issues. Soon after, Australia became the first place in the world to allow both euthanasia and physician-assisted suicide with the NT Rights of the Terminally Ill Act. This was subsequently overturned by the Commonwealth’s Euthanasia Laws Act 1997. In 2000, another study was undertaken to determine whether the community debate that followed the legislation had changed attitudes, and what other factors affected such attitudes. This paper reports the results of the study.

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The Dutch experiment in regulating euthanasia: Some lessons to learn

Albert Klijn, Department of Legal Theory, University of Groningen

During the last thirty years, the Dutch have successively done away with traditional criminal law enforcement in the area of euthanasia. First, the process of legal change, started in the seventies, was finished in the mid-eighties due to decisions of the Supreme Court upholding the defence of necessity when the doctor faces a conflict of duties. At the same time, the medical profession and the courts agreed upon a number of ‘substantive requirements of careful practice’ as well as a number of procedural ones that doctors have to meet in order to be freed from the risk of criminal prosecution. The second phase took off in the beginning of the nineties when the medical profession and the prosecutorial authorities embarked on a reporting procedure essentially based on the self report of doctors to the authorities. The third phase began in the late nineties with the introduction of the so called Regional Assessment Committees. These multidisciplinary agencies were meant to embody a new type of professional-legal control.

The Dutch policy on euthanasia has always been focused on increasing social control of doctors’ behaviour. In order to know whether this policy has been effective the government commissioned three successive national research projects in 1990, in 1995 and in 2000. The results of the latter were reported very recently this year. Based on the empirical findings of especially the most recent study, I will focus on the question to what extent the Dutch policy can be considered to be successful: Do doctors behave in a more accountable fashion? Unlike the conclusion the authors draw from their research, I will argue this is not the case and that substantial changes are required in the structure of the Dutch control regime. This is not because of the failure of the committees but because we should learn from their experiences.

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Ethical issues in suicide research

Brian Mishara, Département de psychologie, Université du Québec à Montréal; David N. Weisstub, Faculté de médecine, Université de Montréal

Three cases are enlisted to clarify central areas of ethical concern in suicide research: non-treatment control groups in testing new interventions, elimination of suicidal participants in evaluating the effectiveness of new psychotropic medications, and decision whether or not to divulge confidential information in order to potentially save the life of a participant. The challenge in all of these cases is whether either general principles and/or effective guidelines can be constructed which fulfil the requirement of respecting values around which there is broad general consensus. In suicide research, as in many other fields of scientific enquiry, there is the persistent dilemma of how to accommodate cultural diversity with the need for global direction.

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Anorexia Nervosa

Therapeutic pathways in treatment of severe Anorexia Nervosa?

Terry Carney, Faculty of Law, University of Sydney; David Tait, Dept. of Sociology, University of Canberra; Dominique Saunders, Research Associate, University of Sydney; Stephen Touyz, School of Psychology, University of Sydney; Alison Wakefield, Dietician, RPA, Sydney; Pierre Beumont, Dept. of Psychological Medicine, University of Sydney

Choices about invoking the law in aid of treatment of severe anorexia nervosa (AN) patients, and the reception given by patients and carers to those choices, reveal that it is a highly complex, and deeply contextualised decision. This paper reports qualitative and quantitative data from a study of ‘choice’ between contemplating the use of, but ultimately not using the law to assist treatment of AN, and actually invoking it to coerce treatment; along with data regarding subsequent choices made between using guardianship or mental health (and other) avenues for achieving such coerced treatment interventions.

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Can psychiatric terminology be translated into legal regulation: The anorexia example

Pierre Beumont, Dept. of Psychological Medicine, University of Sydney; Terry Carney, Faculty of Law, University of Sydney

Psychiatric terminology is fluid and flexible, in the interests of providing responsive care and support to patient needs. Driven by the imperative to secure basic liberties and civil rights of citizens, legal terminology favours technical precision and fine distinctions. In mental health law, these two cultures intersect. Anorexia nervosa is one exemplar of the tension between preservation of liberty and the clinical imperative to treat. This paper demonstrates that there is indeed an oil and water incompatibility between the two dialogues at a formal level. Court interpretations often create angst for psychiatry. In practice, however, mental health admissions and tribunal reviews generally do adopt the more capacious and fluid terminology favoured by psychiatry.

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Understandings of coercion in the treatment of patients with anorexia nervosa

Stephen Touyz, School of Psychology, University of Sydney; Miriam Ingvarson, Dept. of Criminology, University Of Melbourne; David Tait, Dept. of Sociology, University of Canberra

The use of coercion in the treatment of people with eating disorders has been controversial both in terms of its effectiveness and its restrictions on civil liberties. Using data from NSW and Victoria, this paper reports the views of former patients about their memories of coercion, including specific drug, nutritional and behavioural therapies, threats to use legal procedures, and the use of mental health and guardianship legislation to permit involuntary treatment. It places this in the context of a review of the state of operant conditioning research.

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Involuntary treatment of eating disorders: Legal, scientific and ethical dimensions

Laura Ragione, Department of Mental Health, Perugia; Raffaele Ruocco, Monteluce Hospital, Perugia

The compulsory medical treatment of Eating Disorders is one of the most controversial and heavily debated questions of recent years. Among the diagnostic categories of DSM-IV, mental illnesses resulting in eating disorders have the highest mortality rate after drug addictions. In particular, the mortality rate for anorexia nervosa is even higher as treatment is often refused and consequently diagnosis and treatment are delayed for years and the prognosis therefore suffers from these long periods. Consequently, the classic question that we ask ourselves, sometimes in dramatic terms, is: is it better to force treatment or not? The American guidelines for the treatment of Eating Disorders (2000 revision) tackle the problem in two or three passages “Legal interventions, including involuntary hospitalisation and legal guardianship, may be necessary to ensure the safety of treatment of reluctant patients whose general medical conditions are life-threatening”: “On these rare occasions staff have to take over the responsibilities for providing life-preserving care. Nasogastric feedings are preferable to intravenous feedings...total parenteral feeding is required only very rarely and in life-threatening situations”; “In situations where involuntary forced feeding is considered, careful thought should be given to clinical circumstances, family opinion, and relevant legal and ethical dimensions of the patient’s treatment.” In Italian legislation, compulsory medical treatment is specified for mental illnesses of which, however, there is no specific indication. Phenomena such as anorexia nervosa do not have their own position in the legislation. The bibliographic review of the most recent international literature leads us to observe that there are no agreed guidelines on the use of such an extreme measure as compulsory medical treatment. In our medical experience, therapeutic intervention of the cognitive-behavioural type for patients who do not present serious psychiatric comorbidities appears to drastically reduce or even eliminate any recourse to compulsory treatment seen as aggressive, intrusive, no cooperative, hostile and linked to a lack of value of the patients.

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A gendered malady: How gender identity affects treatment of anorexia Nervosa

Joanne Stagg-Taylor, Faculty of Law, Queensland University of Technology

Anorexia nervosa is often characterized as a disease of girls and women. The author examines issues of identity and how the legal systems of several common law jurisdictions (including Australia and the United Kingdom) respond to the treatment of anorexia and other eating disorders. She argues that that legal response creates, is influenced by and reinforces stereotypical gender identity. As part of her examination of the gendered legal response to anorexia, she juxtaposes the legal response to anorexia with the legal treatment of patients with other types of disordered body image and of hunger strikers.

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Law, Equity and Mental Health

International law, reparations and racial health: Global problems and remedies

Alfreda Robinson, George Washington University Law School

The movement for Reparations and the movement for Corporate Social Responsibility have a point of intersection. At that point, the two generate a profound, salubrious, and comprehensive discourse on two of the most powerful forces in the World - race and the corporation. These two subjects, taken together, define, prescribe, or legitimize
Social Dimensions of Law and Mental Health

every aspect of our society and economy, and play critical roles in the formulation of our social, economic, and political agendas. In a soon to be published Rutgers Law Review Article, I discuss the implications of the intersection and bring Critical Race Theory and Reparations Theory to the corporation in order to urge and envision the broadest possible form of Corporate Social Responsibility. The Article examines corporations through the perspective of Critical Race Theory to argue that responsible corporations should join the Reparations movement and voluntarily provide compensation to African Americans for past racially motivated corporate malfeasance. I propose a new theoretical construct called the Critical Race Corporate Law Theory, a new Reparations theory called the Corporate Reparations Paradigm, and a new Reparations Remedy called the Corporate Reparations Investment Remedy. All over the globe, “race matters.” For this reason, Reparations is uniquely suited for application of Critical Race Theory or CRT because - as noted above - CRT posits that racism is part of the American and International experience, is transformative insofar as CRT seeks to construct a new American and global reality (laws, structures, and culture), and adopts Professor Derrick Bell’s interest-convergence view that the advancement of the interests of African American and other subordinated peoples are tied to white interests. The later premises are at the core of Reparations demands. Similarly, the proposed Critical Race Corporate Law Theory and the Corporate Reparations Paradigm are based on the core principles of Critical Race Theory. Today, as we battle terrorism at home and abroad, “race still matters” in America and in the International community. Moreover, the health care crisis is also “racialized.” Indeed, race has always mattered, as both Critical Race Theorists and traditional scholars remind us. Race is an inescapable determinate of every aspect of the American and International society. Consequently, race determines each country’s social, political, legal, and economic structures. Significantly, race and racism divide us into the healthy and diseased, powerful and powerless, rich and poor, employed and unemployed, homeowners and renters, suburbanites and urbanites, executioners and executed, free and incarcerated, professional and unskilled, capitalists and workers, and investors and investment-less. Race creates, governs, influences, and dominates our social order, including the delivery of vital health care. Hence, race determines whether one lives or dies. This is best evidenced by the mental health crisis worldwide, HIV/AIDS crisis in Africa, infant mortality rates worldwide, and the drug epidemic in U.S. Hence, there is a profound racial health care disparity. If Reparations are to be provided by corporations and others for past racially motivated, Human Rights violations, the reparative remedies should address the racial health care disparity.

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A dangerous intersection: Assessing the interplay of race and (mental) disability
Camille Nelson, Saint Louis University School of Law

The concept of intersectionality focuses on identity politics as a process of recognizing as social and systematic what was formerly perceived as isolated and individual. While there is an impressive amount of literature addressing the intersection of race and gender and a growing body of scholarship addressing race and sexual orientation, there is a dearth of information addressing the intersection of disability issues and race. It seems to me that this intersection, especially as it pertains to the criminal law, has implications both for the legal system and the medical profession as it implicates both law enforcement and psychiatric/psychological treatment modalities. I intend to explore this area to assess the utility of considering this intersection as an appropriate location of academic and practical concern.

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Nigger and the economy of citizenship, race epithets as proxy in law & society
Michele Goodwin, School of Law, DePaul University

Although less explored in the context of hate speech, racial epithets and the word nigger in particular, help to shape our notions and understanding of citizenship. Socially and politically, nigger reminds us of the compromised status of blacks in the United States and how they have historically been dispossessed of the freedoms, liberties, rights and privileges enjoyed by white Americans. That America’s forefathers debated whether blacks were worthy of citizenship, and ultimately decided that they were undeserving, is formula and precedent by which critical race theorist suggest that blacks continue to be judged. By doing so, those who helped to shape America’s moral character, criminal laws, religious ideology, policies, and legal doctrine, seemingly and irreparably distinguished blacks as subjects, rather than citizens. In this way blacks were objects to be acted upon rather than autonomous actors or individuals to which rights attached. Justice Taney’s opinion in the Dred Scott case is informative on this point. The Chief Justice concluded that blacks, freed or not, ‘had no rights whites were bound to respect.’ In this seminal decision, Taney struck down the Missouri Compromise and made it clear that all blacks, free or enslaved, were not and could never become citizens of the United States. Taney opined, ‘the Negro might justly and lawfully be reduced to slavery for his benefit. He was bought and sold and treated as an ordinary article of merchandise and traffic, whenever profit could be made by it.’ The High Court’s opinion remains hauntingly unambiguous. The Court held that ‘it is too clear for dispute, that the enslaved African race were not intended to be included, and formed no part of the people who framed and adopted’ the Declaration of Independence. In describing the evolution of nigger, I wish to present several key ideas: the necessary synonymy between black and nigger, the compromised status of black citizenship, biological and psychological explanations used to justify legal and social subordination of blacks, and the racially gendered aspect of slavery and citizenship. This article uses a law in action framework and argues that nigger’s strange and purposeful history in America began with slavery,
The article scrutinizes myths, images and violence associated with the ‘concept of nigger’ including the power of false claims by whites that blacks have harmed them or their families (i.e. Susan Smith, Charles Stuart, etc). I discuss the wounding power of nigger and its connection to gender as historical, psychological and legal construct, and also as a contemporary model in the entertainment industry.

Krista Ralston, Law School, University of Wisconsin-Madison

This paper focuses on the ‘justice’ system’s failure to provide justice for the poor, the homeless and the mentally disabled. For them the concepts of equality, justice, and even simple fairness, tend to be illusory and elusive ideals rather than reality. Some have argued that instead of promoting justice, ‘the defining feature of law is that it operates to facilitate exploitation and discrimination.’ In fact, the concept of substantive justice is often glaringly missing from legal reasoning and discourse, especially in its application to the disenfranchised. In the USA, the richest of the western democracies where equal opportunity is an article of faith, millions of citizens and legal residents are social and legal outcasts or throwaways. Mostly, these are persons who have few financial resources and suffer multiple other social, medical and legal disadvantages, often through little or no fault of their own. Although federal, state, and local governments, as well as private agencies and organizations, provide many vital services to the poor, the stigmas accompanying poverty are extremely difficult to overcome. Unfortunately, the American ‘justice system’, which should be in the forefront of the fight for equality, often tends to be counter-productive, especially when mental health and/or substance abuse issues complicate the picture.

Nada Stotland, Dept. of Psychiatry, Rush Medical College, Chicago

Numerous studies conducted in the United States and elsewhere in the world have confirmed that continued pregnancy and childbirth are associated with a substantially higher rate of psychiatric sequela as than terminated pregnancy, and that psychiatric problems after abortion either existed prior to the procedure or can be explained by the circumstances that occasioned the abortion and the circumstances under which it was performed. Women who are allowed to make autonomous choices about their pregnancies and to receive support for those choices experience the best outcomes. Legal barriers to abortion services undermine women’s autonomy and expose women to the biopsychosocial threats of unwanted childbearing or illegal abortion. Such barriers, despite the scientific data, are often rationalized on the basis of purported mental health advantages or disadvantages, including a need for a mandated period of time in which to make an informed decision; and complications such as depression, suicide, substance abuse, and inability to relate to children born subsequent to the abortion. Mental health practitioners, attorneys, and policy makers need to be aware of these deliberate misrepresentations of mental health findings and oppose laws and interpretations of laws that impose a discriminatory burden on women.

Iyla Davies, Faculty of Law, Queensland University of Technology

Historically, family courts have interpreted marriage narrowly, as a union between a man and a woman. Recently, a decision of the Family Court of Australia has expanded this definition to include a union involving a post-operative transsexual husband. The landmark decision by Justice Chisholm in Re Kevin takes account of the radical advances made in other fields for determining sexual identity. A range of medical, psychological and social contexts will be explored in this paper and a comparative analysis of the law in a number of other jurisdictions will also be conducted. The decision represents a recognition and acceptance of difference by the court. However, the decision has not been universally accepted and the Australian Attorney-General has taken the case on appeal.

Marilyn Price, Brown University School of Medicine

The American law of property and inheritance is based on the Common Law heritage received from medieval England. The rule of primogeniture regulated the inheritance of the major form of wealth – real property, and generally limited inheritance of real property to male heirs. The principle of covertures place control of a woman’s real estate in her husband’s hands. Passage of a statute was necessary in order to allow the making of wills that might disrupt the male inheritance. Thus, it should not be surprising that the principles incorporated into laws of intestate inheritance or the proof of wills would reflect a “male” paradigm and reward relationships consistent with the Common Law’s world view. The presumption favoring blood relatives in inheritance remains in full force. In fact, in dealing with the transfer of an estate at or near death, whether by will or contract, the law traditionally rewards those who would claim the estate by virtue of some status as a blood relative rather than by virtue of a caring relationship. A prime example of this can be seen in the concept of dower estates whereby a widow could...
be put out of her home by the inheriting son on the death of her husband. The widow could be forced to live in poverty on a corner of the estate. Modern culture is also infected with the prejudice against the “gold digging” second wife; and the widow is often the subject of litigation to reclaim the estate when the husband dies. The Common Law also did not give legal weight to many types of relationships that have become quite common today such as domestic partnerships without the benefit of marriage, same sex relationships and other caring relationships that may arise between two consenting adults. For example, two people may spend many years together in a domestic relationship and one may be suddenly stricken with a fatal illness. oftentimes if a will is made favoring the partner over the blood relations, the will will be contested on the grounds of undue influence. This paper will consider the Common Law of undue influence in relationship to feminist ethics and feminist jurisprudence. A description of feminist ethical models will be presented with application to issues of undue influence. We will propose a redefinition of the presumptions of the law favoring blood relatives in favor of an assessment of the multiplicity of relationships that may give rise to a donative intent.

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Abstracts

Public Health – Global Health

The history and future of global bioethics
Peter J. Whitehouse, Fairhill Center on Aging, Case Western Reserve University

The history and future of global bioethics, Van Rensselaer Potter’s original concept of bioethics as a global integration of biology and values, was designed to guide human survival. As the title of his first book stated he saw bioethics as a bridge to the future. As a basic cancer researcher Van was aware of the complexities of biological systems and the dangers of uncontrolled growth. His attention to the creation of human wisdom and the incorporation of ecological concepts in his theory remain important, yet largely neglected, contributions. Van’s attempts to bridge various forms of bioethics to create a global bioethics continued throughout his long career at the University of Wisconsin. He lived and died with a profound sense of humility and was guided in his own life by his own published ethical creed. Recognizing the importance of the spiritual aspects of love of nature Van and I extended the concept of global bioethics to deep bioethics, mirroring the term deep ecology. Our lack of attention to environmental and public health in bioethics itself and society as a whole is too slowly being recognized. The threat of human beings using small pox or other agents to kill fellow human beings is creating a campaign of terror. Yet bioterrorism comes in many forms over different time windows. The dominance of profit making medical claims for cure for age-related conditions is one example of attempted application of limited concepts of health. The challenges of age-related chronic diseases, like the label Alzheimer disease, point out the limitations of these conceptions. Focusing on enhancing our collective wisdom through educational innovations, such as the creation of multi-age learning communities (e.g. The Intergenerational School, Cleveland, Ohio), will provide one long term solution to our current lack of commitment to building sustainable healthy communities. Bioethicists should heed Van’s warnings about our unsustainable health care systems and work towards changing their values, while considering the example of Van’s authentic life style as inspiration.

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Travel in a small world: SARS, globalisation and public health laws
Belinda Bennett, Faculty of Law, University of Sydney

In early 2003 the international community witnessed the emergence of a new infectious disease, severe acute respiratory syndrome (SARS). SARS rapidly became a global phenomenon that sparked international concern. This paper will trace the emergence of SARS, its impact on affected areas and the international responses to the
Globalisation and Health

Jolyon Ford and George F. Tomossy, Faculty of Law, University of Sydney

Globalisation has contributed to the rapid proliferation of clinical trials throughout the world. The conduct of international biomedical research by multinational pharmaceutical corporations, however, has also raised a host of ethical and legal questions. A foremost concern has been for the equitable distribution of the benefits of health innovation, such as in the context of access to HIV/AIDS treatments. Developing nations have asserted their rights of access to expensive medications, despite corporate efforts to protect their profits within a global market. The other aspect of distributive justice in research lies in the equitable distribution of risks. This principle requires that citizens of one jurisdiction should not be exposed to risks of harm in order to benefit others elsewhere. Biomedical research is an inherently risky process, and must rely on the good faith of investigators, sponsors and regulators to protect human subjects by reducing risks and taking all manner of precautions to safeguard their welfare. However, when the system fails and an adverse event does occur, it is a further requirement of ethical research that...
subjects be duly compensated. When this is denied, particularly in a case where death or injury is linked to unethical conduct, the need for compensation is supplemented by broader concerns of justice and human rights. The problem with international research in developing countries from the perspective of the aggrieved human subject is twofold: local infrastructure for human subject protection is virtually nonexistent; and clear lines of international accountability and mechanisms for compensation are lacking. This paper will explore these two themes in reference to the Trovan study, which has received significant media attention. It has been alleged that numerous ethical wrongdoings occurred in the course of the trial, which have been said to be related to the death and disabling injury of a number of children. As of February 14, 2003, class actions against Pfizer have been filed in both Nigeria and the United States.

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After the glass bead game: Biotechnology, economics, ethics and human rights
Derek Morgan, Cardiff Law School

Biotechnology seems to have arrived at a defining constitutional moment. The UK House of Lords Select Committee on Science observed that ‘society’s relationship with science is in a critical phase …’ And the European Commission that; ‘Europe is currently at a cross-roads; … Europe’s policy choice is, therefore, not whether, but how to deal with the challenges posed by the new knowledge and its applications.’

If, but only if, economic unions are really only about the freedom of provision of services then it tends towards (not yet more) the argument that (e.g.,) the European Union may be about the commodification of things which by definition – ought morally speaking to be dissociated from commerce. The core problem and issue in anticipating and regulating biotechnology internationally is that ethical concerns might be perceived as promoting ulterior national standards that might obstruct the World Trade Organisation’s mission to promote international trade. With the development of biotechnology and the emergent bio-economy comes the opportunity, almost the responsibility, to continue the process of defining the status of the unions such as the EU as a polity beyond its economic base.

This arrives, hardly surprisingly, at a time when in international law generally, in international human rights law specifically, and in a drilled down fashion, in domestic legal systems more particularly, the responsibility of state and non state actors to secure more than economic ideals is being actively debated. An international community that believed that it has an economic rationale alone, that abandoned or bequeathed these wider responsibilities solely to private corporations, might be subject to castigation and opprobrium. It would follow that the organs and the institutions of that community, including its courts of justice, would be required to develop a social, indeed a moral, vision with which to respond to biotechnology. Biotechnology and the coming bio-economy requires states to develop a moral vision to complement its economic one because the down side or dark side of the bio-economy will be the ethical problems and dilemmas that it discloses, just as concerns with privacy have been the downside of the information economy. Ethical issues have an umbilical link with the bio-economy and to treat them as an add-on, an afterthought, will be quite insufficient to deal appropriately with this downside.

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END OF PROGRAM
Continuing Education Seminars

28th International Congress on Law & Mental Health


Faculty of Law
University of Sydney
173-175 Phillip St., Lvl 13

The Sofitel Wentworth Sydney
61 Phillip Street, Sydney, NSW
Boardrooms 1 & 2 – Ground Floor
Sydney Room – 3rd Floor

The IALMH is delighted to offer three continuing education events.

The Academy is grateful for collaboration of the Faculty of Law, University of Sydney, and Australian Association of Gerontology in realising these Seminars.
A special Pre-Congress event has been organised for graduate students undertaking research in the field of law & mental health. Academy members with considerable experience in mental health research will offer advice, facilitate problem-solving and give presentations on a range of research issues. These will include:

- Qualitative research
- Quantitative research
- Historical research
- Using theory in research
- Research ethics

The Academy welcomes involvement from graduate students at all stages of their research. This workshop is free of charge to students registering for the 28th Congress.

Programme of Events

9.30: Welcome

Session I

Faculty of Law, University of Sydney (173–175 Phillip St., Level 13)

10.00: Introductions

10.15: Doing Qualitative Research (Terry Carney, University of Sydney)

10.45: Doing Quantitative Research (Philip Boyce, University of Sydney)

11.15: Using Historical Sources (Peter Bartlett, University of Nottingham)

11.45: Using Theory in Research (Kirsty Keywood, University of Manchester)

12.15: Some Ethical Problems in Research with Involuntary Patients (John Dawson, University of Otago)

Lunch

Session II

Faculty of Law, University of Sydney (173–175 Phillip St., Level 6)

2.15 - 5.00

Graduate students will be invited to provide a brief overview of their research topic and share any particular difficulties or challenges they are currently facing. A panel of academics will be on hand to offer advice, guidance and support.
Social Dimensions of Law and Mental Health

Workshop – Dementia Care Ethics

Mon. Sept. 29, 2003 (17:00-19:30)  Sydney Room (3rd Floor)

Convened by:  Anna L. Howe, Consultant Gerontologist, Melbourne

Chair:  Henry Brodaty, Chairman of Alzheimer’s Disease International, Professor of Psychogeriatrics, University of New South Wales, and Director, Aged Care Psychiatry, Prince of Wales Hospital

This special workshop will be led by Peter J. Whitehouse, a leading specialist and scholar in the field of dementia care, Director of Integrative Studies and Professor of Neurology, Psychology, Nursing, Biomedical Ethics and Organizational Behavior & History at Case Western University.

The following topics will be canvassed:

• Ethical frameworks – principles to narrative to global
• Perspectives – affected person, informal and formal caregivers, society
• Specific ethical issues
• Genetic susceptibility testing
• Diagnostic disclosure and informed consent
• Research ethics
  ◦ Conflicts of interest
  ◦ Use of placebos
  ◦ End-of-life issues
• Values in the future of care

CLE – Work and Stress

Wed. Oct. 1, 2003 (18:00-17:30)  Boardroom 2 (Ground Floor)

Convened by:  Ron McCallum and Joellen Riley, Faculty of Law, University of Sydney

Managing stress and mental health in the workplace
Leah Charlson, Cutler Hughes Harris, Sydney

Employers have a duty to protect and promote mental health in the workplace. Employers are also prohibited from discriminating against employees with mental illness, and must take pro-active steps to eliminate employment conditions which are potentially detrimental to mental health, such as bullying and harassment. Various areas of the law, including the common law of negligence, occupational health and safety law, workers’ compensation law, anti-discrimination law and industrial law create duties and obligations for employers. Employers should be aware of all these areas of law in developing strategies to manage mental illness at work.

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De-stressing the workplace: The challenge of “de-legalising” the lawyer’s role in workplace stress management.
David Stewart, Harmers Workplace Lawyers, Sydney

Too often, the lawyer’s role in managing workplace stress is as an advocate for one side or other in a situation of conflict. Conceptualising workplace stress in terms of legal obligations and liabilities can itself promote stress and create barriers to effective solutions. David Stewart, Partner with Harmers Workplace Lawyers, advocates a multi-disciplinary approach, which involves listening to psychologists and mental health experts, and early intervention in workplace situations. Through his professional experience in dealing with many cases - on behalf of both employers and employees - he has identified common early warning signals of potentially stress-inducing workplace conflicts. He will identify common themes in cases of conflict, and strategies for early intervention and prevention.

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New Paradigms in the Australian Law of Causation
Danuta Mendelson, Associate Professor, School of Law, Deakin University

The paper will examine codification of the major principles law of causation undertaken by the Parliaments of Australian States and territories in 2002-03 against the background of such common law precedents as Chappel v Hart (1998) 195 CLR 232 and Rosenberg v Percival (2001) 178 ALR 577. The paper will analyse jurisprudential reasons for the change in the law, differences in formulation of statutory provisions between jurisdictions and their legal consequences, particularly in relation to medical malpractice litigation. It will also discuss applicability of common law doctrines of causation in the context of the new statutory regime.

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Legal Scientism
David Healy, University of Wales School of Medicine

The principles behind any determination of possible linkages between a cause and an effect in the scientific domain such as between microbes and diseases or drugs and adverse effects are commonly termed Koch’s Postulates. Allied to these in the legal domain in the case of drug-induced injury are requirements to demonstrate culpability on the part of a company or agent of a company or acceptance on the part of the company of a link, as well as demonstrations that the relevant causal chain applies in the case of a particular plaintiff.

While this theory still stands in principle, in practice in recent years following Daubert v Merrell Dow in the United States, and actions against the manufacturers of breast implants, there is an increasing emphasis on epidemiology and randomised controlled trials (RCTs) in the determination of drug induced injury. In addition to being scientifically inappropriate, claims that these expensive technologies are needed to settle causation as regards drug induced injury mean that only pharmaceutical companies have the resources to establish cause and effect – if their claims as regards the appropriate methods to establish cause and effect are conceded. Although Merrell Dow lost the Daubert case, company claims as regards cause and effect have led to a series of Daubert hearings in recent years, in which these claims have been put forward. These claims have led in Court to their logical conclusion, which is pharmaceutical company arguments that even the concessions of a causal link between a drug and an adverse effect by members of a company’s scientific staff have no legal validity if they are not supported by RCTs or epidemiological evidence.

Pharmaceutical companies have also begun to adopt pre-emption strategies, effectively claiming that because the regulators have licensed the drug, companies cannot be held responsible for adverse events on treatment in clinical practice. To label a product with warnings that have not been approved by regulators would be illegal, they argue. As most drugs come in classes these days, regulators are faced with the difficult task of getting all companies in the class to agree to a specific warning.

These scenarios along with systematic failures to properly record adverse event data in clinical trials effectively mean that anyone participating in any clinical trial linked to a pharmaceutical company at present is putting everyone else in a state of legal jeopardy.

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A principal aim of the IALMH is to stimulate scholarship in the multidisciplinary field of Law and Mental Health. This area of study has matured over the past decades, encompassing many disciplines that are concerned with the welfare of persons with mental illness or intellectual disability. The Academy’s annual Congresses have followed this evolution. Its official publication, the International Journal of Law and Psychiatry, now in its 26th year and appearing bimonthly, contains scholarly articles that range from empirical research on patterns of violence to reflections on psychiatric ethics. Special issues, such as on Forensic History, Mental Competency and Aging, provide unique resources for researchers. Papers presented at past Congresses have also appeared in numerous other journals and edited volumes.

The Academy wishes to encourage colleagues who have presented their work at the 28th International Congress in Sydney to publish their work, thus stimulating policy development and further enhancing learning in this field that is of ongoing social relevance in jurisdictions throughout the world.

Space will be allocated on the Academy’s web site (www.ialmh.org) to provide details of citations and abstracts for published papers that acknowledge the Sydney Congress, with links to electronic versions of the publication where available and to authors’ home pages or e-mail addresses if desired. The aim is to provide a living resource for future research that will be continued in subsequent Congresses.

For inclusion in this web bibliography, colleagues are requested to do the following:

- Provide an appropriate acknowledgement in their published paper such as: “An earlier version of this paper was presented at the 28th International Congress on Law and Mental Health in Sydney, Australia, Sept. 30-Oct. 3, 2003.”
- Communicate the citation details and abstract (max. 250 words) of the publication once it has been published (and an electronic version or link to an online version where possible and authorised by the publisher) by e-mail to: Sydney2003@ialmh.org
- Please indicate “Sydney Congress Publication” in the e-mail subject header.

Citations should follow the following format:


Citations will also be accepted in MEDLARS, Endnote or Reference Manager formats.

Links to the corresponding author’s e-mail address or web page will be added upon request.
The Academy is pleased to recommend the following peer-reviewed journals and book series for the submission of papers or monographs for publication.

**International Journal of Law and Psychiatry**  
Editor-in-Chief: David N. Weisstub  
Published bimonthly by Elsevier Science (Oxford)  
Instructions for Authors:  
http://www.ialmh.org/General/journal.htm

**International Library of Ethics, Law and the New Medicine**  
Editor-in-Chief: David N. Weisstub  
Publisher by Kluwer Academic Press (Dordrecht)  
Instructions for Authors:  
http://www.wkap.nl/prod/s/LIME

**Sydney Institute of Criminology Monograph Series**  
Series Editors: Chris Cunneen, Mark Findlay & Julie Stubbs  
Author details contact: criminology@law.usyd.edu.au

**Journal of Law and Medicine**  
Editor: Ian Freckelton  
Published quarterly by Thomson Legal and Regulatory.  
Instructions for Authors:  

**Psychiatry, Psychology and Law**  
Editor: Ian Freckelton  
Published biannually by the Australian Academic Press  
Instructions for Authors:  

**Monash Bioethics Review**  
Editors: Justin Oakley & Deborah Zion  
Published quarterly by the Monash University Centre on Human Bioethics (Melbourne)  
Instructions for Authors:  

**Bioethics**  
Editors: Ruth Chadwick & Udo Schüklenk  
Published bimonthly by Blackwell Press  
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http://www.blackwellpublishing.com/journals/bioethics/

**Developing World Bioethics**  
Editor: Udo Schüklenk  
Published biannually by Blackwell Press  
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