Mental Health Regulations and Licensing Restrictions

Argentina • Canada • China • England
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Japan • Mexico • New Zealand • Norway
Russian Federation • South Africa

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Contents

COMPARATIVE SUMMARY

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SUMMARY Fourteen jurisdictions were surveyed as to their mental health care systems, with special attention to mental health background check requirements for licenses for specific activities, including driving and owning firearms**.** In most cases, such checks are routine for issuing firearms licenses but not for drivers' licenses.

The attached reports discuss aspects of mental health law in fourteen jurisdictions. They cover a number of topics, including how mental health care is provided in the particular country, under what conditions such care can be compulsory for patients and what rights such patients have, and whether or not mental health evaluations are required for various types of licenses, such as licenses to drive and to own firearms.

I. Provision of Mental Health Care

Countries with national health care systems generally include mental health care services within those systems. This is the case, for example, in England, Japan, New Zealand, and Norway. In Germany, social health care covers 90% of the populace while private insurance covers the remaining 10%, with both systems providing coverage for mental health treatment. In Canada, such care is organized by each province. In China, mental health care is provided through one of three ministries, each of which maintains its own psychiatric hospitals: The Ministry of Health administers treatment settings (mostly in public hospitals) that cater to the needs of the general public. The Ministry of Civil Affairs, on the other hand, covers military veterans who had mental illnesses while in the service, as well as those who are unable to work or have no other means to afford mental health care. Finally, the Ministry of Public Security (the police) has facilities for those who cause serious incidents because of their mental health conditions.

In Argentina, health care is divided between a public-sector system, supported with taxes; a private-sector system, supported through voluntary private insurance; and the social-security system, supported through mandatory insurance. The National Directorate on Mental Health and Addictions, created in 2010 under the administration of the Ministry of Health, determines policy for mental health services.

In the European Union, mental health care, as all health care, is an area of shared responsibility between the EU and its Member States. While the States define their own health policy and deliver health care services, the EU encourages cooperation between EU Members so that health care services complement each other throughout the EU.

II. Compulsory Treatment

All the jurisdictions surveyed had the possibility of some form of compulsory mental health treatment of patients. The procedures vary; in Japan, for example, if a hospital seeks to have a mentally disabled person admitted without the person's consent, the compulsory admission must be approved by a prefectural governor upon receipt of statements from two psychiatrists that admission is necessary to prevent harm to the patient or to others. However, if a mental patient's guardian agrees, such a person can be hospitalized without the patient's consent upon determination by only one psychiatrist that the hospitalization is needed.

In Germany, commitment to protect a patient or the public interest must be ordered by a judge in accordance with procedures that require a medical or psychiatric opinion on the matter.

In France, when requested by a third party, hospitalization or other forms of required mental health care can be ordered based on two medical certificates issued within the fifteen days prior to the order. However, if there is a grave risk to the health of the patient, one medical certificate suffices. If there is imminent danger to the patient's health, the director of a health care institution may order hospitalization even in the absence of a third party request. Hospitalization can be challenged before a special judge who rules on detention and other deprivations of freedom.

In England, the trend is to use orders for community-based treatment in place of institutionalization when possible, but forced hospitalization can be ordered for two categories of individuals: for convicted offenders with mental disorders who pose a danger to the public and for other persons with diagnosed, treatable, mental health disorders who are a threat to themselves or others. In Argentina as well, there is a trend toward providing care outside of a hospital setting. If commitment to a hospital is considered to be the only way to treat a patient, there is a set of controls and court-based guarantees to keep such institutionalizations as short as possible.

While Mexico's General Law of Health provides that institutionalization of individuals with mental and behavioral disorders must be the last therapeutic resource, such institutionalization, even without the patient's consent, is possible following a request from a family member, guardian, or legal representative, with a doctor's concurrence. The decision to involuntarily hospitalize an individual must be communicated to the patient's representative and judicial authorities. That decision may be reviewed by judicial authorities at the request of the patient or of his or her representative.

In Canada, the procedure depends on the rules adopted in the various provinces. There are three predominant ways people can be institutionalized: through certification by a physician, after being apprehended by the police, and after being served a judicial warrant. All provinces apply the "harm to self and others" standard, but several in addition have adopted the broader "serious mental or physical deterioration" standard for hospitalization.

Norway has a two-level system, which may involve both compulsory observation of a patient with mental health issues and compulsory treatment. In order for compulsory treatment to be

implemented**,** it must be established that compulsory care is necessary to prevent the person's condition from worsening, to avoid a situation in which chances for improvement are reduced, or to deal with someone whose mental condition poses an obvious and serious risk to him or herself or others.

Chinese law provides that when people have injured themselves, or there is a danger of self-injury, they may be hospitalized upon agreement of their guardian. When people have harmed others, or there is a danger that they may do so, they may be hospitalized without their agreement or that of their guardian.

III. Drivers' Licenses

In most of the countries surveyed, a prior mental health evaluation is not required to obtain a license to drive, although mental health professionals may be required to file a report if they become aware that a person is unstable and thus not fit to drive. This is the case, for instance, in both Israel and Norway. Once a disabling condition is reported, drivers' licenses are suspended or revoked. In South Africa, the authorities can require an evaluation to determine fitness to drive. In the European Union, Mexico, and Canada, the rules on drivers' licenses are left to component administrative units: the Member States for the EU, the states and Federal District for Mexico, and the provinces for Canada. Mexico has a two-tiered system that, at least in the Federal District, requires a mental health evaluation for prospective commercial drivers, but only a sworn statement from the applicant concerning fitness to drive for ordinary drivers' licenses.

In England, applicants for licenses must sign a declaration that they do not suffer from any relevant disabilities, including mental health disabilities. Extensive guidance is provided on which disorders qualify as relevant; they include severe anxiety and depressive disorders, memory or concentration problems, agitation, disturbed behavior, or suicidal thoughts.

In China, applicants for driving and boating licenses are required to report if they suffer from several specified illnesses, including a mental illness.

Exceptions to the predominant pattern are found in Argentina and Russia, where a psychological test or psychiatric evaluation is required to obtain drivers' and boating licenses.

IV. Firearms Licenses

Generally the rules for firearms licenses are stricter than those for drivers' licenses. All the surveyed jurisdictions require some form or license or permit. The usual standard is that the person must be fit to handle a firearm, and that fitness includes mental health. The EU, although it does not have specific guidelines, directs its Member States to permit the acquisition and possession of firearms only by people who have a real need to have arms and who are not likely to be a danger to themselves or others.

Extensive background checks are performed in Canada to determine if a firearms license can be issued. In Israel also there is a required review to determine if an applicant has any record of mental health problems. In South Africa, applications for firearms must be accompanied by a

competency certificate, attesting that the applicant is a "fit and proper" person to have a firearm and is stable, without a proclivity for violence, a substance abuse problem, or any mental illness that makes them unfit to have a firearm. In Japan and Russia as well, applicants must submit a medical certificate to prove that they are not addicted to alcohol or drugs and do not suffer from dementia or any mental problem or seizure disorder that causes loss of ability. Health reports are also required in England France, and Mexico.

Germany does not issue licenses for firearms to the mentally ill. If the licensing authority suspects a problem, it requires the applicant to submit a medical or psychiatric evaluation report, done at the applicant's expense. In addition, a mental health evaluation is always required for first-time applicants under the age of twenty-five.

Argentina requires that applicants for firearms licenses not have a physical or psychological disorder; a physician's report may be required if there are grounds to believe the applicant's fitness should be assessed.

China strictly limits who may have firearms, so outside of persons with a work-related need, extremely few private individuals have firearms. While there are no national rules requiring health evaluations, local and specialized rules for particular occupations may apply.

In New Zealand, while there are no specific mental health conditions for license applicants, the police apply a broad standard to determine whether the applicant is a "fit and proper" person to have a firearms license. Norway also requires applicants for firearms licenses "not to be deemed unfit" but does not require them to undergo a mental health examination.

ARGENTINA

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SUMMARY Argentina underwent a mental health reform in 2010. The new mental health law aims at reducing institutionalization of the mentally ill and focuses on community-based services and an interdisciplinary approach to mental health treatment. Implementation of the new law is pending, primarily due to resistance from mental health professionals. Mental health fitness is required in order to be issued driver's, boating, and firearms licenses.

I. Introduction

Argentina's health care system includes a public sector system, supported with taxes; a private sector system, supported through voluntary private insurance; and the social security system, supported through mandatory insurance.[1]

The Ministry of Health is responsible for establishing and executing health care policies and programs under the direction of the Executive Branch. The Ministry also oversees the operation of health services, facilities, and institutions, and conducts overall planning for the sector in coordination with provincial health authorities.[2] Regarding mental health, the National Directorate on Mental Health and Addictions (Dirección Nacional de Salud Mental y Adicciones, DNSMA) within the Ministry of Health, created by Decree 457/2010,[3] is in charge of the promotion, policy making, and coordination of mental health services and institutions throughout the country in conjunction with provincial authorities.[4]

According to a 2010 study conducted by the Ministry of Health,[5] out of a total population of 6.2 million adults aged fifteen years or older, it is estimated that approximately 21% are affected by

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[1] CENTRO DE ESTUDIOS PARA EL DESARROLLO INSTITUCIONAL, EL FUNCIONAMIENTO DEL SISTEMA DE SALUD ARGENTINO EN UN CONTEXTO FEDERAL 5 (Sept. 2002), http://faculty.udesa.edu.ar/tommasi/cedi/dts/dt77.pdf.

[2] Decreto 828/2006 Modifícase la Ley de Ministerios [Amending the Law on Ministries] art. 3, BOLETIN OFICIAL [B.O.], July 10, 2006, http://www.infoleg.gov.ar/infolegInternet/anexos/115000-119999/117720/norma.htm.

[3] Decreto 457/2010 Modifícase la Ley de Ministerios [Amending the Structure of the Ministry of Health], B.O., Apr. 7, 2010, http://www.infoleg.gov.ar/infolegInternet/anexos/165000-169999/165815/norma.htm; *and* Dirección Nacional de Salud Mental y Adicciones (DNSMA) portal, http://www.msal.gov.ar/saludmental/ (last visited Feb. 21, 2013).

[4] DNSMA, http://www.msal.gov.ar/saludmental/index.php/institucional/ique-es-la-dnsmya (last visited Feb. 21, 2013).

[5] SISTEMA DE VIGILANCIA EPIDEMIOLÓGICA EN SALUD MENTAL Y ADICCIONES, MINISTERIO DE SALUD PRESIDENCIA DE LA NACIÓN, ESTIMACIÓN DE LA POBLACIÓN AFECTADA DE 15 ANOS Y MÁS POR TRASTORNOS MENTALES Y DEL COMPORTAMIENTO EN ARGENTINA: ANO 2010, http://www.inclusionmental.com.ar/contents/biblioteca/1329413814_-estimacion-de-la-poblacion-afectada-por-salud-mental-arg.pdf.

mental disorders.[6] Among the most prevalent of the pathologies, addictions such as alcoholism account for 32.2% and depression for 31% of all mental illnesses.[7]

The number of people affected by mental illness in Argentina is very high, with numbers comparable to those in developed countries.[8] However, mental health services have usually been concentrated on the most serious or extreme cases.[9] The current challenge is to redirect mental health services to the prevention and treatment of chronic illnesses and disorders beyond the extreme cases,[10] shifting from services that have been limited to psychiatric hospitals to the overall primary health care system.[11]

The incorporation of mental health into primary care is at the core of the country's goal of providing mental health to the population, replacing psychiatric hospitals with psychiatric beds in general hospitals as well as networks of community-based services, with mental health centers and psychosocial rehabilitation programs spread throughout the country.[12]

II. 2010 Mental Health Law

Law 26657 on Mental Health Protection (Ley del Derecho a la Protección de la Salud Mental, LPDSM) was enacted in December 2010 to guarantee state protection of the mental health and human rights of those with mental illnesses or disorders.[13] Regulations to implement several provisions of the Law are still pending.[14]

The LPDSM was based on the United Nations Principles for the Protection of People with Mental Illness and the Improvement of Mental Healthcare,[15] adopted by the UN General Assembly on December 17, 1991; the Pan American Health Organization Caracas Declaration of November 14, 1990, for the Restructuring of Psychiatric Care in Latin America Within the Local

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[6] *Id.* at 32.

[7] *Id.*

[8] *Id.*

[9] *Id*. at 33.

[10] *Id.*

[11] MINISTERIO PÚBLICO TUTELA DE LA CIUDAD AUTÓNOMA DE BUENOS AIRES, PANORÁMICAS DE SALUD MENTAL A UN ANO DE LA SANCIÓN DE LA LEY NACIONAL NO. 26657 at 22 (Eudeba, Buenos Aires, 2011).

[12] GUILLERMO ALONSO SAINZ, LEY NACIONAL DE SALUD MENTAL NO. 26657: COMENTARIOS INTERDISCIPLINARIOS 64 (Ediciones Centro Norte, Buenos Aires, 2011).

[13] Ley 26657, de 2 de Diciembre de 2010, del Derecho a la Protección de la Salud Mental (LDPSM) [Law on the Right to Mental Health Protection] art. 1, B.O., Dec. 3, 2010, http://www.infoleg.gov.ar/infolegInternet/anexos/175000-179999/175977/norma.htm.

[14] *Abogaron por la Reglamentación de la Ley de Salud Mental*, PANAMERICAN HEALTH ORGANIZATION (Aug. 22, 2012), http://new.paho.org/arg/index.php?option=com_content&task=view&id=1021&Itemid=1.

[15] Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, G.A. Res. 46/119 Annex, U.N. Doc. A/RES/46/119 (Dec. 17, 1991), http://www.un.org/documents/ga/res/46/a46r119.htm.

Health Systems Model;[16] and the Brasilia Principles for the Development of Mental Health Care in the Americas of November 9, 1990.[17]

The Law considers mental health as a condition that is determined by historical, social, economic, cultural, biological, and psychological factors.[18]

According to the LPDSM, a diagnosis of mental illness does not automatically mean that the person is presumed to pose a risk of harm or incapacity. This may only be determined after an interdisciplinary evaluation of each particular situation.[19] Psychologists, psychiatrists, social workers, nurses, occupational therapists, and other professionals in related fields are considered part of the team of interdisciplinary professionals in charge of providing mental health care.[20]

The Law recognizes that people with mental disorders have to following rights:

(a) To receive comprehensive and adequate health and social care;

(b) To privacy;

(c) To live integrated in the community;

(d) To have family support and keep family connections;

(e) To receive or refuse spiritual or religious assistance;

(f) To designate an attorney or legal representative of his or her choice, with access to family and medical records;

(g) In case of involuntary or prolonged voluntary commitment, to have the patient's records examined periodically by a review board;

(h) To non discrimination because of a current or prior mental disorder;

(i) To be appropriately informed about his or her health condition and treatment;

(j) To make his or her own decisions regarding care and treatment;

(k) To not be the object of clinical trials or experimental treatments without informed consent;

(l) To not be subjected to forced labor; and

(m) To receive fair compensation for work therapy or community works jobs.[21]

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[16] Pan American Health Organization/World Health Organization, Caracas Declaration for the Restructuring of Psychiatric Care in Latin America Within the Local Health Systems Model (Nov. 14, 1990), http://www2.paho.org/hq/dmdocuments/2008/DECLARATIONOFCARACAS.pdf.

[17] Brasilia Principles for the Development of Mental Health Care in the Americas, Nov. 9, 1990, http://www2.paho.org/hq/dmdocuments/2008/principles_of_Brazilia.pdf; *and* LDPSM art. 2.

[18] LDPSM art. 3.

[19] *Id*. art. 5.

[20] *Id.* art. 8.

[21] *Id*. art. 7.

III. Mental Health Treatment

Mental health care under the LPDSM must be provided outside of the hospital commitment setting whenever possible. It should be primarily based on primary healthcare principles in an interdisciplinary framework, and oriented towards the reinforcement, restoration, and promotion of social bonds.[22]

Central to the new Law is the prohibition on creating new asylums or mental health hospitals, either public or private,[23] mandating that those that already exist must adapt to the objectives and principles of the new Law until their full and definite replacement with alternative facilities,[24] such as short-term admission in general hospitals; interdisciplinary community-based mental health care teams; outpatient services; supervised home care; daytime hospitalization; work cooperatives and training centers; and foster care.[25]

Commitment in a mental hospital is considered the remedy of last resort, only acceptable when it would provide better therapeutic benefits than the treatment that would be provided in a family, community, or social setting.[26] In extremely serious cases when commitment in a hospital is the only viable solution the Law establishes a set of controls and guarantees by the courts and the medical community, to ensure that hospitalizations are exceptional, short-term, and not prolonged unnecessarily.[27]

The LPDSM places all the emphasis on the prevention of mental health disorders through education, social development, labor initiatives, communication, and awareness, as the best strategy to secure the mental health of the Argentine people.[28] Social and labor inclusion of the mentally ill are considered the main mechanisms for ensuring a long-term and successful mental health policy in the country.[29]

The Ministry of Health must promote the inclusion of mental health coverage in employer-based health insurance plans.[30] The LPDSM also requires the training of mental health care professionals in human rights and mental health standards established both in national and international laws.[31]

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[22] *Id.* art. 9.

[23] *Id.* art. 27.

[24] *Id.*

[25] *Id*. art. 11.

[26] *Id.* art. 14.

[27] *Id.* arts. 15–18.

[28] *Id*. art. 36.

[29] *Id.*

[30] *Id.* art. 37.

[31] *Id.* art. 33.

In order to implement all of these changes, the new Law provides for a gradual increase in the funding of mental health services of up to 10% of the overall expenditures in the general budget for health.[32]

IV. Driver's, Boating, and Firearms Licenses

A psychophysical test is required for any applicant to obtain driver's[33] and boating licenses.[34] In order to obtain a firearms license, the petitioner may not have a disqualifying physical or psychological disorder. A physician's report may be required if there are grounds to believe that the petitioner is not fit to hold a firearms license.[35] Firearms licenses are valid for five years and are not automatically renewed. In order to obtain a new license, the applicant must meet all of the original requirements, including physical and psychological fitness to bear arms.[36]

[32] *Id*. art. 32.

[33] Ley Nº 24.449 de Tránsito [Law No. 24.449 on Transit] art. 13(c), Dec. 23, 1994, B.O., Feb. 10, 1995, http://www.infoleg.gov.ar/infolegInternet/anexos/0-4999/818/texact.htm.

[34] Decreto 4516 de Régimen de la Navegación Marítima, Fluvial y Lacustre (Reginave) [Legal Regime of Maritime, River and Lake Navigation] art. 402.0409, B.O., May 30, 1973, http://www.infoleg.gov.ar/infolegInternet/anexos/65000-69999/66137/norma.htm.

[35] Ley 20.429 de Nacional de Armas y Explosivos [National Law on Arms and Explosives], B.O., July 5, 1973, as amended, http://www.infoleg.gov.ar/infolegInternet/anexos/15000-19999/19953/texact.htm; *and* its regulation, Decreto [Decree] 395/75 arts. 55.2, B.O., Mar. 3, 1975, http://www.infoleg.gov.ar/infolegInternet/anexos/35000-39999/38821/texact.htm.

[36] *Id.* arts. 64, 65.

CANADA

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SUMMARY In Canada, mental health laws, policies, and programs are primarily within the jurisdiction of the provinces and territories. Each jurisdiction has its own Mental Health Act that regulates the voluntary and involuntary admission of persons to a hospital for psychiatric treatment.

There are three predominant methods of commitment in Canada: certification through a physician, police apprehension, and a judicial warrant. The involuntary admission criteria for patients vary for each province/territory but all jurisdictions appear to apply the "harm to self and others" standard. Ontario, British Columbia, Alberta, Nova Scotia, Manitoba, and Saskatchewan also appear to apply the much broader "serious mental or physical deterioration" standard.

At the federal level, licensing and permits for firearms are regulated by the Firearms Act and the Criminal Code. Though the Firearms Act includes provisions for background checks, including mental health checks, there is no provision for a full psychiatric evaluation of each license applicant.

Motor Vehicle licensing is also regulated by each province and territory of Canada. Many, if not all, of these Motor Vehicle Acts require physicians or other medical practitioners to report on patients who are unfit to operate a motor vehicle. Many of these Acts also give the Motor Vehicle Authority the power to suspend or deny the privilege of a license if they have reason to believe the applicant is unfit to drive. An authority can require the applicant to take a medical examination before reaching a decision. Restrictions and conditions can also be placed on a license due to serious health reasons. Most jurisdictions have appeals processes.

I. Overview of Canada's Mental Health Care System

Canada's health care system is predominantly regulated by the Canada Health Act,[1] a federal law. However, provinces and territories are largely responsible for the "administration and delivery of health care services across Canada."[2] According to Professor John Arnett,

> [w]ith financial assistance from the federal government, which is contingent on meeting certain conditions set forth in the 1984 Canada Health Act, provinces and territories plan, finance, organize, evaluate, and assess the need for the wide range of required health services and ensure that the required personnel are in place to meet the needs for health services.[3]

[1] Canada Health Act, R.S.C., 1985, c. C-6, http://laws-lois.justice.gc.ca/eng/acts/C-6/.

[2] John L. Arnett, *Health and Mental Health in Canada*, *in* MENTAL HEALTH SYSTEMS COMPARED: GREAT BRITAIN, NORWAY, CANADA AND THE UNITED STATES 138, 142 (R. Paul Olson ed., 2006).

[3] *Id.*

The responsibility for policies, programs, and regulations making up Canada's mental health system is divided between the federal government and the provincial/territorial governments.[4] Provinces and territories are responsible for "the organization, governance, funding and delivery of mental health services and supports."[5] In addition, laws and regulations governing mental health institutions are also the jurisdiction of the provinces and the territories.[6]

According to Canadian mental health expert Simon Davis, "the field of mental health has seen considerable change in a relatively short period of time."[7] In the 1960s, "the locus of treatment shifted from institutions to the community with the downsizing and closure of the 'asylums.' "[8] Moreover, "laws concerning involuntary detention and treatment were amended to provide persons with mental disorders greater procedural and substantive protections."[9] However, as a result of many mentally ill people in the community not getting adequate treatment, some ending up homeless, and others winding up in jail, "the pendulum, which had been moving in the direction of greater civil liberties, began to swing back."[10] According to Davis, "the legal criteria for involuntary hospitalization, narrowed in the 1970s, were broadened again in a number of jurisdictions"[11] and community treatment orders were increasingly implemented.[12]

II. Canada's Mental Health Laws

A. Mental Health Acts

According to a Canadian Senate Committee report, the provinces and territories have "primary responsibility for delivering mental health services and addiction treatment within their jurisdiction."[13] Therefore, each province and territory has enacted its own Mental Health Act, "except Nunavut in which the Northwest Territories law applies."[14]

All provincial and territorial Mental Health Acts regulate, among other mental health issues, the voluntary and involuntary admission of persons to a hospital for psychiatric treatment. According to leading experts in the field, Canadian Mental Health Acts typically regulate the following issues:

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[4] THE STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY, MENTAL HEALTH, MENTAL ILLNESS AND ADDICTION: OVERVIEW OF POLICIES AND PROGRAMS IN CANADA (INTERIM REPORT) 147 (Nov. 2004), http://www.parl.gc.ca/Content/SEN/Committee/381/soci/rep/report1/repintnov04vol1-e.pdf.

[5] *Id.*

[6] *Id.*

[7] SIMON DAVIS, COMMUNITY MENTAL HEALTH IN CANADA: THEORY, POLICY, AND PRACTICE xi (2006).

[8] *Id.*

[9] *Id.*

[10] *Id.*

[11] *Id.*

[12] *Id.*

[13] THE STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, *supra* note 4, at 166.

[14] *Id.*

- Voluntary admission procedures and criteria;
- Involuntary admission procedures and criteria;
- Treatment authorization and refusal;
- Rights and safeguards;
- Assisted community treatment (leave and community treatment orders);
- Mandated services; and
- Other provisions (e.g., confidentiality, restraint, and so forth).[15]

Provincial laws must also be in accordance with the Canadian Charter of Rights and Freedoms,[16] part of the amalgamation of laws that make up Canada's Constitution, which guarantees political and civil rights such as the (1) right to life, liberty, and security of person;[17] (2) right not be arbitrarily detained;[18] (3) right not to be subjected to any cruel and unusual punishment;[19] and (4) right to equal protection of the law without discrimination,[20] "including discrimination based on mental disability."[21]

Provincial and territorial laws are based on a Uniform Mental Health Act[22] which was adopted in 1987 by a working group established under the Uniform Law Conference as model provincial mental health legislation.[23] As stated by Davis, the Uniform Act was drafted "with the hope that this would lead to greater standardization of the various provincial and territorial mental health acts."[24] Most jurisdictions in Canada have enacted legislation "which conforms with its fundamental principles."[25] However, "significant differences in the provisions of the relevant mental health statutes [still remain] among the various jurisdictions."[26]

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[15] JOHN E. GRAY, MARGARET A. SHONE & PETER F. LIDDLE, CANADIAN MENTAL HEALTH LAW & POLICY 20 (2000).

[16] Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, *being* Schedule B to the Canada Act, 1982, c. 11 (U.K.), http://laws-lois.justice.gc.ca/eng/Const/page-15.html.

[17] *Id.* § 7.

[18] *Id.* § 9.

[19] *Id.* § 12.

[20] *Id.* § 15

[21] DAVIS, *supra* note 7, at 272.

[22] Uniform Law Conference of Canada (ULCC), Uniform Acts, Mental Health Act, http://www.ulcc.ca/en/ uniform-acts-en-gb-1/500-mental-health-act/324-mental-health-act.

[23] THE STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, *supra* note 4, at 167.

[24] DAVIS, *supra* note 7, at 273.

[25] THE STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, *supra* note 4, at 168.

[26] *Id.*

B. Criteria for Involuntary Admission

The criteria or standards for involuntarily admitting a patient vary from province to province. Furthermore, in a single statute there can be multiple bases upon which a patient can be involuntarily committed. All jurisdictions appear to follow the "harm to self or others" standard, with some qualifying that standard by specifying physical harm. Other jurisdictions, in addition to the "harm" standard, also stipulate a much broader standard that includes prevention of serious or substantial mental or physical deterioration.

Below are some of the conditions for involuntary admission found in the provincial and territorial Mental Health Acts. The person must have a "mental disorder" (the term used in all jurisdictions) that is likely to cause

- serious harm to himself/herself or others or is threatening to do so[27] (all jurisdictions appear to have a variation of this provision including Ontario,[28] British Columbia,[29] Manitoba,[30] Saskatchewan,[31] Alberta,[32] Nova Scotia,[33] Yukon,[34] the Northwest Territories, and Nunavut[35]); **or**
- serious physical impairment (Alberta, Nova Scotia, Yukon,[36] the Northwest Territories); **or**
- serious mental or physical deterioration (Ontario, British Columbia, Alberta, Nova Scotia, Manitoba, Saskatchewan); **and**
- needs continuing treatment that can reasonably be provided only in a facility (Manitoba, British Columbia); **or**
- is unsuitable for admission to a facility other than as a formal patient or cannot be admitted as a voluntary patient because he or she refuses or is not mentally competent to consent to a voluntary admission (Alberta, Manitoba, Nova Scotia, British Columbia).

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[27] *Id.*

[28] Mental Health Act, R.S.O. 1990, c. M.7, http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm (Ontario).

[29] Mental Health Act, RSBC 1996, c. 288, http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96288_01 (British Columbia).

[30] Mental Health Act, CCSM c. M110, http://web2.gov.mb.ca/laws/statutes/ccsm/m110e.php (Manitoba).

[31] Mental Health Services Act, SS 1984-85-86, c. M-13.1, http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/M13-1.pdf (Saskatchewan).

[32] Mental Health Act, RSA 2000, c. M-13, § 2(b), http://www.qp.alberta.ca/1266.cfm?page=M13.cfm&leg_type=Acts&isbncln=0779748727&display=html (Alberta).

[33] Involuntary Psychiatric Treatment Act, SNS 2005, c. 42, § 7(1)(b), http://www.canlii.org/en/ ns/laws/stat/sns-2005-c-42/latest/sns-2005-c-42.html (Nova Scotia).

[34] Mental Health Act, RSY 2002, c. 150, § 5(1), http://www.gov.yk.ca/legislation/acts/mehe.pdf (Yukon).

[35] Mental Health Act, RSNWT 1988, c. M-10, http://www.canlii.org/en/nt/laws/stat/nav/m.html (Northwest Territories, also applicable to Nunavut).

[36] Mental Health Act, RSY 2002, c. 150, § 5(1)(b). This condition must be met in addition to the person having "a lack of ability to care for themselves."

C. Commitment Procedures

In Canada, there appear to be three mechanisms by which a person can be institutionalized involuntarily: by a certificate signed by a physician, through police apprehensions, or pursuant to a judicial warrant.[37]

A certificate signed by a physician appears to be the most frequent method in most jurisdictions. In all jurisdictions except Nova Scotia, only one certificate is required.[38] The single certificate authorizes involuntary institutionalization for twenty-four to seventy-two hours, depending on the jurisdiction.[39] To keep the patient longer, a hospital must get a second certificate within a certain amount of time.[40]

All of the provincial and territorial Mental Health Acts authorize the police to apprehend persons with an apparent mental disorder who meet certain criteria.[41] Those criteria usually require an element of physical danger or harm, or disorderly conduct.[42] According to Davis, the second method is typically used "in evenings or on weekends when medical offices may be closed. There is a presumption that accessing a physician in these cases is impossible or impractical."[43]

Warrants issued by judges are also available in all jurisdictions in Canada.[44] In British Columbia, "[a]nyone, including family members and neighbors, who reasonably believes a person has a mental disorder and needs to be hospitalized can apply to court."[45] The court can issue a warrant that authorizes the police to take the person to hospital, where they will be assessed.[46]

D. Consent and Treatment Refusal

All the provinces and territories appear to approach consent to treatment differently.[47] In British Columbia, Saskatchewan, Newfoundland, and Prince Edward Island (PEI), the attending physician can treat the patient with or without consent.[48] In other jurisdictions, "treatment is

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[37] DAVIS, *supra* note 7, at 275.

[38] *Id.*

[39] *Id.*

[40] *Id.*

[41] *Id.*

[42] *Id.*

[43] *Id.*

[44] *Id.* at 276.

[45] *Id.*

[46] *Id.*

[47] *Id.*

[48] *Id.*

considered a separate issue,"[49] and involuntary treatment decisions are taken by a tribunal or a court (Quebec, New Brunswick),[50] or by a substitute decision maker (Ontario, Alberta, Manitoba, Yukon, and the Northwest Territories).[51]

E. Legal Protections

The most common method of review for involuntary admission and treatment decisions is by "application to a review board or panel,"[52] which is available in all Canadian jurisdictions except the Northwest Territories. The second most common method of challenging certification is through the courts.[53]

III. Mental Health Checks and Evaluation for Licenses

A. Firearms Licenses

In Canada, the Firearms Act[54] and its subordinate regulations govern the licensing and registration of firearms. All licensing and registration is managed by the Royal Canadian Mounted Police's (RCMP's) Canadian Firearms Program (CFP). The RCMP is required to conduct thorough and rigorous background checks on individuals applying for a firearms license, which is needed to acquire and/or possess a firearm. According to section 5(1) of the Firearms Act, "[a] person is not eligible to hold a [firearms] licence if it is desirable, in the interests of the safety of that or any other person, that the person not possess a firearm."[55] Therefore, "[a]n applicant for a firearm licence in Canada must pass background checks which consider criminal, mental, addiction and domestic violence records."[56] In order to determine eligibility under the Act, authorities must consider whether, within the previous five years, the applicant

> has been treated for a mental illness, whether in a hospital, mental institute, psychiatric clinic or otherwise and whether or not the person was confined to such a hospital, institute or clinic, that was associated with violence or threatened or attempted violence on the part of the person against any person; or
> has a history of behavior that includes violence or threatened or attempted violence on the part of the person against any person.[57]

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[49] *Id.*

[50] *Id.*

[51] *Id.*

[52] *Id.* at 280.

[53] *Id.*

[54] Firearms Act, S.C. 1995, c. 39, http://laws-lois.justice.gc.ca/eng/acts/F-11.6/.

[55] *Id.* § 5(1).

[56] *Canada – Gun Facts, Figures and the Law*, GUNPOLICY.ORG, http://www.gunpolicy.org/firearms/ region/canada (last updated Dec. 21, 2012).

[57] Firearms Act § 5(2)(b)–(c).

In addition to background checks, "third party character references for each gun licence applicant are required."[58]

Applicants are screened using a two-tiered process. According to a 2010 evaluation report on Canada's Firearms Program, "[t]his process entails submitting an application requesting that the applicant provide detailed personal information; when this application is assessed by the CFP, special attention is given to those applying for a Prohibited and Restricted Firearm License."[59] All applicants are also "screened on an on-going basis through the provisions of 'continuous eligibility', a monitoring function that has a licensee 'flagged' for a review of their license should a matter of public safety arise after they have obtained their license."

A person's authority to transport[60] or carry[61] restricted firearms can be revoked if a chief firearms officer becomes aware that an "individual's physical or mental state has deteriorated to an extent that may affect the safety of the individual or of any other person."[62]

No provisions were located in Canada's federal laws and policies that required psychiatric evaluations or exams for licensing or permit purposes.

B. Driver's License

Motor vehicle licensing rules are contained in provincial/territorial laws and regulations. Most provinces have Motor Vehicle Acts that typically grant a Registrar or Superintendent of Motor Vehicles with the authority to suspend a driver's license or the privilege of obtaining a license if the authority is satisfied that the person is not able or is unfit to safely operate a motor vehicle, or lacks competency. Among other matters, this decision can be based, as it is in Nova Scotia, "on a medical opinion or the results of a medical examination."[63] In Alberta, for example, the Registrar

> has the authority to require a person to submit to a medical or physical examination and may place special conditions or restrictions on a driver's licence or suspend driving privileges. These actions will only be taken where there is reasonable and probable grounds to believe that the person is a safety risk to himself or to the motoring public.[64]

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[58] GUNPOLICY.ORG, *supra* note 56.

[59] RCMP, RCMP CANADIAN FIREARMS PROGRAM: PROGRAM EVALUATION – FINAL APPROVED REPORT 38 (Feb. 2010), http://www.rcmp-grc.gc.ca/pubs/fire-feu-eval/eval-eng.pdf.

[60] Authorizations to Transport Restricted Firearms and Certain Handguns Regulations (Firearms Act), § 5, SOR/98-206, http://laws-lois.justice.gc.ca/eng/regulations/SOR-98-206/index.html.

[61] Authorizations to Carry Restricted Firearms and Certain Handguns Regulations (Firearms Act), § 7(1), SOR/98-207, http://laws-lois.justice.gc.ca/eng/regulations/SOR-98-207/index.html.

[62] *Id.*

[63] *Suspension of a Drivers Licence*, NOVA SCOTIA REGISTRY OF MOTOR VEHICLES (2013), http://www.gov.ns.ca/snsmr/rmv/licence/suspend.asp.

[64] *Reporting Concerns About Driver Fitness*, ALBERTA TRANSPORTATION (2013), http://www. transportation.alberta.ca/2561.htm.

In some jurisdictions, including Manitoba and Ontario, this decision of the Motor Vehicle Authority is appealable, typically to a Medical Review Committee[65] or a License Appeal Tribunal.[66] In other jurisdictions, such as British Columbia, the Superintendent can review a previous decision, but it is only appealable to a court of law.[67]

Many provincial jurisdictions in Canada appear to require physicians to report to the Motor Vehicle Authority any patient who may be suffering from a medical condition that may impair driving ability. In Ontario and British Columbia, medical practitioners are obligated to submit a report to the Motor Vehicle Authority if in the opinion of the practitioner a person is suffering from a condition "that may make it dangerous for the person to operate a motor vehicle."[68] British Columbia, however, only requires a report if the patient "continues to drive a motor vehicle after being warned of the danger"[69] by the health professional. British Columbia law specifies that a report of a registered psychologist can also be considered.

Alberta allows the police to suspend a driver's license for twenty-four hours if they reasonably suspect that the driver of a motor vehicle has a medical or physical condition that affects the driver's physical or mental ability.[70]

Most, if not all, jurisdictions require a medical report when applying for or renewing a commercial driver's license.

C. Other Licenses

In order to hold a Canadian pilot's license, one must first have a Canadian medical certificate.[71]

Information on medical checks as part of Canada's pleasure boat licensing process could not be located.

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[65] *Medical Review Committee*, MANITOBA.CA, http://www.gov.mb.ca/mit/boards/medical.html (last visited Feb. 14, 2013); *see also Medical Review Section*, ONTARIO MINISTRY OF TRANSPORTATION, http://www.mto.gov.on.ca/english/dandv/driver/medical-review/ (last modified Oct. 23, 2012).

[66] *About Us*, LICENCE APPEAL TRIBUNAL (Ontario), http://www.sse.gov.on.ca/lat/english/Pages/default.aspx (last visited Feb. 20, 2013).

[67] *Disputes, Appeals and Reviews*, BRITISH COLUMBIA MINISTRY OF JUSTICE, http://www.pssg.gov.bc.ca/osmv/disputes/index.htm#med (last visited Feb. 14, 2013).

[68] Highway Traffic Act, R.S.O. 1990, c. H.8, § 203(1), http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h08_e.htm (Ontario).

[69] Motor Vehicle Act, [RSBC 1996]c. 318, § 230 (1)(b), http://www.bclaws.ca/EPLibraries/bclaws_new/document/LOC/freeside/--%20M%20--/45_Motor%20Vehicle%20Act%20RSBC%201996%20c.%20318/00_Act/96318_07.xml.

[70] Traffic Safety Act, R.S.A. 2000, c T-6, § 89(1), http://www.qp.alberta.ca/documents/Acts/T06.pdf.

[71] Canadian Aviation Regulations (CARs) 2012-1, § 404.03(1), http://www.tc.gc.ca/eng/civilaviation/regserv/cars/menu.htm.

CHINA

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SUMMARY The Ministry of Health, Ministry of Civil Affairs, and Ministry of Public Security administer three different types of mental health hospitals in China. Institutionalization of patients suffering a serious mental disorder must be on a voluntary basis unless the patients are a danger to themselves or to others. When a patient has injured himself, or there is a danger of self-injury, compulsory institutionalization must be agreed to by the patient's guardian. If the patient has harmed others or there is a danger that he will do so and he or his guardian disagrees with the psychiatric evaluation, a second evaluation and an expert evaluation may be requested. Compulsory medical treatment of persons with mental illness who have been deemed not liable in criminal proceedings due to their illness are subject to the procedures provided by the newly-amended Criminal Procedure Law, which requires judicial review and a court decision.

I. Introduction

A. Psychiatric Health Care System

In China, three ministries are largely responsible for providing psychiatric health care: the Ministry of Health, the Ministry of Civil Affairs, and the Ministry of Public Security (the police). The three ministries administer or run three different types psychiatric hospitals. The Guiding Opinions on Further Strengthening Mental Health Work forwarded by the State Council in 2004 described the roles of the hospitals under the different ministries as follows:[1]

- The mental health institutions administered by the Ministry of Health provide treatment to those who are mentally ill.

- The mental health institutions run by the Ministry of Civil Affairs admit two special groups of patients: military veterans who suffered mental illness when they served in the army, and "three have-nots" with mental illness. The "three have-nots" refer to people without the ability to work, without a means of livelihood, and without support who cannot afford the expense of ordinary hospitals.

- Ankang hospitals of the Ministry of Public Security, which are forensic psychiatric hospitals that implement compulsory medical treatment for persons who have "created serious incidents and disasters."[2]

[1] *Guowuyuan Bangongting Zhuanfa Weishengbu Deng Bumen Guanyu Jinyibu Jiaqiang Jingshen Weisheng Gongzuo Zhidao Yijian de Tongzhi* [*Notice of the State Council Regarding Forwarding Ministry of Health, et al. Guiding Opinions on Further Strengthening Mental Health Work*] (Guo Ban Fa [2004] No. 71, Sept. 20, 2004), Central People's Government of People's Republic of China website, http://www.gov.cn/ztzl/gacjr/content_459454.htm.

[2] *Id.* § 3(2).

According to government statistics, there are nearly five million people in China with psychiatric diseases who have been recorded by the government.[3] According to 2011 national health statistics, there are a total of 657 psychiatric hospitals, 20,732 hospital beds, and 18,040 licensed psychiatrists in the psychiatric hospitals nationwide.[4] The majority of the psychiatric hospitals are established by the government and owned by the state.[5] The official news agency, Xinhua, however, quoted the statistics released by the China Centre for Disease Control and Prevention in 2009, indicating that China has one hundred million people who suffer from mental illnesses of various types, 80% of whom are not receiving proper medical treatment.[6]

B. Application of Laws

China's Criminal Procedure Law was recently amended in 2012. The new Law adds a chapter governing the procedures for compulsory medical treatment of mentally ill persons who are held not criminally responsible. The Law took effect on January 1, 2013.[7]

Drafting of a mental health law was started in 1985.[8] After almost three decades, on October 26, 2012, the long-awaited Mental Health Law of the People's Republic of China was released by the Standing Committee of the National People's Congress, and will take effect on May 1, 2013.[9] The purposes of the Law, according to the released version, are to develop mental health institutions, regulate mental health services, and protect the lawful rights and interests of persons with mental disorders.[10] Instead of using the terms "mental illness" or "mental disease" (*jing shen bing*), as used in previous government instruments, the new Law adopts the term "mental disorder" (*jing shen zhang ai*). The Law expressly claims to protect the dignity, safety, property, and privacy of patients with mental disorders.[11]

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[3] *Prevention and Treatment of Psychiatric Diseases (2009)*, NATIONAL BUREAU OF STATISTICS OF CHINA, http://www.stats.gov.cn/tjsj/qtsj/shtjnj/2009/t20120904_402836779.htm.

[4] 2011 Zhongguo Weisheng Tongji Nianjian [2011 Yearbook of Chinese Health Statistics], Ministry of Health Website, http://www.moh.gov.cn/htmlfiles/zwgkzt/ptjnj/year2011/index2011.html. The statistics may be based on the hospitals under the administration of the Ministry of Health only and may not include those under the administration of the Ministry of Civil Affairs and the Ministry of Public Security.

[5] *Id.*

[6] *Bei Jingshenbing Shijian Pingxian, Jingshen Weisheng Fa Yunniang 26 Nian Reng Wei Chutai* [*Incidents of Compulsory Commitment Appeared Frequently, Mental Health Law Not Passed after 26 Years of Preparation*] (Xinhua Report), XINHUANET (May 16, 2011), http://news.xinhuanet.com/politics/2011-05/16/c_121419361.htm.

[7] Zhonghua Renmin Gongheguo Xingshi Susong Fa [The Criminal Procedure Law of the People's Republic of China] (promulgated by the National People's Congress on July 1, 1979, amended Mar. 17, 1996, last amended Mar. 14, 2012), pt. V, ch. 4, 4 ZHONGHUA RENMIN GONGHEGUO XIN FAGUI HUIBIAN 2012 [NEW LAWS AND REGULATIONS OF THE PEOPLE'S REPUBLIC OF CHINA 2012] 26 (Beijing, 2012).

[8] Xinhua Report, *supra* note 6.

[9] Zhonghua Renmin Gongheguo Jingshen Weisheng Fa [The Mental Health Law of the People's Republic of China] (promulgated by the Standing Committee of the National People's Congress on Oct. 26, 2012, effective May 1, 2013), 11 ZHONGHUA RENMIN GONGHEGUO XIN FAGUI HUIBIAN 2012 [NEW LAWS AND REGULATIONS OF THE PEOPLE'S REPUBLIC OF CHINA 2012] 1–13 (Beijing, 2012).

[10] *Id.* art. 1.

[11] *Id.* art. 4.

II. Mental Health Institutions

A. Psychiatric Hospitals and Departments Administered by the Ministry of Health

The Ministry of Health oversees and administers the country's medical institutions in general, which include specialized psychiatric hospitals and psychiatric departments in general hospitals.[12] In 2001, the Ministry issued a notice to the psychiatric hospitals nationwide, indicating that it will strengthen the administration over these hospitals because this is important to maintain social stability and promote economic development.[13] Meanwhile, the notice requires the rights and interests of patients of psychiatric hospitals to be fully protected.[14]

General requirements for establishing a medical institution that diagnoses and treats mental disorders are provided by the new Mental Health Law and include licensed psychiatrists, nurses, relevant facilities and equipment, management systems, and quality monitoring rules.[15] Other regulations and rules governing medical institutions apply; applications for establishing such an institution must be made with the government health authorities and a license to operate must be obtained.[16]

B. Psychiatric Hospitals Under the Ministry of Civil Affairs

Historically, the Ministry of Civil Affairs was charged with providing shelter for destitute people with a mental illness who were found wandering the streets.[17] According to the current information released by the Ministry, it is responsible for providing medical assistance to people without a livelihood. The Ministry is also responsible for providing care to veterans.[18]

In the late 1970s, in order to serve veterans who suffered mental illness during their military service, China began establishing specialized veterans' psychiatric hospitals in different localities. According to the Ministry of Civil Affairs, in 2006 there were eighty-three veterans' psychiatric hospitals among a total of 155 welfare hospitals run by the Ministry of Civil Affairs. As social welfare hospitals under the Ministry of Civil Affairs, these veterans' psychiatric hospitals are also taking "three have-nots" and even ordinary patients in some localities.[19]

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[12] *Jigou Gaikuang* [*Overview of the Ministry*], MINISTRY OF HEALTH, http://www.moh.gov.cn/zwgkzt/pjggk/list_jggk.shtml (last visited Feb. 8, 2013).

[13] *Weishengbu Guanyu Jiaqiang dui Jingshenbing Yuan Guanli de Tongzhi* [*Notice of the Ministry of Health on Strengthening Administration on Psychiatric Hospitals*] (Nov. 23, 2001), downloadable from Department of Health of Jiangxi Province website, http://www.jxwst.gov.cn/cszw/yljg/zcxx/201102/t20110214_104181.htm.

[14] *Id.*

[15] Mental Health Law art. 25.

[16] *Id.*

[17] VERONICA PERSON, MENTAL HEALTH CARE IN CHINA 65 (London, 1995).

[18] *Minzheng Bu Zhuyao Zhize* [*Major Duties and Responsibilities of the Ministry of Civil Affairs*], MINISTRY OF HEALTH, http://www.mca.gov.cn/article/zwgk/jggl/zyzz/ (last visited Feb. 7, 2013).

[19] *Youfu Yiyuan de Jiben Qingkuang* [*Overview of Youfu Hospitals*] (July 24, 2008), MINISTRY OF CIVIL AFFAIRS, http://yaj.mca.gov.cn/article/yfsydwgl/ywjs/200807/20080700018714.shtml. A list of the eighty-three veterans'

C. Ankang Hospitals of the Ministry of Public Security

The Ministry of Public Security runs forensic psychiatric hospitals, known as "Ankang hospitals."[20] These hospitals are treated as a special means of maintaining social stability and are a part of the Ministry's prison system. According to the Ministry, by implementing compulsory medical treatment of mentally ill people who have "created serious incidents and disasters," Ankang hospitals serve dual purposes: maintaining social stability and providing medical treatment.[21] As of 2010, there were twenty-four Ankang hospitals established in twenty provinces. The police at various localities have sent more than 40,000 persons to Ankang hospitals for compulsory treatment since 1998, according to the official statistics provided by the Ministry.[22]

III. Institutionalization of Patients

From time to time, scandals involving the forcible commitment of ordinary sane people to psychiatric hospitals for treatment have come to public attention. The reasons may vary, from domestic disputes to political dissent.[23] As a response, the Mental Health Law expressly prohibits the institutionalization of individuals who are not suffering from a mental disorder.[24]

The Law allows the immediate relatives of an individual who is suspected of suffering from a mental disorder to bring him or her to a hospital for evaluation. Local government authorities such as the civil affairs authority may send vagrants or beggars for compulsory evaluation where their immediate relatives cannot be found. The police, together with immediate relatives and "work units," may use force to stop suspected mentally disordered people from harming themselves or others, and send them to a hospital for evaluation.[25]

If the hospital concludes that a person is suffering a serious mental disorder, institutionalization must be on a voluntary basis unless the person is a danger to himself or others, with the Mental Health Law stating as follows:

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psychiatric hospitals is provided by the Ministry of Civil Affairs, at http://yaj.mca.gov.cn/article/mzfwjg/yfyy/200712/20071200006015.shtml (last visited Feb. 7, 2013).

[20] For more on Ankang hospitals, *see* HUMAN RIGHTS WATCH AND GENEVA INITIATIVE ON PSYCHIATRY, DANGEROUS MINDS: POLITICAL PSYCHIATRY IN CHINA TODAY AND ITS ORIGINS IN THE MAO ERA 117 (2002).

[21] Quanguo Gongan Jiguan Diyici Jingshenbing Guanzhi Gongzuo Huiyi Jiyao [Minutes of the First National Conference on Administration and Control of the Mentally Ill] (Gong Fa [88] No. 5, Jan. 29, 1988), *available at* Westlaw China (by subscription).

[22] *Qiangzhi Geli Jiedu Suo, Ankang Yiyuan, Jiedu Kangfu Changsuo de Xianzhuang ji Weilai* [*The Present and Future of Compulsory Isolated Drug Addiction Treatment Centers, Ankang Hospitals, and Drug Rehabilitation Centers*], MPS (Mar. 23, 2010), http://www.mps.gov.cn/n16/n1976136/n2280587/2363078.html.

[23] Xinhua Report, *supra* note 6. *See also*, Wan Yanhai, *The Madness of China's Mental Health System*, FOREIGN POLICY (Jan. 26, 2011), http://www.foreignpolicy.com/articles/2011/01/26/the_madness_of_china_s_mental_health_system.

[24] Mental Health Law art. 78.

[25] *Id.* art. 28.

- When the patient has injured himself, or there is a danger of self-injury, he may be institutionalized upon agreement of his guardian (normally a close family member). If the guardian does not agree, the patient may be taken home to be cared for and monitored by the guardian.[26]

- When the patient has harmed others, or there is a danger that he may do so, he may be hospitalized without the agreement of himself or his guardian.

Under the second situation, if the patient disagrees with the conclusion of the initial evaluation, he or his guardian may ask the hospital to provide two different psychiatrists or go to another qualified medical institution to request a second evaluation. If the individual and his family still have objections to the second evaluation's conclusion, they may then choose a lawfully credentialed institution with expertise to conduct an expert evaluation.[27] Hospitals are prohibited from taking a patient if the second evaluation or the expert evaluation concludes that he is not suffering from a serious mental disorder or that hospitalization is unnecessary.[28]

Unlike compulsory medical treatment in criminal proceedings, which is discussed below, the compulsory hospitalization of patients under the Mental Health Law does not involve a court decision. The Law, however, does contain a general provision that individuals or their close relatives may file a lawsuit if they believe their legal rights and interests have been infringed.[29]

IV. Compulsory Medical Treatment in Criminal Proceedings

Procedures for compulsory medical treatment of the mentally ill in criminal proceedings were introduced in the newly amended Criminal Procedure Law. Under the new Law, persons with mental illness who have been deemed not criminally liable due to their illness may be subject to compulsory medical treatment, which must be reviewed and decided by a court.

According to the Law, a mentally ill person who has endangered public security or seriously endangered other persons by committing acts of violence, but is determined not criminally liable upon expert evaluation, may be placed under compulsory medical treatment if he or she is likely to continue to pose a threat to society.[30] The procedure may be initiated by the police or the People's Procuratorate. If deemed necessary, the People's Procuratorate may apply to the court for compulsory medical treatment.[31]

The court must form a panel to hear the application for compulsory medical treatment and make a decision within one month.[32] The person against whom the decision on compulsory medical

[26] *Id.* arts. 30 & 31.

[27] *Id.* art. 32.

[28] *Id.*

[29] *Id.* art. 82.

[30] Criminal Procedure Law art. 284.

[31] *Id.* art. 285.

[32] *Id.* arts. 286, 287.

treatment is made, or the victim and his statutory representative or close relatives, may apply for reconsideration at the next higher level court if any of them disagree with the lower court's decision.[33] While waiting for the court to make a decision, the police may take the person into custody, which is described as taking "protective and temporary restraining measures" in the Criminal Procedure Law.[34]

V. Restrictions on Obtaining Licenses

A. Driver's License

People suffering a psychiatric disease are prohibited from applying for a driver's license, according to the Provisions on the Application and Use of Automobile Driver's License.[35] A license is revoked if a driver is found to be suffering a psychiatric disease.[36] A medical certificate issued by a qualified hospital must be submitted when obtaining or renewing a driver's license.[37] Drivers are required by the Provision to report any change of physical condition to the automobile management authority.[38]

B. Firearms

China's Firearms-Control Law[39] generally prohibits any private possession of firearms in China, with extremely limited exceptions. Aside from the military, police, and prosecutors, guards and escort personnel working for important state defense enterprises, financial institutions, storehouses, and scientific research institutions may carry firearms for official use if the firearms are necessary for the performance of their duties.[40] Firearms for civilian use are permitted for specified work units in three areas: sports; hunting; and wildlife protection, breeding, and research. Individual hunters in hunting areas and herdsmen in pastoral areas may possess hunting rifles, which cannot be removed from those areas.[41]

The Law does not specify the health requirements for carrying guns. Special and local rules may apply, however. For example, the regulations on firearms used by guards and escort personnel prohibit any individuals having a medical history of suffering from an illness that makes him

[33] *Id.* art. 287.

[34] *Id.* art. 285.

[35] Jidongche Jiashizheng Shenling he Shiyong Guiding [Provisions on the Application and Use of Automobile Driver's License] (Ministry of Public Security Order [2012] No, 123, Sept. 12, 2012, effective Jan. 1, 2013), art. 12, http://www.gov.cn/flfg/2012-10/09/content_2239595.htm.

[36] *Id.* art. 67.

[37] *Id.* arts. 18 & 48.

[38] *Id.* art. 52.

[39] Qiangzhi guanli Fa (Firearms-Control Law), ZHONGHUA RENMIN GONGHEGUO GUOWUYUAN GONGBAO [GAZETTE OF THE STATE COUNCIL OF THE PEOPLE'S REPUBLIC OF CHINA] 805–14 (Aug. 1, 1996), English translation *available at* Westlaw China (by subscription).

[40] *Id.* art. 5.

[41] *Id.* art. 6.

unable to control his own conduct, such as a mental disorder, from working as a guard and escort personnel carrying guns for official use.[42] Dalian City in Liaoning Province has issued its own gun control rules, which prohibit mentally ill persons from carrying any firearms.[43]

C. Boating

The requirement of not suffering from a mental illness is not specified in the Provisions of Safety Management of Yachts, which in general requires applicants to be physically fit to operate yachts.[44] When applying for a license to operate yachts, however, applicants are required to submit a medical certificate, in which they must truthfully report if they are suffering certain illnesses including a mental disorder.[45]

[42] Zhuanzhi Shouhu Yayun Renyuan Qiangzhi Shiyong Guanli Tiaoli [Regulations on the Administration of Firearms Used by Professional Guards and Escort Personnel] (State Council Order [2002] No. 356, July 27, 2002), art. 3, http://www.gov.cn/gongbao/content/2002/content_61669.htm.

[43] Dalian Shi Qiangzhi Guanli Guiding [Dalian City Provisions on Firearms Control] (Da Zheng Fa [1996] No. 38, May 8, 1996), *available at* Westlaw China (by subscription).

[44] Youting Anquan Guanli Guiding [Rules of Safety Management of Yachts] (Ministry of Transportation Order [2008] No. 7, July 22, 2008), http://www.gov.cn/flfg/2008-08/13/content_1070955.htm.

[45] A sample of the certificate is available on the Hainan Maritime Safety Administration website, http://www.hnmsa.gov.cn/webfiles/UploadPicture/file/4/1234324345.pdf (last visited Feb. 14, 2013).

ENGLAND

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SUMMARY Free health care is provided in England, including for those suffering from mental disorders. Individuals who pose a danger to themselves or others can be compelled to either be subjected to a medical assessment or receive treatment in hospital upon the application of two registered medical practitioners.

Gun ownership in England is strictly regulated, and a medical evaluation is one part of the application process to own a weapon. The mental health of the applicant is taken into account and, when considering whether the weapon will be securely stored, the mental health or other issues of any known associates of the applicant are also considered. Driving licenses are issued contingent upon the health of the holder, who is under a duty to notify the authorities in England if he suffers from a condition that makes it unsuitable for him to drive. These conditions include mental disorders.

I. Mental Health Care System

The health care system in England[1] provides free health care to people with mental health issues and vests the Secretary of State with statutory responsibility to ensure the provision of such service:

> 1(1) The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement
> (a) in the physical and mental health of the people of England, and
> (b) in the prevention, diagnosis and treatment of illness.[2]

Citizens have a right to the administrative law remedy of judicial review in cases where they believe they have been unfairly denied access to health services. The fact that the British health care system is funded by taxpayers has led to shortages in services in certain areas, as decisions concerning how resources are allocated are required to be "impartial, reasonable and responsible" and to take into account the competing needs of all patients.

II. Regulation of Mental Health Institutions

As noted above, the Secretary of State's duty includes the provision of hospital accommodation for individuals detained under the Mental Health Act, or those who "in the opinion of the Secretary of State require treatment under conditions of high security on account of their

[1] England is part of the United Kingdom, which is comprised of four countries, England, Wales, Scotland, and Northern Ireland. Health care is a devolved issue, meaning that the four countries can legislate independently on this issue. This report focuses on the law of England.

[2] National Health Service Act 2006, c. 41, § 1, http://www.legislation.gov.uk/ukpga/2006/41/section/1.

dangerous, violent or criminal propensities."[3] There are currently three health care trusts that provide high-security psychiatric services: the Ashworth, Broadmoor, and Rampton Hospitals.[4]

The Care Quality Commission is the independent regulator of health and social care in England. This regulator ensures that providers of health care services meet the national standards, which include respecting patients and meeting their needs.[5]

There are extensive directions for safety and security at high-security hospitals, and written records must be kept of certain searches or actions taken under them.[6] These directions regulate the circumstances in which particular searches can be performed on patients and written instructions regarding how tools, equipment, and materials must be secured in the hospital. Either prior to or within six hours of a patient's admission, a clinical team in the hospital must assess the risk that each patient poses to himself or others and prepare a risk management plan to avert these risks. Such steps may include monitoring the patient's phone calls, or locking the patient's room at night.[7]

The directions also require members of staff of the hospital to be subjected to security measures. These include x-raying members of staff and their possessions when they enter secure areas. It also requires random searches of members of staff at least 10% of the times when they enter secure areas and 5% of the times when they leave these areas.[8] Any visitors, including children, are required to have a "rub down search," which occurs over the top of clothing, and have their possessions inspected.[9] If the visitor refuses this search they are refused entry into the secure area.

Patients are tested for illicit substance use upon admission and at any later point where they are suspected of using illicit substances. Five percent of hospital patients may also be randomly selected for testing each month.[10] The security director is required to establish and maintain security records for the hospital that include information on plans for escape, and what to do if disturbances arise at the hospital.[11]

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[3] *Id*. § 4(2).

[4] Department of Health, Guidance on the High Security Psychiatric Services (Arrangements for Safety and Security at Ashworth, Broadmoor and Rampton Hospitals) Directions 2011 (June 2011), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128208.

[5] Health and Social Care Act 2008, c. 14, http://www.legislation.gov.uk/ukpga/2008/14/contents. *See also National Standards*, CARE QUALITY COMMISSION, http://www.cqc.org.uk/public/what-are-standards/national-standards (last visited Feb. 11, 2013).

[6] Department of Health, *supra* note 4, ¶ 19.

[7] *Id*. ¶ 33.

[8] *Id*. ¶ 10.

[9] *Id*. ¶ 12.

[10] *Id*. ¶ 17.

[11] *Id*. ¶ 20.

Patients and visitors are not allowed to possess or use cell phones in secure areas.[12] Patients are permitted to use computers and game consoles; however, this use is subject to any conditions that each individual hospital sees fit and must be monitored and supervised.[13]

III. Institutionalization of Patients

There has been a move in England to try to keep individuals with mental health illnesses out of psychiatric hospitals through the provision of community-based care and the use of Community Treatment Orders. These orders allow people to continue living in the community under supervision with conditions that must be met, such as receiving treatment.[14]

Despite the availability and use of these Orders there are certain instances where it is necessary to detain people who have mental health issues, often times against their will, to protect either themselves or the public at large.

A. Detention of Individuals with Mental Health Disorders

Individuals can be detained without charge or trial if they are mentally ill and pose a danger to themselves or others. Article 5 of the European Convention on Human Rights (ECHR), while preserving the right to liberty, distinguishes people of "unsound mind" and permits their detention.[15] In England, the Mental Health Act 1983 provides a number of different mechanisms through which individuals suffering from mental disorders may be detained against their will for a period of assessment and/or treatment. Section 1 of this Act broadly defines mental disorder as "any disorder or disability of the mind."[16]

Emergency admission for psychiatric assessment is provided for by section 4 of the Mental Health Act. If it appears necessary, it may be converted to admission under another section to allow treatment or assessment for a longer period. Emergency applications for admission can be made by an approved mental health professional or the nearest relative of the patient. The application must include "a statement that it is of urgent necessity for the patient to be admitted and detained."[17]

Section 2 of the Mental Health Act provides for patients to be admitted to the hospital for up to twenty-eight days for assessment and/or treatment. This period of assessment may not be extended; however, it may be converted into admission under the other provisions of the Act.

[12] *Id*. ¶ 30.

[13] *Id*. ¶ 23.

[14] Mental Health Act 1983, c. 20, § 17(A), http://www.legislation.gov.uk/ukpga/1983/20/section/17A.

[15] *Id.*

[16] *Id.* § 4(2), http://www.legislation.gov.uk/ukpga/1983/20/section/1.

[17] *Id*. § 4(2).

This is the most common way through which people are detained.[18] In order to be detained under this section, two medical practitioners must make a written recommendation that the patient be admitted and detained in the hospital on the grounds that

> (a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
> (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.[19]

Compulsory admission for treatment is provided for by section 3 of the Act. Admission is for an initial period of up to six months. It may be renewed for an additional six-month period, and annually thereafter. In order to be detained under section 3, two medical practitioners must make a written recommendation that the patient be admitted and detained in the hospital on the grounds that

> (a) he is suffering from [a] mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
> (b) . . .
> (c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and
> (d) appropriate medical treatment is available for him.[20]

In 2011–12 the detention powers provided for by the Mental Health Act were used to detain 48,600 individuals.[21]

B. Criminal Detention of Mentally Ill Offenders to Protect the Public

The court has the ability to order that criminal offenders who suffer from mental disorders be admitted to the hospital under part III of the Mental Health Act 1983.[22] These orders may be made for offenders convicted of an offense punishable with imprisonment where two registered medical practitioners, one of whom must be approved by the Secretary of State as having expertise in the diagnosis and treatment of mental disorders,[23] provides written or oral evidence that the offender is suffering from a mental disorder and either

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[18] *Section of Mental Health and Other Orders*, DEPARTMENT FOR WORK AND PENSIONS, http://www.dwp.gov.uk/publications/specialist-guides/medical-conditions/mental-health-act.shtml (last visited Feb. 11, 2013).

[19] Mental Health Act 1983, c. 20, § 2(2), http://www.legislation.gov.uk/ukpga/1983/20/section/2.

[20] *Id*. § 3(2).

[21] NATIONAL HEALTH SERVICE, RESOURCES INPATIENTS FORMALLY DETAINED IN HOSPITALS UNDER THE MENTAL HEALTH ACT 1983 AND PATIENTS SUBJECT TO SUPERVISED COMMUNITY TREATMENT – ENGLAND, 2011–2012, ANNUAL FIGURES (Oct. 2012), http://www.ic.nhs.uk/catalogue/PUB08085/inp-det-m-h-a-1983-sup-com-eng-11-12-rep.pdf.

[22] Mental Health Act 1983, c. 20, http://www.legislation.gov.uk/ukpga/1983/20/part/III.

[23] *Id*. § 54(1).

> (a) . . .
> (i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him; or
> (ii) in the case of an offender who has attained the age of 16 years, the mental disorder is of a nature or degree which warrants his reception into guardianship under this Act; and
> (b) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section.[24]

Hospital admission may be ordered, even in cases where there is no causal link between the mental disorder and the offense committed.[25] The order lapses after six months, but is renewable for an additional six months and annually thereafter with no limit on the number of renewals that may be made, provided the following requirements are met:[26]

> (a) the patient is suffering from [a] mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
> (b) . . .
> (c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and that it cannot be provided unless he continues to be detained; and
> (d) appropriate medical treatment is available for him.[27]

When the court makes a hospital order, it may not impose a term of imprisonment, fine, or community service order in respect of the offense for which the hospital order is made.[28]

IV. Psychiatric Evaluation Requirements for Gun Permits and Driver's Licenses

A. Gun Permits

England has the reputation of having some of the tightest gun control laws in the world.[29] Only police officers, members of the armed forces, or individuals with written permission from the Home Secretary may lawfully own a handgun.[30] This stringent legislation may, in part, account for Britain's relatively low statistics for the use of firearms in crime: in 2008–2009 firearms were

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[24] *Id*. § 37(2).

[25] BLACKSTONE'S CRIMINAL PRACTICE 2011 ¶ E22.2 (Peter Murphy et al. eds., 2011).

[26] Mental Health Act 1983, c. 20, § 20, http://www.legislation.gov.uk/ukpga/1983/20/section/20.

[27] *Id*. § 20(4).

[28] *Id*. § 37(8).

[29] Ian Burrell, *Legitimate Firearm Users Think that Tougher Restrictions Miss the Target*, THE INDEPENDENT (London), Jan. 15, 2001, at 3.

[30] Firearms Act 1968, c. 27, § 5, http://www.legislation.gov.uk/ukpga/1968/27/section/5. *See also* Burrell, *supra* note 29.

used in only 0.3% of all recorded crimes and were responsible for the deaths of thirty-nine people.[31]

The Firearms Act 1968 makes it unlawful to possess, purchase, or acquire a firearm, shotgun, or ammunition that is not prohibited in Britain without a certificate,[32] although this regulation is subject to certain exemptions.[33] One of the factors in granting a certificate for the lawful ownership of a firearm is the mental health of both the applicant and his or her associates.

The application forms for both firearm and shotgun certificates require information such as the medical history of the applicant, including a release that allows the police to obtain the applicant's medical history from his/her doctor. The police typically check with the doctor if there is "evidence of alcoholism, drug abuse or signs of personality disorder. Social services can also be asked for reasons to turn down an applicant."[34]

Guidance on the implementation of the firearms law states that the authority to obtain the applicant's medical history is not routinely used, but rather used

> . . . in cases where there are genuine doubts or concerns about the applicant's medical history that may have a bearing on the applicant's suitability to possess firearms. The authority should be used only where the doubts or concerns about the applicant's medical history appear to require more detailed information to enable the final assessment of the application to be conducted. Such doubts or concerns might be prompted by the applicant's answers to the medical questions on the application, or they may arise from other information available to the police.[35]

The ability of the police to check the applicant's medical history is not time limited to the initial application period for the certificate. The police may, at any time during the life of the certificate, check with the applicant's doctor if concerns over the applicant's fitness to possess firearms arise.[36]

Once granted, a firearm certificate is typically valid for a five-year period.[37] However, firearm certificates may be revoked if the person is

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[31] HOME OFFICE STATISTICAL BULLETIN, HOMICIDES, FIREARM OFFENCES AND INTIMATE VIOLENCE 2008/09, *available at* http://webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/pdfs10/hosb0110.pdf.

[32] Firearms Act 1968, c. 27, §§ 1–2, http://www.legislation.gov.uk/ukpga/1968/27/.

[33] *Id*. §§ 7–15.

[34] Dominic Casciani, *Gun Control and Ownership Laws in the UK*, BBC (Nov. 2, 2010), http://www.bbc.co.uk/news/10220974.

[35] Home Office, *supra* note 31, ¶ 10.20.

[36] *Id*. ¶ 10.24.

[37] Firearms Act 1968, c. 27, § 28A, http://www.legislation.gov.uk/ukpga/1968/27/section/28A.

- a danger to public safety or to the peace;
- of intemperate habits;
- of unsound mind;
- unfit to be entrusted with such a firearm;
- a prohibited person under the Firearms Act; or
- no longer has 'good reason' for possession.[38]

Each case is judged on its own merits and circumstances. The police have provided guidance on how the above terms should be interpreted. Criteria that justify the revocation of a certificate for "intemperate habits" include evidence of alcohol or drug abuse; aggressive or antisocial behavior, such as domestic disputes; or hostility towards a group of people. Consideration is also given to

> … disturbing or unusual behaviour of a kind which gives rise to well-founded fears about the future misuse of firearms. A pattern of abuse should generally be regarded more seriously than a single incident, although isolated incidents should not be disregarded in the assessment of the person concerned and their fitness to possess a firearm.[39]

When determining whether a person is unfit to possess a firearm, the police consider whether the person is a prohibited person under the Firearms Act, whether they have any convictions or cautions, or whether they have any other known involvement in criminal offenses.[40] Cases where a refusal to grant a certificate, or the revocation of a certificate, have been upheld include where the holder had drunk driving convictions and where a spouse of the holder had two prior drug convictions but continued to associate with drug users.[41]

Refusing to grant, or revoking, a license on the grounds that the applicant or holder is of "unsound mind" is a sensitive area. Guidance to the police notes the difficulties of providing a definition of the term that covers every eventuality, and points out that it is "impractical for a psychiatric assessment to be conducted on an applicant's suitability to possess firearms."[42] Instead, the police are required to consider any "signs of depression, suicidal tendencies, long-standing or intermittent periods of either emotional instability or unpredictable behaviour. Chief officers should also be alert to any of these signs exhibited by existing certificate holders."[43] Periods of detention under the Mental Health Act are considered; however, the guidance specifically notes that there should be "no correlation between periods of imprisonment and

[38] *Id*. §§ 27–28; Home Office, *supra* note 31, ¶ 13.2.

[39] Home Office, *supra* note 31, ¶ 12.8.

[40] *Id*. ¶ 12.3.

[41] *Id*. (citing Dabek v. Chief Constable of Devon and Cornwall, 155 J.B. Rep. 55 (1990)).

[42] *Id*. ¶ 12.9.

[43] *Id*.

periods of detention under the Mental Health Act."[44] In cases where there have been past instances of mental health issues such as depression, the police must

> remember[] that simply because a person has received treatment in the past for certain illnesses or conditions, such as depression or stress, it does not automatically follow that they are unfit to possess a firearm. It is simply one of the factors to be considered with all other evidence relating to the applicant's character and history. In such cases, account should be taken of the latest medical opinion.[45]

Shotgun certificates may be revoked by the chief officer of police if he is satisfied that the holder is prohibited by the Act from possessing a shotgun, or if the individual poses a danger to public safety or the peace through his or her possession of the shotgun.[46]

B. Driving Licenses

In order to obtain a driving license in England, the applicant must

- be a resident of Great Britain;
- meet the minimum age requirement;
- meet the minimum eyesight requirement;
- not be prevented from driving for any reason;
- [pay a fee by specified means];
- have a valid UK passport or other form of identity;
- have [a] National Insurance number if known; and
- provide addresses where [the applicant has] lived for the last three years.[47]

Once granted, the driving license is valid until the holder's seventieth birthday.[48] After this period, the license may be renewed annually, or every three years thereafter this birthday.

1. Disqualification for Disability

There are a number of medical standards that must be taken into account when considering whether a person is fit to drive and the Secretary of State for Transport, acting through the Driver and Vehicle Licensing Agency's (DVLA's) Driver Medical Group (DMG), is responsible for determining whether a person is fit to drive. The law governing the issuance of driving licenses

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[44] *Id.*

[45] *Id.*

[46] Firearms Act 1968, c. 27, § 30C, http://www.legislation.gov.uk/ukpga/1968/27/section/30C.

[47] *Apply for Your First Provisional Driving Licence*, GOV.UK, https://www.gov.uk/apply-first-provisional-driving-licence.

[48] Road Traffic Act 1988, c. 52, § 99, http://www.legislation.gov.uk/ukpga/1988/52/section/99.

is contained in the Road Traffic Act 1988[49] and the Motor Vehicles (Driving Licences) Regulations 1999.[50] Failing to meet these medical standards can result in the refusal to grant, or revocation of a driving license.

When granting a license, the applicant must pass several tests as well as sign a declaration on the application form stating whether or not he suffers from any prescribed, relevant,[51] or prospective,[52] disability. The term "disability" in this context does not solely apply to physical disabilities, but also encompasses diseases.[53] Extensive guidance has been provided that covers a wide range of medical disorders, including psychiatric disorders.[54] For example, the guidance provides that individuals with severe anxiety or depressive disorders who also have "significant memory or concentration problems, agitation, behavioural disturbance or suicidal thoughts" should not be permitted to drive.[55]

A prescribed disability is one that serves as a bar on driving unless specific conditions can be met. These disabilities include epilepsy, severe mental disorders, people prone to sudden attacks of disabling fainting or giddiness, or individuals who persistently misuse drugs or alcohol, regardless of whether the abuse amounts to a dependence.[56] A relevant disability includes prescribed disabilities, or one that is likely to cause the driver to be a danger to the public if operating a vehicle on the roads.[57]

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[49] *Id*. § 92, http://www.legislation.gov.uk/ukpga/1988/52/contents.

[50] Motor Vehicles (Driving Licences) Regulations 1999, SI 1999/2864, http://www.legislation.gov.uk/uksi/1999/2864/contents/made.

[51] Section 92(2) of the Road Traffic Act 1988 defines "relevant disability" as

(a) any prescribed disability, and

(b) any other disability likely to cause the driving of a vehicle by him in pursuance of a licence to be a source of danger to the public.

[52] A prospective disability is one that, over the course of time will progress into a relevant or prescribed disability. Section 92(2) of the Road Traffic Act 1988 defines "prospective disability" as

in relation to any person means any other disability which—

(a) at the time of the application for the grant of a licence or, as the case may be, the material time for the purposes of the provision in which the expression is used, is not of such a kind that it is a relevant disability, but

(b) by virtue of the intermittent or progressive nature of the disability or otherwise, may become a relevant disability in course of time.

[53] Road Traffic Act 1988, c. 52, § 92, http://www.legislation.gov.uk/ukpga/1988/52/section/92.

[54] Driver and Vehicle Licensing Agency, *For Medical Practitioners, At a Glance Guide to the Current Medical Standards of Fitness to Drive* (May 2012), http://www.dft.gov.uk/dvla/medical/~/media/pdf/medical/at_a_glance.ashx.

[55] *Id*. ch. 4.

[56] The Motor Vehicles (Driving Licences) Regulations 1999, SI 1999/2864, ¶ 71, http://www.legislation.gov.uk/uksi/1999/2864/regulation/71/made; Road Traffic Act 1988, c. 52, § 92, http://www.legislation.gov.uk/ukpga/1988/52/section/92.

[57] Road Traffic Act 1988, c. 52, § 92, http://www.legislation.gov.uk/ukpga/1988/52/section/92.

Providing false information in the declaration is an offense. If, through the information provided in the declaration or other methods of inquiry, the Secretary of State determines that the applicant is suffering from a prescribed disability the Secretary is required to refuse to grant the driving license.[58] If the applicant passes a test[59] and the disability does not become more acute, or meets conditions that sufficiently control the disability, the Secretary of State may grant the license.

2. Revoking a License Due to a Disability

In addition to not granting a driving license in the first instance on the grounds that the applicant has a relevant disability, or a prospective disability, that precludes him or her from safely operating a motor vehicle, the Secretary of State also has the authority to revoke a license if he is satisfied that the holder is suffering from a disability and that would have precluded the granting of a license.[60] The Secretary of State is required to notify the license holder in writing that his license is being revoked. The holder must then deliver the license to the Secretary of State. Failing to do so without reasonable excuse is an offense under the Act.[61]

If an individual takes a test of competence to drive, or information is obtained through other methods and the Secretary of State is satisfied that the person is suffering from a disability and is likely to pose a danger to the public if the person drives a vehicle, the Secretary of State must serve notice on the person either revoking his or her license or grant a license that limits the individual to a particular class of vehicle or imposes certain conditions, such as renewing a driving license annually. Once a driving license has been revoked, the holder must deliver it to the Secretary of State. Failure to do so is an offense.[62]

The decision to withdraw or refuse an application for a driving license may be appealed to a Magistrates' Court in England and Wales, or a Sheriff Court in Scotland.

3. Disability Notification Requirement

Holders of driving licenses are under a legal obligation to notify the Secretary of State of the type and extent of any disability, or prospective disability, they become aware of developing after their license has been granted.[63] Individuals that have previously notified the Secretary of State of a disability, or prospective disability, must also provide notification if the disability becomes more acute after the license is granted. Failing to notify the Secretary of State is an

[58] *Id*. § 92(3).

[59] Section 92(8) of the Road Traffic Act 1988 provides that a "relevant test" is "any such test of competence as is mentioned in section 89 of this Act or a test as to fitness or ability in pursuance of section 100 of the Road Traffic Act 1960 as originally enacted, being a test authorising the grant of a licence in respect of vehicles of the classes to which the application relates."

[60] *Id*. § 93(1).

[61] *Id*. § 93(2)–(4).

[62] *Id*. § 92(7).

[63] *Id*. § 94.

offense, as well as operating a motor vehicle on the road with the knowledge that the Secretary of State should be notified of a new or prospective disability. This duty does not arise in cases of new disabilities that will be less than three months in duration.[64] Drivers who fail to notify the DVLA and later become involved in an accident in which their health condition is a contributing factor are liable to be prosecuted and, depending on the terms of each particular contract, the driver's car insurance may be invalid. Doctors have the ability to violate patient confidentiality if they believe that their patient has a condition that makes driving unsafe but refuses to understand this, or refuses to stop driving.[65]

If the Secretary of State has reasonable grounds to believe that a license holder is suffering from a disability, or a prospective disability, he may provide written notification requiring the holder to undergo a medical examination.[66] If the driver receives the notice and does not follow through with the requirements, the Secretary of State may revoke the license.[67]

Insurance companies who refuse to insure drivers on the grounds that the health of the driver is unsatisfactory must notify the Secretary of State of the refusal and include the personal details of the individual refused insurance.[68]

4. Criticisms of the System

The driving license system for those with medical issues is over forty years old. It recently underwent an independent review, which criticized the reliance of self-notification by drivers who "are generally ignorant of their duties, have virtually no incentive to notify DVLA and strong reasons to not do so."[69] It found that the system had become overburdened due to a growing caseload and more complex cases, resulting in longer times to reach decisions.[70] Several recommendations were made and the DVLA is introducing "incremental changes to the medical licensing process." Such changes include providing clearer guidance to health service workers on how to provide advice on whether a patient is fit to drive and additional literature to help drivers understand when they need to notify the DVLA about a medical condition.[71]

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[64] *Id*. § 94(2).

[65] DAVID SEMPLE & ROGER SMYTH, OXFORD HANDBOOK OF PSYCHIATRY 843 (2d ed., 2009).

[66] Road Traffic Act 1988, c. 52, § 94(4)–(5), http://www.legislation.gov.uk/ukpga/1988/52/section/94.

[67] *Id*. § 94(4)–(5).

[68] *Id*. § 95.

[69] RISK SOLUTIONS, REVIEW OF THE DVLA MEDICAL DRIVER LICENSING PROCESS IN THE UK at iii (Feb. 2006), *available at* http://www.dft.gov.uk/dvla/medical/medical_advisory_information/~/media/pdf/medical/Medical%20Licensing%20Risk%20Solutions%20Report.ashx.

[70] *Id*. at iv.

[71] *Review of Medical Driver Licensing*, DEPARTMENT FOR TRANSPORT, DRIVER AND VEHICLE LICENSING AGENCY, http://www.dft.gov.uk/dvla/medical/medical_advisory_information/reviewofdm.aspx (last updated Aug. 11, 2012).

EUROPEAN UNION

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SUMMARY The regulation of mental health care institutions and the institutionalization of patients are issues that fall within the domain of the European Union (EU) Member States, since they are primarily responsible for the provision and delivery of health care and medical services. Based on the Treaty on the Functioning of the EU, the EU's role is to complement and support the national policies of the EU Members.

Psychiatric evaluations of individuals seeking to obtain a firearms license is also a matter left to the Member States. The general requirement for acquisition of a firearm, as contained in Directive 2008/51/EC, is that an individual must not be a danger to himself or to public safety and security; but no guidelines have been adopted on this issue.

I. Introduction

At the European Union level, public health, including mental health, is an area of shared competence between the European Union (EU) and its Member States. The EU is empowered by the Treaty on the Functioning of EU (TFEU) to ensure "a high level of human health protection in the definition and implementation of all Union policies and activities."[1] In addition, the TFEU specifies that the EU's action in the field of health is intended to complement the national policies of the Member States and has three specific objectives: (a) improve public health, (b) prevent physical and mental illness and diseases, and (c) obviate sources of danger to physical and mental health.[2] While the Member States have primary responsibility for defining their health policy, organizing and delivering health care services and medical care, and allocating resources for health care services,[3] the EU is mandated to encourage cooperation between EU Members, especially in order to ensure complementarity of health care services throughout the EU.[4]

In 2005, EU Members, along with members of the World Health Organization (WHO) of the European region and the European Commissioner for Health and Consumer Protection, adopted the Mental Health Declaration for Europe.[5] The participating states endorsed the statement that

[1] Consolidated Version of the Treaty on the Functioning of the European Union (TFEU) art. 168, para. 1, 2012 OFFICIAL JOURNAL OF THE EUROPEAN UNION [O.J.] (C 326) 47, http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2012:326:0047:0200:EN:PDF.

[2] *Id.*

[3] *Id.* art. 168, para. 7.

[4] *Id*. para. 2.

[5] Mental Health Declaration for Europe, WHO European Ministerial Conference on Mental Health, Facing the Challenges, Building Solutions, Finland, 2005, http://www.euro.who.int/__data/assets/pdf_file/0008/88595/E85445.pdf.

"there is no health without mental health"[6] and affirmed their commitment to making mental health care a priority and considering the impact of public policies on mental health for their population.

II. Adoption of EU Instruments on Mental Health

At the EU level, discrimination in employment and occupation based on mental health is prohibited based on Council Directive 2000/78/EC of 27 November 2000 Establishing a General Framework for Equal Treatment in Employment and Occupation.[7] Article 1 of the Directive prohibits discrimination on several grounds including disability.[8] The Directive does not define the term "disability." However, the term includes physical and mental disability based on the definition adopted by the European Court of Justice (ECJ) in the case of *Chacón Navas v. Eurest Colectividades SA*. The ECJ stated that disability is "a limitation which results in particular from physical, mental or psychological impairments and which hinders the participation of the person concerned in professional life"[9]

The European Commission, as the EU's executive body, is tasked by the TFEU with taking any appropriate initiative to promote cooperation and coordination of policies and programs adopted by the Member States and, in particular, to establish guidelines and indicators, promote the exchange of best practices, and monitor and evaluate such practices.[10]

Within the framework of its mandate, in 2005 the Commission prepared a Green Paper titled *Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union*, which was designed to launch a debate among EU institutions and establish an EU strategy.[11] Following the publication of the Green Paper, the Commission and EU Members in 2008 adopted the European Pact for Mental Health and Well-Being.[12] The Pact recognized mental health as a human right and established a number of priorities. Subsequently, the Commission published the White Paper *Together for Health: A Strategic Approach for the EU 2008–2013*,[13] with the key objective of improving health across the EU.

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[6] *Id.* para. 8.

[7] Council Directive 2000/78/EC of 27 November 2000 Establishing a General Framework for Equal Treatment in Employment and Occupation, 2000 O.J. (L 303) 17, http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2000:303:0016:0022:EN:PDF.

[8] *Id.* art. 1.

[9] Case C-13/05, Chacón Navas v. Eurest Colectividades SA, 2006 E.C.R. I-6467, Judgment of the Grand Chamber of 11 July 2006 (2007), http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:62005CJ0013: EN:HTML.

[10] TFEU, *supra* note 1, art.168, para. 2.

[11] *Commission Green Paper on Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union*, COM (2005) 484 (Oct. 14, 2005), http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf.

[12] European Pact for Mental Health and Well-Being, EU High Level Conference Brussels, June 12–13, 2008, http://ec.europa.eu/health/mental_health/docs/mhpact_en.pdf.

[13] *Commission White Paper, Together for Health: A Strategic Approach for the EU 2008–2013*, COM(2007) 630 final (Oct. 23, 2007), http://ec.europa.eu/health-eu/doc/whitepaper_en.pdf; *see also* WHO, POLICIES AND PRACTICES

In a resolution on mental health adopted on February 2009, the European Parliament urged the European Commission and EU Member States to undertake a number of measures in the area of mental health.[14]

III. Mental Health Institutions

As stated above, the establishment, organization, and other aspects of mental health institutions are issues dealt with by the EU Members individually. In particular, the institutionalization and care of mental health patients are subject to national legislation and policies. However, EU Members must ensure that legislation and policies are in line with human rights standards and principles, as provided by constitutional and international obligations.

IV. Evaluation of Persons Seeking to Acquire Firearms

Directive 2008/51/EC,[15] which amended Directive 91/477/EEC of 18 June 1991 on the Control of the Acquisition and Possession of Weapons,[16] requires EU Member States to permit the acquisition and possession of firearms only by persons who meet the age requirement of eighteen years old, have good cause, and are not likely to be a danger to themselves, to public order, or to public safety.[17] No guidelines have been adopted on this issue. The EU, based on the principle of subsidiarity, which on issues of shared competence, such as public health, requires that the EU give discretion to EU Members to regulate issues of lesser significance as they see fit.

FOR MENTAL HEALTH IN EUROPE: MEETING THE CHALLENGES (2008), http://www.euro.who.int/__data/assets/pdf_file/0006/96450/E91732.pdf.

[14] European Parliament Resolution of 19 February 2009 on Mental Health, http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P6-TA-2009-0063+0+DOC+XML+V0//EN.

[15] Directive 2008/51/EC of the European Parliament and of the Council of 21 May 2008 Amending Council Directive 91/477/EC on Control of the Acquisition and Possession of Weapons, 2008 O.J. (L 179) 5, http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2008:179:0005:0011:EN:PDF.

[16] Council Directive 91/4777/EEC on Control of the Acquisition and Possession of Weapons, 1991 O.J. (L 256) 51, http://eur-lex.europa.eu/smartapi/cgi/sga_doc?smartapi!celexapi!prod!CELEXnumdoc&lg=EN&\numdoc=31991L0477&model=guichett.

[17] Directive 2008/51/EC art. 5.

FRANCE

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SUMMARY Since the end of World War II, the focus of health care in France has gradually evolved from "assisting the sick" to "providing health care to users" and increasing patients' rights. The overall legislative purpose has been to humanize hospitals, transforming their traditional role as asylums for the poor to that of institutions where integral health care is provided to all citizens. In the case of mental health patients, governmental powers to institutionalize patients have been greatly expanded, but also a more detailed and comprehensive legal framework for requiring patient access to information and patient consent to treatment has been incorporated. Judicial procedures allowing the appeal of institutionalization decisions made by health authorities are now regulated in detail. Finally, the current legislation regulating the granting of firearms permits strictly requires the submission of psychiatric certificates attesting to the sound mental health of permit applicants.

I. Overview of the French Mental Health Care System

A. Main Legislation

France has increased patients' rights in various ways since 1945,[1] as the policy focus evolved from "assisting the sick" to "providing health care to users." The overall legislative purpose has been to humanize hospitals by transforming their traditional role as asylums for the poor to that of institutions that provide integral health care to all citizens. In the case of mental health patients, governmental power to authorize the institutionalization of patients has been greatly expanded, but also a more detailed and comprehensive legal framework for requiring patient access to information and patient consent to treatment has been incorporated. Judicial procedures allowing the appeal of institutionalization decisions made by health authorities are now regulated in detail.[2] Finally, the current legislation regulating the granting of firearms permits strictly requires the submission of psychiatric certificates attesting to the sound mental health of permit applicants.

The main changes concerning the French mental health care system are contained in Law 2011-803 of 2011,[3] and its implementing legislation, Decree 2011-898 of 2011,[4] Decree 2011-846 of 2011,[5] and Decree 2011-847 of 2011.[6]

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[1] *Vos droits expliqués: L'historique depuis 1945* [*Your Rights Explained: The History Since 1945*], MINISTERE DES AFFAIRES SOCIALES ET DE LA SANTE (Mar. 4, 2011), http://www.sante.gouv.fr/l-historique-depuis-1945,8148.html.

[2] *La réforme de la loi relative aux soins psychiatriques* [*The Reform of the Law Relating to Psychiatric Treatments*], MINISTERE DES AFFAIRES SOCIALES ET DE LA SANTE (Feb. 8, 2013), http://www.sante.gouv.fr/la-reforme-de-la-loi-relative-aux-soins-psychiatriques.html.

[3] Loi n° 2011-803 du 5 juillet 2011 relative aux droits et à la protection des personnes faisant l'objet de soins psychiatriques et aux modalités de leur prise en charge [Law No. 2011-803 of July 5, 2011, Relating to the Rights and the Protection of Persons Under Psychiatric Care and the Modalities for their Care], JOURNAL OFFICIEL DE LA REPUBLIQUE FRANÇAISE [J.O.] [OFFICIAL GAZETTE OF FRANCE], July 6, 2011,

Law 2011-803, which took effect on August 1, 2011, and broadly amended Law 90-527 of 1990,[7] created a new legal framework for the regulation of mental health care in France. Law 2011-803 brought the existing legislation into conformity with the French Constitution pursuant to a decision issued by the Conseil constitutionnel [Constitutional Council] in 2011, which had invalidated certain legislation as being unconstitutional.[8]

The new legal framework greatly strengthened the obligation to inform patients about their rights and remedies,[9] to enable them to consider their options regarding the medical care decisions affecting them,[10] and to allow them to give input at all stages of their treatment and recovery. The Charter of the Hospitalized Person of 2006 explicitly changed the legal nomenclature from referring to the sick person as the "object of care" to the "subject of care."[11]

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http://www.legifrance.gouv.fr/jopdf/common/jo_pdf.jsp?numJO=0&dateJO=20110706&numTexte=1&pageDebut=11705&pageFin=11718#. A full explanation of the new provisions of Law No. 011-803 of 2011 is provided in Circulaire N° DGOS/R4/2011/312 du 29 juillet 2011 relative aux droits et à la protection des personnes faisant l'objet de soins psychiatriques et aux modalités de leur prise en charge [Circular No. DGOS/R4/2011/312 of July 29, 2011, Relating to the Rights and the Protection of Persons Under Psychiatric Care and the Modalities for their Care], http://circulaire.legifrance.gouv.fr/pdf/2011/08/cir_33575.pdf.

[4] Décret n° 2011-898 du 28 juillet 2011 relatif aux dispositions d'application en Polynésie française et en Nouvelle-Calédonie de la Loi n° 2011-803 du 5 juillet 2011 relative aux droits et à la protection des personnes faisant l'objet de soins psychiatriques et aux modalités de leur prise en charge [Decree No. 2011-898 of July 5, 2011, Relating to Provisions for the Implementation in French Polynesia and New Caledonia of Law No. 2011-803 of July 5, 2011, Relating to the Rights and the Protection of Persons Under Psychiatric Care and the Modalities for their Care], J.O., July 29, 2011, http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000024409473&fastPos=1&fastReqId=1537770415&categorieLien=cid&oldAction=rechTexte.

[5] Décret n° 2011-846 du 18 juillet 2011 relatif à la procédure judiciaire de mainlevée ou de contrôle des mesures de soins psychiatriques [Decree No. 2011-846 Relating to the Judicial Procedure for the Release or Control of Psychiatric Treatment Measures], J.O., July 19, 2011, http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000024374011&fastPos=2&fastReqId=1890019250&categorieLien=cid&oldAction=rechTexte.

[6] Décret n° 2011-847 du 18 juillet 2011 relatif aux droits et à la protection des personnes faisant l'objet de soins psychiatriques et aux modalités de leur prise en charge [Decree No. 2011-847 Relating to the Rights and the Protection of Persons Under Psychiatric Care and the Modalities for Their Care], J.O., July 19, 2011, http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000024374063&fastPos=1&fastReqId=1179297276&categorieLien=cid&oldAction=rechTexte.

[7] Loi n° 90-527 du 27 juin 1990 relative aux droits et à la protection des personnes hospitalisées en raison de troubles mentaux et à leurs conditions d'hospitalisation [Law No. 90-527 of June 27, 1990, Relating to the Rights and the Protection of Persons Hospitalized for Mental Problems and to the Conditions of their Hospitalization], J.O., June 30, 1990, http://legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000349384.

[8] Décision n° 2011-174 QPC du 6 octobre 2011 [Decision No. 2011-174 QPC of October 6, 2011], http://www.sante.gouv.fr/IMG/pdf/Decision_QPC_2011-174_du_6_octobre_2011.pdf.

[9] Code de la santé publique [Code of Public Health], art. L1111-7, as amended by Loi n° 2005-370 du 22 avril 2005 relative aux droits des malades et à la fin de vie [Law No. 2005-370 of April 22, 2005, Relating to the Rights of Sick Persons and the End of Life], J.O., Apr. 23, 2005, http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000446240&dateTexte=.

[10] Code of Public Health art. L. 3211-5, as amended by Law 2011-803 of 2011.

[11] Ministère de la Santé et des Solidarités, Circular No. DHOS/E1/DGS/SD1B/SD1C/SD4A/2006/90 of March 2 2006, Relating to the Rights of Hospitalized Individuals and Comprising a Charter for Hospitalized Individuals, http://www.sante.gouv.fr/IMG/pdf/anglais.pdf.

B. Regulations Regarding Hospitalization and Institutionalization of Patients

1. Forced Hospitalization of Mental Health Patients

Under the current legal regime,[12] hospitalization of patients for mental health reasons may be authorized without the patient's consent in two situations: (a) at the request of a third party based on the medical needs of the person suffering from the mental disorder,[13] and (b) when ordered by the local prefect of police for the sake of maintaining public security and order.[14]

In the case of hospitalization requested by a third party, usually a family member of the patient,[15] two medical certificates issued within the fifteen days prior to the hospitalization are required.[16] Only one medical certificate issued by a psychiatrist is necessary when there is a grave risk to the health of the patient.[17]

When there is an imminent danger to the health of the patient[18] and it is not possible to contact a third party to petition for the patient's hospitalization, the director of a health facility may order the hospitalization of a patient.[19] The director of a health facility may also oppose the termination of a hospitalization that was requested by a third party when the termination would cause an imminent danger to the patient.[20] The director must also send all of the information related to the patient to a representative of the government, including the medical certificate previously mentioned, at least forty-eight hours before the date of the patient's exit from the facility.[21]

A person can also be forcibly hospitalized when a judge[22] or representative of the State[23] declares the person to be criminally irresponsible. In the case of judicially ordered hospitalizations, the initial control of the patient must take place within six months from the date

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[12] La réforme de la loi relative aux soins psychiatriques [The Reform of the Law Relating to Psychiatric Treatment], Feb. 8, 2013, http://www.loipsy2011.sante.gouv.fr (last visited February 13, 2013).

[13] Code of Public Health art. L. 3212-1, as amended by Law 2011-803 of 2011.

[14] *Id.*

[15] *Id.* art. L. 3212-1(II)(1).

[16] *Id.* art. L. 3211-12-1(I)(1).

[17] *Id.* art. L. 3211-12-3.

[18] *Id.* art. L. 3212-1(II)(2).

[19] *Id.* art. L. 3212-3.

[20] *Id.* art. L. 3212-1(II)(2).

[21] Code de la santé publique [Code of Public Health], art. L3211-11-1, as amended by Loi n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé [Law No. 2002-303 Relating to the Rights of Sick Persons and the Quality of the Health System] art. 19, J.O., Mar. 5, 2002, http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000227015&dateTexte=&categorieLien=id.

[22] Code de procédure pénale [Code of Criminal Procedure] art. 706-135.

[23] Code of Public Health art. L. 3213-7, as amended by Law 2011-803 of 2011.

of the judicial decision, which may be renewed every six months. The judge may order the lifting of the hospitalization order at any time.

2. Types of Hospitalization of Mental Health Patients

A patient may be subject to full hospitalization or to other care measures: partial hospitalization, home care, ambulatory care, therapeutic activities, consultations, etc.[24] When full hospitalization is not required, patients are prescribed a specific health care program, which must specify the type of care, the place where the care will be provided, and the frequency of the care.[25]

An initial phase of observation and care[26] involving the full hospitalization of the patient is necessary to evaluate his or her ability to consent to the treatment and to determine the type and level of health care the patient will receive. During the first twenty-four hours after the admission of the patient, a medical doctor conducts a complete examination of the patient,[27] and a psychiatrist of the health institution hosting the patient issues a mental health certificate confirming the need for full hospitalization, which must later be confirmed by the another psychiatrist within seventy-two hours.[28] When both psychiatric certificates confirm the need to maintain the psychiatric treatment for the patient, one of the psychiatrists proposes a treatment program.[29]

The person who is subject to psychiatric treatment must, to the extent possible, be informed of the planned treatment program and can be made to submit to observation by any means appropriate to his or her condition.[30] After five days but no later than eight days from the day of admission, a psychiatrist must certify whether the psychiatric treatment is still necessary.[31]

If it is in their best interests, minors who are arrested may be hospitalized in mental health institutions.[32]

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[24] *Id.* art. L. 3211-2-1(2).

[25] *Id.*

[26] This initial phase of observation and care [période initiale d'observation et de soins] is described in detail in a Ministry of Interior circular: Ministère de l'intérieur, de l'outre-mer, des collectivités territoriales et the l'immigration et le Ministère du travail, de l'emploi et de la santé, Circulaire NOR IOCD1122419C du 11 août 2011 relative aux droits et à la protection des personnes faisant l'objet de soins psychiatriques et aux modalités de leur prise en charge [Circular No. IOCD1122419C of Aug. 11, 2011, Relating to the Rights and the Protection of Persons Under Psychiatric Care and the Modalities for their Care], http://circulaire.legifrance.gouv.fr/pdf/2011/08/cir_33643.pdf.

[27] Code of Public Health art. L. 3213-3, as amended by Law 2011-803 of 2011. This provision was amended pursuant to the Décision du conseil constitutionnel du 6 octobre 2011—Décision QPC 2011-174 [Decision QPC 2011-174 of the Constitutional Council of October 6, 2011], No. 12, http://www.sante.gouv.fr/IMG/pdf/Decision_QPC_2011-174_du_6_octobre_2011.pdf.

[28] Code of Public Health art. L. 3211-2-2.

[29] *Id.*

[30] *Id.* art. L. 3211-3.

[31] *Id.* art. L. 3212-7.

[32] *Id.* art. L. 3214-1.

French governmental agencies intervene in all decisions concerning the hospitalization of patients for mental health reasons[33] by making recommendations, approving certain medical decisions and vetoing others, or making final decisions on other mental health treatment measures.[34]

3. Regulations Concerning Particular Mental Health Patients

Certain categories of mental health patients are subject to a "reinforced regime"; that is, patients whose condition could be considered dangerous are subject to compulsory measures under a regime of strict control. The reinforced regime applies to patients under psychiatric treatment following a declaration of criminal irresponsibility and to those under psychiatric treatment provided in units for difficult sick persons (*unité pour malades difficiles*, UMD), as decided by a representative of the State.[35]

4. Challenging Mental Health Care Measures

When the psychiatrist considers the termination of full hospitalization for a given patient, a tripartite group of health professionals provides its opinion to the prefect of police,[36] and reviews the further psychiatric measures determined necessary by the health institution's director when the duration of the measures exceeds one year.[37] The law contemplates intricate provisions concerning the resolving of disagreements within the group.

Mental health care measures, including hospitalizations without consent, may also be challenged before the Judge for Freedoms and Detentions (juge des libertés et de la détention, JLD) through a special judicial procedure.[38] JLDs uphold or reject the health care treatment plans but may not

[33] Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique qui renforce la participation des usagers aux politiques publiques de santé [Law N° 2004-806 of August 9, 2004, Relating to the Public Health Policy that Strengthens User Participation in Public Health Policies], J.O., Aug. 11, 2004, http://www.legifrance.gouv.fr/affichLoiPubliee.do;jsessionid=FE077AF45D72D98D74C5E35A54014551.tpdjo16v_1?idDocument=JORFDOLE000018157637&type=contenu&id=1.

[34] Code of Public Health art. L. 3213-4, as amended by Law 2011-803 of 2011.

[35] *Id.* art. L. 3213-7.

[36] *Id.* art. L. 3211-9.

[37] *Id.* art. L. 3211-11.

[38] *Id.* art. L. 3211-12. The procedure is described at length in a Ministry of Justice circular: Circulaire NOR: JUSC1120428C du 21 juillet 2011 relative à la présentation des principales dispositions de la loi n° 2011-803 du 5 juillet 2011 relative aux droits et à la protection des personnes faisant l'objet de soins psychiatriques et aux modalités de leur prise en charge et du décret n° 2011-846 du 18 juillet 2011 relatif à la procédure judiciaire de mainlevée ou de contrôle des mesures de soins psychiatriques [Circular No. JUSC1120428C of July 21, 2011, Relating to the Presentation of the Main Provisions of Law No. 2011-803 of July 5, 2011, Relating to the Rights and the Protection of Persons Under Psychiatric Care and the Modalities for their Care, and Decree No. 2011-846 Relating to the Judicial Procedure for the Release or Control of Psychiatric Treatment Measures], BULLETIN OFFICIEL DU MINISTÈRE DE LA JUSTICE ET DES LIBERTÉS, July 29, 2011, http://circulaire.legifrance.gouv.fr/pdf/2011/08/cir_33567.pdf.

amend them on their own initiative.[39] If the JLD decides to lift the full hospitalization regime, he or she must give the medical team an opportunity to implement a care program for the patient.[40]

5. Territorial Organization of Psychiatric Institutions

Departmental commissions for psychiatric care (commissions départementales des soins psychiatriques, CDSP) deal with the most sensitive situations involving mental health patients, that is, when there is imminent danger and psychiatric care is needed.

The general director of the regional health agency (Agence Régionale de Santé, ARS) designates the health facilities responsible for providing public-service psychiatric care for each health territory, giving prior notice to the respective prefect of police.

A patient admitted for emergency care to a facility not authorized to treat patients under psychiatric stress must be transferred to an authorized facility within forty-eight hours. ARS establishes a response mechanism for psychiatric emergencies within each health territory and organizes the means of transportation for psychiatric patients.

The directors of health facilities, prefect of police, General Director of ARS, and other territorial collectivities execute interagency agreements for all purposes related to the enforcement of mental health care legislation, and for the treatment and release of persons under psychiatric treatment.

II. Requirements for Psychiatric Evaluation for Firearms Permit Applicants

Law 2012-304 of 2012[41] is a new law on firearms control in France that will become effective by September 2013. It requires applicants for a permit for Category B weapons[42] to submit a medical certificate issued not more than fifteen days prior to the date of application, evidencing a physical and mental condition compatible with the possession of a firearm.[43] A similar provision

[39] *Id.* art. L. 3211-12(2), para 2.

[40] *Id.* art. L. 3211-12-1.

[41] Loi n° 2012-304 du 6 mars 2012 relative à l'établissement d'un contrôle des armes moderne, simplifié et préventif [Law No. 2012-304 of March 6, 2012, on the Establishment of a Modern, Simplified, and Preventative Gun Control System], J.O., Mar. 7, 2012, http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000025445727&dateTexte=&categorieLien=id.

[42] *Nouvelles règles applicables à la détention d'une arme*, [New Rules Applicable to the Possession of a Weapon], NET-IRIS (7 March 2012), http://www.net-iris.fr/veille-juridique/actualite/29542/nouvelles-regles-applicables-a-la-detention-une-arme.php. (The following are the weapons listed by Law 2012-304 of 2012 in Category B (those subject to permit): short semiautomatic or repeating firearms; short gunshot firearms with central percussion; short gunshot rimfire weapons with a total length less than 28 cm; long semiautomatic firearms whose magazine and chamber can together hold more than three rounds; long semiautomatic firearms whose magazine and chamber can together hold more than three rounds, whose charger is not removable, or where it is not certain that the weapon can not be converted using ordinary tools into firearms whose magazine and chamber can together hold more than three rounds; long repeating and semiautomatic shotguns with a barrel not exceeding 60 cm; and semiautomatic civilian firearms which have the appearance of an automatic firearm).

[43] Loi n° 2012-304, art. 3, amending article 2336.1.IV of the Code de la Défense.

in Law No. 2003-239 of 2003[44] required applicants for a permit for certain weapons (mainly semiautomatics) to submit a medical certificate indicating that their physical and mental health was not incompatible with the possession of such weapons.[45] This requirement is currently provided in the Code of Internal Security, which contains the governing gun-control legislation.[46]

Furthermore, when applicants are undergoing or have undergone psychiatric treatment, they must produce a medical certificate issued by a psychiatrist attesting that they are mentally healthy.[47]

[44] Loi n° 2003-239 du 18 mars 2003 pour la sécurité intérieure [Law No. 2003-239 of March 18, 2003, on Internal Security], J.O., Mar. 19, 2003, http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000412199&dateTexte=&categorieLien=id.

[45] *Id.* art. 82.

[46] Code de la sécurié interieure, Livre III, Titre 1, Armes et Munitions, art. L 312-6, http://www.legifrance.gouv.fr/affichCode.do?cidTexte=LEGITEXT000025503132&dateTexte=20130129.

[47] Loi n° 2003-239, art. 82.

GERMANY

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SUMMARY In Germany, those suffering from mental health problems can be institutionalized for the purpose of protecting themselves and others. If commitment is sought to protect the public interest, the process is to be initiated by the administrative authorities of the states on the basis of state laws. Commitment must be ordered by a judge in accordance with procedural rules that require a medical or psychiatric opinion and that protect the individual's right to due process.

In Germany, the treatment of the mentally ill has largely shifted from institutionalizing the patient to treating him with drugs; the medical community sees both advantages and disadvantages in this changed practice.

German weapons law prevents those who have been declared incompetent from acquiring a weapons license, and it requires medical and/or psychiatric evaluations of weapons license applicants who raise the suspicion that they may have a mental health problem. The effectiveness of the mental health evaluations is enhanced by the frequency of license renewals.

I. The Treatment of Mental Illness

In Germany's universal health care system close to 90 percent of the population is insured in the statutory (social) health insurance scheme,[1] while the remaining ten percent is insured privately.[2] Treatment for mental health issues is among the benefits provided by the statutory health scheme[3] as well as by private insurers.[4]

As to treatment methods for mental illness, Germany has experienced similar developments to those encountered in the United States. In the last few decades, the focus in treatment has shifted from institutionalizing patients to the dispensing of drugs,[5] which in many instances are deemed

[1] STATISTISCHES JAHRBUCH DEUTSCHLAND UND INTERNATIONALES 2012, DESTASIS 227, https://www.destatis.de/DE/Publikationen/StatistischesJahrbuch/StatistischesJahrbuch2012.html.

[2] *Zahlen zur privaten Krankenversicherung*, PKV, http://www.pkv.de/zahlen/.

[3] Sozialgesetzbuch Fünftes Buch. Gesetzliche Krankenversicherung [SGB V] [Social Code. Book V, Statutory Health Insurance], Dec. 20, 1988, BGBL. I at 2477, as amended § 27, http://www.gesetze-im-internet.de/sgb_5/index.html.

[4] *Psychiatrie*, GKV SPITZENVERBAND, http://www.gkv-spitzenverband.de/krankenversicherung/krankenhaeuser/psychiatrie/psychiatrie.jsp (last visited Feb. 13, 2013).

[5] ERWIN DEUTSCH & ANDREAS SPITHOFF, MEDIZINRECHT 521 (6th ed. 2008).

to have curative effects for mental illnesses that formerly were considered incurable.[6] In the German experience, this shift has proven to be beneficial in part, in that patients are treated with respect and not deprived unnecessarily of their liberty. On the other hand, the new treatment methods have led to a reduced level of observation of patients and have been of limited usefulness for certain patients, particularly those displaying sexually aberrant behavior.[7]

II. Civil Status of the Mentally Ill

A protector can be appointed for a person whose mental state prevents him from functioning on his own.[8] The duties of the protector are prescribed individually by the court and depend on the extent of the person's illness or disability. The purpose of the protectorate is to allow the person who is mentally ill or physically or mentally disabled as much ability to act independently as he is capable of while providing all the help that is needed.[9]

A person who suffers from more than a temporary mental disturbance that prevents him from exercising his free will can be declared incompetent, that is, incapable of being legally responsible for his transactions.[10] This form of incapacity is primarily an instrument of civil law intended to invalidate the transactions of the incapacitated person, though civil incapacity is also a criterion for denying a weapons license (see Part IV below).

III. Commitment of the Mentally Ill

A mentally ill person can be committed to a closed institution either upon request of the public authorities of the German states when the person is a danger to others or himself, or upon request of the ill person's protector when institutionalization is sought to protect the ill person from himself. In either event, the placement of the mentally ill person in an institution where he is deprived of his liberty requires a proceeding before the family court in which the due process rights of the ill person are upheld.[11]
Commitment upon request of the protector is an instrument of civil law. It is governed by the Civil Code and permitted only if the mentally ill or disabled person consents or if institutionalization is necessary to prevent suicide or serious self-inflicted harm.[12] Commitment upon request of the public authorities is governed by laws of the states.

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[6] Elmar Habermeyer & Henning Sass, *Voraussetzungen der Geschafts[un]fähigkeit—Anmerkungen aus psychopathologischer Sicht*, MEDIZINRECHT 543 (2003).

[7] DEUTSCH & SPITHOFF, *supra* note 5.

[8] BÜRGERLICHES GESETZBUCH [BGB] [CIVIL CODE], repromulgated Jan. 2, 2002, BUNDESGESETZBLATT [BGBL.] I at 42, as amended, §§ 1896–1908i, *translation at* http://www.gesetze-im-internet.de/englisch_bgb/ index.html.

[9] BGB § 1896.

[10] BGB § 104.

[11] Gesetz über das Verfahren in Familiensachen und in den Angelegenheiten der freiwilligen Gerichtsbarkeit [FamG] [Act on Proceedings in Matters of Family Law and Non-Contentious Jurisdiction], §§ 312–339, http://www.gesetze-im-internet.de/famfg/index.html#BJNR258700008BJNE002400000.

[12] BGB § 1906.

An example of a state law is Baden-Württemberg's Act on the Commitment of the Mentally Ill.[13] It provides that persons need to be institutionalized if as a result of their illness they endanger their life, their health, or the legal interests of other persons.[14] The petition to the court may be brought by the local administrative authority or, for the continuation of a commitment, by the institution. The petition must include the expert opinion of the resident psychiatrist of the public health office.[15] In urgent cases, a person can be institutionalized before the proceeding takes place provided that a physician of the institution immediately confirms the necessity of commitment and a proceeding is held as soon as possible.[16]

The legal issues surrounding the commitment of a person to a closed institution have been clarified by ample case law, which established the guiding principle of balancing the rights of the ill individual with the public interest in his confinement and treatment.[17] The Federal Constitutional Court has pointed out the importance of granting the ill person a hearing prior to any judicial decision on commitment, even when a temporary injunction is sought, so that the judge can gain a personal impression of the condition of the individual.[18]

IV. Mental Health as a Weapons Licensing Criterion

Mental health is a criterion for the granting of a weapons license. German law stipulates that anyone who owns or acquires a firearm must obtain a weapons possession license and anyone who wants to carry a gun must obtain a carrying license.[19] These weapons licenses may not be granted to individuals who are legally incompetent.[20] In addition, a license may not be granted to an individual who justifies the assumption that he is addicted to alcohol or drugs, mentally ill, feeble-minded or physically unfit, or unable to handle or store a weapon properly. If the authority in charge of licensing suspects such grounds for denial, it must investigate further by involving local police and searching the register for juvenile correctional measures. For mental or physical health issues, the authority in charge must require the applicant to submit, at his own expense, a medical or psychiatric evaluation.[21] These measures relating to mental and physical

[13] Gesetz über die Unterbringung psychisch Kranker [Act on the Commitment of the Mentally Ill], repromulgated Dec. 2, 1991, GESETZBLATT FÜR BADEN-WÜRTTEMBERG 794 (1991), http://www.landesrecht-bw.de/jportal/portal/t/2bfg/page/bsbawueprod.psml;jsessionid=01478EA8BC0B70530AA152CD4896B678.jpb4?doc.hl=1&doc.id=jlr-UbrgGBW1991pP1&documentnumber=1&numberofresults=22&showdoccase=1&doc.part=X&paramfromHL=true#focuspoint.

[14] *Id*. § 1(4).

[15] *Id*. § 2.

[16] *Id*. § 4.

[17] DEUTSCH & SPITHOFF, *supra* note 5, at 540.

[18] Bundesverfassungsgericht [Federal Constitutional Court] Oct. 7, 1981, ENTSCHEIDUNGEN DES BUNDESVERFASSUNGSGERICHTS 208, 1981.

[19] Waffengesetz [WaffG] [Weapons Act], Oct. 11, 2002, BGBL. I at 3970, as amended, § 10, http://www. gesetze-im-internet.de/waffg_2002/index.html.

[20] WaffG § 5.

[21] WaffG § 6; BERND HEINRICH & CHRISTIAN PAPSTHART, WAFFENRECHT 166-170 (9th ed. 2010).

suitability are merely part of an extensive background check that also seeks to determine if the applicant has a criminal record.[22]

Psychiatric evaluations are always required for anyone under the age of twenty-five who is applying for the first time for a weapons possession license. Such persons must submit an evaluation from a physician from the public health office or from a psychiatrist or qualified psychologist.[23] Exempted from this requirement are marksmen over the age of twenty-one, those applying for a permit to possess or purchase a low-caliber weapon that is ordinarily used at shooting ranges, and hunters who have obtained a hunting license.[24]

The psychiatric evaluation of those under the age of twenty-five was enacted in 2002 after the massacre of Erfurt, when a nineteen-year-old who had been expelled from his high school entered the school armed with a semiautomatic pistol, shot and killed sixteen persons, most of them teachers, and then shot himself.[25] At that time, a new weapons law was in the last stages of being approved in Parliament, and this process was halted for the purpose of agreeing on many last-minute changes in the proposed law, among them the requirement of a psychiatric evaluation for those under twenty-five.[26]

The mental health status of a gun owner remains the object of scrutiny by the authorities even after licensing because licenses must be frequently renewed and because the authorities are charged with continuously monitoring license holders. For the purchase of a weapon, a weapons possession license is valid for only one year.[27] Although a weapons possession license has no time limits for the purposes of possessing a weapon, the authorities are nevertheless required to review the physical and mental health and criminal record of weapons owners at least every third year.[28] Carrying licenses are also subject to renewal after a period of no longer than three years.[29]

[22] WaffG § 5.

[23] WaffG § 6(3).

[24] HEINRICH & PAPSTHART, *supra* note 21, at 170.

[25] *Medieninformation 22/2004, Bericht der Gutenberg-Kommission zu den Vorgängen am Erfurter Gutenberg-Gymnasium*, THÜRINGER JUSTIZMINISTERIUM, http://www.thueringen.de/de/homepage/presse/12251/ uindex.html (last visited Feb. 10, 2013).

[26] HEINRICH & PAPSTHART, *supra* note 21, at 12.

[27] WaffG § 10(1).

[28] WaffG § 4.

[29] WaffG § 10(4).

ISRAEL

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SUMMARY The provision of mental health care in Israel is strictly regulated by law. Mandatory hospitalization and compulsory outpatient treatment of mental health patients require approval following a medical examination conducted by a psychiatrist or at a mental health hospital or hospital psychiatric unit, depending on the circumstances. The conditions of voluntary hospitalization, types of treatment afforded in compulsory hospitalization and outpatient settings, and the rights of patients under treatment are all clearly delineated. The granting of licenses for access to firearms or to operate motor vehicles, and small boats is dependent on verifying the psychological competency of the applicant. Information regarding the mental impairment of persons who may endanger themselves or others while using such equipment is transferred by physicians to the Ministry of Health and, when necessary and under strict confidentiality rules, to relevant licensing authorities.

I. Regulation of Mental Health Institutions and Institutionalization of Patients

The Treatment of Mental Health Patients Law, 5751-1991[1] (the Law) regulates both voluntary and compulsory hospitalization and the treatment of patients at hospitals and outpatient clinics in Israel.

The Law prohibits the hospitalization of patients in the absence of either a court order or a medical determination based on mental and physical examinations indicating the need for hospitalization. In the case of a patient who is a minor, the Law requires that the examination be done by a psychiatrist specializing in children and juveniles.[2]

A. Psychiatric Examinations

A person may be subjected to an urgent compulsory mental examination upon the request of a psychiatrist, defined as a physician qualified as a specialist in psychiatry in accordance with regulations, who is employed by the State as a district psychiatrist. A request for an urgent compulsory mental examination can be made if the district psychiatrist has been presented with prima facie evidence that the patient's mental judgment has been greatly impaired by his[3] disease, that he poses an imminent physical risk to himself or to others, and that he has refused to be examined by a psychiatrist. A request for an urgent examination of a minor can be approved based on a recommendation of a social worker and must be performed by a psychiatrist who specializes in children and juveniles.[4]

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[1] Treatment of Mental Health Patients Law, 5751-1991, SEFER HAHUKIM No. 1339, p. 58.

[2] *Id.* § 3.

[3] The use of masculine pronouns in this report should be taken to refer to both males and females.

[4] Treatment of Mental Health Patients Law, 5751-1991 § 6.

A non-urgent psychiatric examination may be ordered by the district psychiatrist upon presentation of prima facie evidence that the patient's sense of judgment is impaired by his disease, that he has refused to be examined by a psychiatrist, and that one of the following conditions has been met: that he poses a nonimminent danger to himself or to others, that his ability to care for his basic needs has been severely harmed, or that he is causing someone severe mental pain or harm to another's property.[5]

B. Voluntary Hospitalization

A patient who requests to be hospitalized must sign a form for voluntary hospitalization and receipt of treatment.[6] A patient who wishes to be released after having voluntarily admitted himself for mental treatment will be permitted to leave the hospital within forty-eight hours after signing a release request form. If he refuses to sign a consent form for hospitalization, for receipt of treatment, or for release, his wish to be hospitalized or released, as appropriate, will be recorded in a protocol that will be drafted and signed by two physicians or by one physician and one nurse. A patient who requests to be released after having been voluntarily hospitalized but is found by the hospital manager to have met the criteria for compulsory hospitalization will be released within forty-eight hours from the time the request is made unless a compulsory hospitalization order has been issued by the district psychiatrist.[7]

A person may request hospitalization of his minor child, his adopted child, or a child for whom he serves as a guardian, unless the minor was legally removed from his care. A request for hospitalization of a minor at a mental institution or a psychiatric unit in a hospital requires signing a consent form for admission.[8] Admission of minors under the age of fifteen against their will must be evaluated by a district committee for children and juveniles, which can order that the minor be released or that his hospitalization be continued if it is determined that hospitalization is the only way that he can be treated. An order for hospitalization of minors over the age of fifteen against their will requires a court order.[9]

C. Compulsory Hospitalization

A medical administrator of a hospital may admit a person for urgent hospitalization against his will upon determination that the hospitalization is required, following a mental and physical examination of the patient that has been conducted at a mental health hospital or the psychiatric unit of a hospital.[10]

The period in which a patient can be hospitalized under urgent circumstances should not exceed forty-eight hours. This period can be extended by a decision of the district psychiatrist based on

[5] *Id.* § 7.

[6] *Id.* § 4(a).

[7] *Id.* § 4(b-d).

[8] *Id.* § 4A(a) & (b).

[9] *Id.* § 4A & B.

[10] *Id.* § 5.

a psychiatric examination that the person's judgmental capacity has been significantly impaired by his disease and that he poses an imminent danger to himself or to others. Hospitalization based on the district psychiatrist's order can be implemented within ten days and cannot exceed seven days unless extended for seven additional days.[11]

An order for compulsory treatment at an outpatient clinic may be issued by the district psychiatrist under similar circumstances if such treatment is available. The treatment may be ordered by the district psychiatrist for a period that cannot exceed six months and can be renewed for additional periods not exceeding six months each. The Law authorizes the district psychiatrist to issue a hospitalization order for a person who has not complied with an order for compulsory treatment at an outpatient clinic.[12]

D. Patients' Rights

The Law provides that the main objective of hospitalization is to provide a patient with medical care. The hospitalization of any person for the purpose of protecting him or others must meet the requirements established under the Law.[13] The Law further requires that patients should get treatment in accordance with their physical and medical condition and according to the regulations that apply "in the health system in Israel."[14]

Hospitalized patients are entitled to send and receive closed letters and other types of mail; receive guests at times and under conditions as determined by the hospital manager; maintain contact with persons outside of the hospital; and hold personal items and wear their own clothes to the extent reasonable as determined by the manager. These rights may be limited if necessary but only for medical reasons, as long as the patient's right to send closed letters or maintain any other contact with his lawyer, guardian, district psychiatrist, district psychiatric committee, or the Attorney General is not restricted.[15]

The Law regulates the type of treatment that can be provided to patients under compulsory hospitalization and under an outpatient treatment plan and requires sharing with them both general and individual information on their rights and their condition. Although patients have a right to obtain medical information regarding their status, the delivery of such information is subject to the medical discretion of their physician.[16]

Any personal information received in the course of implementing the Law must be kept confidential except: when the patient consents to its disclosure; when in the opinion of the treating physician disclosure is necessary for treatment or for implementation of the Law; when permitted by a court; or when authorization for disclosure is granted for investigative purposes

[11] *Id.* § 9.

[12] *Id.* § 11.

[13] *Id.* § 35(b).

[14] *Id.* § 35(c), as translated by the author, R.L.

[15] *Id.* § 35(d-e).

[16] *Id.* § 35(f-k).

by high-level police officers or persons authorized by the Minister of Justice to receive such information, subject to the approval of the head of mental health services, hospital manager, or district psychiatrist, as appropriate.[17]

II. Psychiatric Evaluation Requirements for Purpose of Licensing

A. Firearms Licenses

The Firearms Law, 5709-1949[18] requires any physician, psychologist, mental health officer, or social worker to report to the Ministry of Health any patient under their care who they suspect has access to a firearm or would constitute a danger to himself or to the public if he had access to one. Such a report may be forwarded by the Ministry's manager to the Israel Defense Forces[19] or to state security agencies, such as the police or prison authorities, who routinely inform the Ministry of Health of the names of their applicants for employment.[20]

License applications and information regarding an applicant's eligibility for employment with a security agency must be forwarded by licensing officials to the Ministry of Health manager, who will inform them of any record of the mental health hospitalization of the applicant.[21]

B. Motor Vehicle Licenses

The Traffic Ordinance (New Version),[22] as amended, requires any physician to report to a special medical authority designated by the Minister of Health any patient older than sixteen years of age whom the physician has diagnosed as having a disease that might endanger him or another if he was driving.[23]

The Ordinance requires the medical authority to provide the licensing authority in the Ministry of Transportation recommendations regarding the granting or canceling of any regular or conditional driver's license based on information it has received from treating physicians or from security agencies about an applicant's relevant debilitating diseases.[24]

C. Boating Licenses

Persons who wish to obtain boating licenses for small vessels are subject to similar rules as those applicable to motor vehicle licensees. In accordance with the Shipping (Skippers of Small

[17] *Id.* § 42.

[18] Firearms Law, 5709-1949, § 11, 3 LAWS OF THE STATE OF ISRAEL [LSI] 61 (5709-1949), as amended.

[19] *Id.* § 11A(a).

[20] *Id.* § 11A(b).

[21] *Id.* § 11B.

[22] The Traffic Ordinance (New Version), 1 LSI 222 (1967).

[23] *Id.* § 12B(a), as amended.

[24] *Id.* § 12B(c), as amended.

Vessels) Regulations 5758-1998,[25] once the appropriate licensing authority has been informed that the licensee's health is impaired, it may request the licensee to provide a medical confirmation that he is qualified to operate the vessel designated in the license. The authority may void the license or place conditions on its application if a medical confirmation has not been received.[26]

In accordance with the Shipping (Seamen) Regulations 5762-2002,[27] all seamen employed as crew members must undergo a medical examination, which includes a psychological test, by a qualified medical team. An additional exam conducted by a psychiatrist may be required upon the discretion of a licensed physician following the initial or a repeated exam.[28]

[25] Shipping (Skippers of Small Vessels) Regulations 5758-1998, KOVETZ HATAKANOT [KT] No. 5901, p. 751.

[26] *Id.* § 18.

[27] Shipping (Seamen) Regulations 5762-2002, KT No. 6157, p.500.

[28] *Id.* §§ 56-58 & App. 7th § 13.

JAPAN

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SUMMARY Japan has a universal health insurance system. Psychiatric care is also covered by health insurance. Under the Mental Health and Mentally Disabled Welfare Law, prefecture governments must establish mental health welfare centers and mental hospitals or mental care departments in public hospitals in their jurisdictions. Three types of psychiatric admissions exist in Japan: voluntary admissions, compulsory admissions, and admissions for medical protection. Compulsory admission does not require a court decision. If a person commits a serious crime and harms others while insane, a court decides whether he or she should be hospitalized or placed under supervision. Authorization by a medical doctor is required when a person applies for a gun possession permit.

I. General Overview of Psychiatric Health Care System and Mental Health Institutions

Japan has a universal health insurance system. Mental health care is covered under a statutory benefit package. Providers are generally paid fee-for-service.[1] Under the People with Disabilities Independence Support Law, a mentally disabled person can receive a government subsidy to cover mental medical care costs.[2] In general, a mentally disabled person pays 10% of his or her mental health care costs. The rest is covered by health insurance and an independence-support subsidy system.

The Mental Health and Mentally Disabled Welfare Law (the Mental Health Law) prescribes medical treatment and protection of the mentally disabled.[3] Prefecture governments must establish mental health welfare centers and mental hospitals or mental care departments in public hospitals in their jurisdictions.[4]

The Medical Services Law prescribes the requirements and procedures for establishing medical clinics and hospitals. Medical doctors or medical jurists can establish a medical clinic or hospital. The board chairperson of a hospital must be a medical doctor unless the prefecture approves an exception.[5] Medical clinics and hospitals are nonprofit organizations.[6] However,

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[1] *Wagakuni no iryō hoken ni tsuite* [*About Our Country's Health Insurance*], MINISTRY OF HEALTH, LABOUR AND WELFARE (MHLW), http://www.mhlw.go.jp/seisakunitsuite/bunya/kenkou_iryou/iryouhoken/iryouhoken01/index.html (last visited Feb. 7, 2013).

[2] People with Disabilities Independence Support Law, Law No. 123 of 2005, art. 52.

[3] Mental Health and Mentally Disabled Welfare Law, Law No. 123 of 1950, *last amended by* Law No. 123 of 2005, art. 1.

[4] *Id*. art. 6, para. 1 & art. 19-7.

[5] Medical Services Law, Law No. 205 of 1948, *last amended by* Law No. 40 of 2012, art. 46-3, para. 1.

[6] *Id*. art. 54.

they are not tax-exempt. The national government pays half of the cost of running the mental hospital or mental care department that the prefectures are obligated to establish under the Mental Health Law. The national government also subsidizes up to 50% of the cost of running a private mental hospital.[7]

Japan has the largest number of psychiatric beds per capita in the world.[8] The number of beds for people with mental problems started to increase after the 1954 amendment of the Mental Health Law was implemented.[9] The amendment added a provision that enabled the government to grant subsidies to mental hospitals and mental care departments of hospitals.[10] In the 1970s, "social hospitalization" had become an issue. "Social hospitalization" means hospitalization of a person for a long time for non-medical reasons, such as family circumstances, a shortage of nursing care facilities,[11] or lack of other community care options. Discussing this phenomenon, Dr. Isao Shibata, a psychiatrist in Japan, stated that

> [i]n Japanese psychiatric hospitals, there are many in-patients who don't seem to need admission, but the hospital has a role as an accommodation facility for stable patients whose family reject them. . . . In Japan, there are few social resources available as accommodation for psychiatric patients.[12]

Reforms have shifted care from hospitals to rehabilitation centers and more recently to communities, with greater emphasis on outpatient care and social integration.[13] In 2004, the Ministry of Health, Labour and Welfare (MHLW) issued the policy document *A Vision for Reforming Mental Health and Welfare Services*,[14] which promotes the policy "from institutionalized care toward community-based care." It set as a goal the release within ten years of 72,000 hospital patients who could be released if the necessary social conditions were met.[15]

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[7] Mental Health and Mentally Disabled Welfare Law, art. 19-10.

[8] Hamada Hamid et al., *Evaluating the WHO Assessment Instrument for Mental Health Systems by Comparing Mental Health Policies in Four Countries*, 86-6 BULLETIN OF THE WORLD HEALTH ORGANIZATION 467 (June 2008), http://www.who.int/bulletin/volumes/86/6/07-042788.pdf.

[9] Law No. 179 of 1954. *See* SEISHIN HOKEN FUKUSHI KENKYŪKAI, SEISHIN HOKEN FUKUSHI HŌ SHŌKAI [DETAILED COMMENTARIES ON MENTAL HEALTH LAW] 10–12 (2007).

[10] Mental Health and Mentally Disabled Welfare Law art. 6-2, *amended by* Law No. 179 of 1954 (current art. 19-10).

[11] TAKEHISA TAKIZAWA, POLICY RECOMMENDATIONS FOR A GENERAL IMPROVEMENT IN PSYCHIATRIC CARE IN JAPAN 13 (Apr. 2010), http://www.wfmh.com/2010DOCS/Takizawabooklet_English2010.pdf.

[12] Eddie Landsberg, *Japan's Mental Health Policy: Disaster or Reform?*, JAPAN TODAY (Oct. 14, 2011), http://www.japantoday.com/category/opinions/view/japan%E2%80%99s-mental-health-policy-disaster-or-reform.

[13] Jeff Kingston, *Shedding Light on Problems with Japan's Psychiatric Care*, JAPAN TIMES (Nov. 25, 2012), http://www.japantimes.co.jp/culture/2012/11/25/books/shedding-light-on-problems-with-japans-psychiatric-care/.

[14] Mental Health and Welfare Headquarters, MHLW, Seishin hoken iryō fukushi no kaikaku bijon (gaiyō) [A Vision for Reforming Mental Health and Welfare Services (Summary)] (Sept. 2004), http://www.mhlw.go.jp/topics/2004/09/dl/tp0902-1a.pdf.

[15] *Id*.

However, things did not change as the government had planned, and the number of hospitalized people did not decrease.[16]

II. Institutionalization of Patients

Three types of psychiatric admissions exist in Japan: (1) voluntary admissions,[17] (2) compulsory admissions,[18] and (3) admissions for medical protection.[19]

When a mentally disabled person is hospitalized for a mental problem, the mental hospital must try to obtain the consent of the hospitalized person.[20] Among the three types of hospitalizations, voluntary admission is the most desirable because it respects the will of the person. Written consent is required for such voluntary hospitalizations.[21]

A compulsory admission is ordered by a prefecture governor when the patient does not consent to admission but two psychiatrists examine the patient and find that admission is necessary to prevent the patient from harming him- or herself or others.[22] A governor usually directs psychiatrists to examine a person based on a report or notice from various people, but may direct examination on his own initiative.[23] Any person may report the identity of a mentally disabled person or one suspected of being mentally disabled and, through a local health center, submit a written request to the governor that the mentally disabled person be protected.[24] Some public officials are obligated to report the identity of a mentally disabled person to the governor. For example, when a police officer encounters a person whose unusual behavior or acts suggest he or she might harm him- or herself or others, the officer must report the person to the governor through the local health center.[25] In addition, a prosecutor must report to the governor either the disposition of a case when he or she decides not to indict a suspect or the court judgment, unless the judgment is imprisonment.[26] Similarly, the director of a probation center must report the identity of a person on probation to the governor when the director has recognized that the person is mentally disabled.[27]

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[16] Social Welfare and War Victims' Relief Bureau, MHLW, Iryō keikaku (seishin shikkan) ni tsuite [Regarding Medical Plans (Mental Illness)] 3, http://www.mhlw.go.jp/seisakunitsuite/bunya/kenkou_iryou/iryou/iryou_keikaku/dl/shiryou_a-3.pdf (last visited Feb. 5, 2013).

[17] Mental Health and Mentally Disabled Welfare Law, Law No. 123 of 1950, *last amended by* Law No. 123 of 2005, art. 22-4, para. 1.

[18] *Id*. art. 29.

[19] *Id*. art. 33.

[20] Mental Health and Mentally Disabled Welfare Law art. 22-3.

[21] *Id.* art. 22-4, para. 1.

[22] *Id*. art. 29, paras. 1 & 2.

[23] *Id*. art. 27, paras. 1–3.

[24] *Id*. art. 23.

[25] *Id*. art. 24.

[26] *Id*. art. 25, para. 1.

[27] *Id*. art. 25-2.

When people who have been voluntarily hospitalized want to be discharged from the hospital, the hospital must discharge them.[28] However, if a designated doctor determines that it is necessary to keep them hospitalized, the hospital may hold them for seventy-two hours.[29] Subsequently, the hospital notifies the governor about the situation and, after two psychiatric examinations, the hospitalization may be made compulsory.[30]

An admission for medical protection is decided by a manager of the hospital when patients are unwilling to consent to the admission but their guardian gives consent and one psychiatrist determines that the admission is necessary.[31] In other words, even if it is unlikely that people would harm themselves or others, when a psychiatrist diagnoses them as being mentally disabled and their guardian agrees to the admission, the mental hospital can hospitalize them and treat them against their will. It is assumed that such people do not understand the necessity of medical care because of their mental disability. Admissions for medical protection comprise 40% of hospitalized mentally disabled people (185,000 voluntary admissions, 1,800 compulsory admissions, and 125,000 admissions for medical protection). The number of admissions for medical protection has increased recently because more elderly people with dementia have been hospitalized under this system.[32] The MHLW established a team to discuss community-based mental health care, including matters concerning admissions for medical protection. The team brought up their concern for the human rights of the hospitalized and recommended, among other things, that there be assigned advocates instead of guardians.[33]

When people are involuntarily hospitalized, they must be informed of their rights regarding how to request a discharge or changes to their treatment.[34] The Psychiatric Review Board (PRB) examines a hospitalized person's request.[35] Each prefecture must have a PRB.[36] Members of the PRB consist of the designated mental health physicians, persons with legal knowledge, and other qualified persons, such as educators specially trained to work with the disabled.[37] The PRB can

[28] *Id*. art. 22-4, para. 2.

[29] *Id*. art. 22-4, para. 3.

[30] *Id*. arts. 26-2, 27 & 29.

[31] *Id*. art. 33, para. 1.

[32] TEAM FOR CONSTRUCTING NEW COMMUNITY-BASED MENTAL HEALTH CARE SYSTEM, MHLW, IRYŌ HOGO NYŪIN NI TSUITE [REGARDING ADMISSIONS FOR MEDICAL PROTECTION] (Jan. 11, 2012), http://www.mhlw.go.jp/stf/shingi/2r9852000001zwut-att/2r9852000001zx2u.pdf (in Japanese).

[33] TEAM FOR CONSTRUCTING NEW COMMUNITY-BASED MENTAL HEALTH CARE SYSTEM, MHLW, NYŪIN SEIDO NI KANSURU GIRON NO SEIRI [SUMMARY OF DISCUSSIONS ON HOSPITAL ADMISSION SYSTEMS] (June 28, 2012), http://www.mhlw. go.jp/stf/shingi/2r9852000002e9rk-att/2r9852000002e9u6.pdf.

[34] Mental Health and Mentally Disabled Welfare Law, Law No. 123 of 1950, *last amended by* Law No. 123 of 2005, arts. 29, paras. 3, 33-3, & 38-4.

[35] *Id*. art. 38-5.

[36] *Id.* art. 12.

[37] *Id*. art. 13.

meet with the hospitalized person, request reports from the hospital, and obtain the hospitalized person's medical records.[38]

III. Medical Treatment and Supervision Act

The Act for the Medical Treatment and Supervision of Insane Persons Who Have Caused Serious Harm (Medical Treatment and Supervision Act) deals with offenders who have committed serious crimes and harmed others while insane.[39] Serious crimes include homicide, arson, robbery, rape, indecent assault, and bodily injury.[40] The Act aims to provide such offenders with medical mental care and supervision, prevent them from perpetrating further criminal acts, and facilitate their return to society.[41]

A public prosecutor must seek a decision of the District Court as to whether medical treatment and supervision under the Medical Treatment and Supervision Act are necessary (1) when criminal charges against a person are withdrawn on the grounds of insanity or diminished responsibility, or (2) when a person is acquitted or given a mitigated sentence without imprisonment on the grounds of insanity or diminished responsibility.[42] In such cases the offenders are hospitalized for evaluation[43] A judge and a psychiatrist examine the case and make a decision.[44] A person may be hospitalized, be obligated to visit a designated hospital, or receive no medical care under the Act.[45] A designated hospital and a probation office supervise the person.

IV. Psychiatric Evaluation for People Applying for Gun Permits or Driver's Licenses

To apply for a permit to possess a gun, applicants must submit a doctor's certificate to prove that

- they are not subject to a mental problem or seizures that cause the loss of full mental ability or ability to properly handle a gun;
- they do not have dementia; and
- they are not addicted to alcohol, narcotics, cannabis, opium, or stimulant drugs.[46]

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[38] *Id*. art. 38-5, para. 4.

[39] Act for the Medical Treatment and Supervision of Insane Persons Who Have Caused Serious Harm (Medical Treatment and Supervision Act), Act No. 110 of 2003, art. 1.

[40] *Id*. art. 2, para. 2.

[41] *Id*. art. 1.

[42] *Id*. arts. 33 & 42.

[43] *Id*. art. 34.

[44] *Id*. art. 11.

[45] *Id*. art. 42.

[46] Law Controlling the Possession of Firearms and Swords, Law No. 6 of 1958, *last amended by* Law No. 72 of 2011, art. 5, para. 1, items 3 & 4; *and* Enforcement Ordinance of Law Controlling the Possession of Firearms and

On the other hand, a psychiatric evaluation is not usually necessary when people apply for a driver's license. Driver's licenses are denied to people who have certain mental problems that would affect their driving ability.[47] When people apply for a license after passing skill and knowledge tests, they must report whether they have certain mental issues that are specified on the application form. Applicants who do report having such issues may be required to be evaluated by a designated medical doctor or to submit a doctor's certificate.[48]

Swords, Prime Minister's Office Ordinance No. 16 of 1958, *last amended by* Cabinet Office Ordinance No. 58 of 2012, art. 10.

[47] Road Traffic Law, Act No. 105 of 1960, *last amended by* Act No. 90 of 2007, art. 90, para. 1; Enforcement Order of Road Traffic Law, Order No. 270 of 1960, *last amended by* Order No. 54 of 2012.

[48] Road Traffic Law, art. 90, para. 8; and Enforcement Ordinance of Road Traffic Law, Cabinet Office Ordinance No. 60 of 1960, *last amended by* No. 39 of 2012.

MEXICO

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SUMMARY Mexico's General Law of Health provides that treatment of mental disorders must be aimed at psychosocial reintegration through measures that include the creation of social and assistance programs. Institutionalization of individuals with mental and behavioral disorders must be the last therapeutic resource considered.

Mexico's Federal Law of Firearms and Explosives provides that one of the requirements for issuing a license to carry firearms is that the applicant may not have physical or mental impairments impacting the ability to handle firearms. Mexico is a federal republic formed by thirty-one states and a Federal District, and as such, every state and the Federal District has its own laws and regulations concerning the issuance of driver's licenses.

I. Introduction

Mexico's General Law of Health provides that treatment of mental and behavioral disorders must be aimed at psychosocial reintegration and provided with respect for the human rights of the patients.[1] More specifically, this Law provides that treatment of mental and behavioral disorders includes reintegration of individuals with mental and behavioral disorders into his/her family and community through the creation of social and assistance programs, such as community residences and "protected workshops," which are training institutions for individuals with mental disorders who voluntarily join in order to learn a craft while being paid.[2]

Mexico's General Law of Health provides that institutionalization of individuals with mental and behavioral disorders must be the last therapeutic resource considered, as explained below.[3]

II. Regulations Regarding Mental Health Institutions and Institutionalization of Patients

The most relevant regulation on mental health institutions is the Mexican Standard for Health Services Provided by Psychiatric Institutions.[4] This Standard provides that treatment of mental

[1] Ley General de Salud [General Law of Health], *as amended*, art. 72, DIARIO OFICIAL DE LA FEDERACIÓN [D.O.], Feb. 7, 1984, available on the website of Mexico's House of Representatives, *at* http://www.diputados.gob.mx/LeyesBiblio/pdf/142.pdf.

[2] *Id*. art. 74(III). *See also* PROYECTO de Norma Oficial Mexicana NOM-025-SSA2-2012, para la prestación de servicios de salud en unidades de atención integral hospitalaria médico-psiquiátrica [Proposal of Mexican Standard for Health Services Provided by Psychiatric Institutions] arts. 4.1.26, 4.1.28, D.O., Nov. 13, 2012, http://dof.gob.mx/nota_detalle.php?codigo=5277384&fecha=13/11/2012.

[3] Ley General de Salud [General Law of Health] art. 75.

[4] Norma Oficial Mexicana NOM-025-SSA2-1994, para la prestación de servicios de salud en unidades de atención integral hospitalaria médico-psiquiátrica [Mexican Standard for Health Services Provided by Psychiatric

disorders must be aimed at social reintegration of the patient, favoring treatment through outpatient and community programs with an emphasis on prevention.[5]

Mexico's health authorities recently published a proposal to enact a new standard governing health services provided by psychiatric institutions, which is currently subject to regulatory review.[6] This proposal also provides that treatment of mental and behavioral disorders must be aimed at social reintegration of the patient, preferably through outpatient and community programs with an emphasis on prevention, but it takes into account health policies developed both at the international and national level that did not exist at the time that the current Standard was enacted.[7]

Mexico's General Law of Health provides that institutionalization of individuals with mental and behavioral disorders must be the last therapeutic resource considered.[8]

Involuntary institutionalization takes place when the patient cannot request institutionalization on his/her own due to permanent or temporary incapacity, and therefore it is requested by a relative, guardian, or legal representative.[9] The request must be certified by a qualified physician who must determine the existence of a mental disorder that poses grave or immediate danger for the patient or third parties.[10] The patient's representative and judicial authorities must be notified of the decision to institutionalize the patient.[11]

Involuntary institutionalization may be reviewed by judicial authorities on the request of the patient or his/her representative.[12] The decision made by judicial authorities must be supported by an expert opinion. If the institutionalization is ordered to be terminated, a specific period of time for terminating it must be established.[13] During the proceedings, the interests of the institutionalized individual must be protected.[14]

Institutions], D.O., Nov. 16, 1995, available on the website of Mexico's National Council of Mental Health, *at* http://www.consame.salud.gob.mx/contenidos/consame/nom_025.html.

[5] *Id*. Introducción [Introduction].

[6] PROYECTO de Norma Oficial Mexicana NOM-025-SSA2-2012, para la prestación de servicios de salud en unidades de atención integral hospitalaria médico-psiquiátrica [Proposal of Mexican Standard for Health Services Provided by Psychiatric Institutions] arts. 4.1.26, 4.1.28, D.O., Nov. 13, 2012, http://dof.gob.mx/nota_detalle.php?codigo=5277384&fecha=13/11/2012.

[7] *Id*. Considerando, Introducción [Preamble, Introduction].

[8] Ley General de Salud [General Law of Health], *as amended*, art. 75.

[9] *Id.*

[10] *Id.*

[11] *Id.*

[12] *Id.*

[13] *Id.*

[14] *Id.*

III. Mental Health Requirements for Gun and Driver's Licenses

A. Licenses to Carry Firearms

Mexico's Federal Law of Firearms and Explosives provides that one of the requirements for issuing a license to carry firearms to an individual is that the applicant may not have physical or mental impairments that impact the ability to handle firearms.[15] More specifically, the Regulation of this Law provides that the physical and mental ability to handle firearms must be proved with a certificate issued by a physician who holds a diploma duly registered with Mexican authorities.[16]

B. Driver's Licenses

Mexico is a federal republic formed by thirty-one states and a Federal District, best known as Mexico City. Every state and the Federal District has its own regulations concerning the issuance of driver's licenses. For example, the regulation that governs the issuance of driver's licenses in the Federal District provides that applications for such licenses for private purposes must include a sworn statement from the applicant indicating that he/she is capable of driving.[17] Furthermore, this regulation provides that applicants for commercial driver's licenses must submit a Certificate of Comprehensive Health Evaluation, which includes a psychometric evaluation.[18]

[15] Ley Federal de Armas de Fuego y Explosivos [Federal Law of Firearms and Explosives], *as amended*, art. 26(I-C), D.O., Jan. 11, 1972, http://www.diputados.gob.mx/LeyesBiblio/pdf/102.pdf.

[16] Reglamento de la Ley Federal de Armas de Fuego y Explosivos [Regulation of the Federal Law of Firearms and Explosives], D.O., May 6, 1972, art. 25(3), http://www.diputados.gob.mx/LeyesBiblio/regley/Reg_LFAFE.pdf.

[17] Reglamento para el control vehicular y de licencias y permisos para conducir en el Distrito Federal, as amended [Regulation for Vehicle Control and Licences and Permits to Drive in the Federal District], arts. 18-I, 19, available on the website of the government of the Federal District, *at* http://www.consejeria.df.gob.mx/LeyesYReglamentos/REGLAMENTODECONTROLVEHICULARYDELICENCIASYPERMISOSPARACONDUCIRENELDISTRITOFEDERAL.pdf.

[18] *Id*. arts. 18, 20-IV.

NEW ZEALAND

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SUMMARY Mental health services are provided by District Health Boards as part of New Zealand's public health care system. Strategies and guidance relating to the sector are developed at the national level. The system involves primary and specialist services and includes both inpatient and community-based treatment options, with greater emphasis being placed on the latter options in recent years. The Mental Health (Compulsory Assessment and Treatment) Act 1992 sets out the processes and rules for requiring persons who are considered "mentally disordered" to undergo assessment and treatment. The processes involve various stages of assessment prior to the issuing of a court order for compulsory treatment. Persons can be admitted and detained in a hospital for the purposes of assessment and treatment. Hospitals that provide mental health services are subject to a range of standards and accountability requirements.

There are restrictions based on mental health concerns in the rules and processes that apply to driver licensing, firearms licensing, and other types of documents that allow legal access to potentially dangerous items. The New Zealand Police have broad discretion in determining whether someone is a "fit and proper person" to possess firearms. The firearms licensing process involves, among other matters, criminal background checks, interviews with the applicant and referees, and the possibility of requiring the applicant to provide medical information. A license may be declined where a person has exhibited signs of "mental ill health."

I. Introduction

The New Zealand government operates a public health care system that is primarily funded from general taxation.[1] Mental health services, including primary and specialist services, fall within this system.[2] The day-to-day running of the healthcare system, including the provision of mental

[1] *See Funding,* MINISTRY OF HEALTH, http://www.health.govt.nz/new-zealand-health-system/funding; *Publicly Funded Health and Disability Services*, MINISTRY OF HEALTH, http://www.health.govt.nz/new-zealand-health-system/publicly-funded-health-and-disability-services (last visited Feb. 5, 2013). About twenty pieces of legislation are included in New Zealand's health and disability statutory framework: *Statutory Framework*, MINISTRY OF HEALTH, http://www.health.govt.nz/new-zealand-health-system/statutory-framework (last visited Feb. 5, 2013).

[2] Primary services include "general practice teams, school-based health services, prison-based health services, and other first point of contact community health services provided by non-governmental organisations (NGOs)." Specialist services comprise "all district health board (DHB) and NGO mental health and addiction services either funded from DHB ring-fenced mental health and addiction funding or directly funded by the Ministry of Health." MINISTRY OF HEALTH, RISING TO THE CHALLENGE: THE MENTAL HEALTH AND ADDICTION SERVICE DEVELOPMENT PLAN 2012–2017, at 1 (Dec. 2012) (hereinafter "Rising to the Challenge"), *available at* http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017. *See also Specialist Services*, HEALTH AND DISABILITY COMMISSIONER, http://www.hdc.org.nz/about-us/mental-health-and-addictions/help-and-support/specialist-services (last visited Feb. 5, 2013).

health services,[3] is largely devolved to twenty District Health Boards (DHBs).[4] The DHBs "manage, provide and purchase health services for the population of their district to ensure services are arranged effectively and efficiently for all of New Zealand. This includes funding for primary care, hospital services, public health services, aged care services, and services provided by other non-government health providers including Māori and Pacific providers."[5]

The Ministry of Health is the central government agency tasked with providing policy advice to the Minister of Health, funding national services, and performing various regulatory functions.[6] Separate from DHBs, service providers, and the Ministry of Health, the Mental Health Commissioner, who is part of the Office of the Health and Disability Commissioner (an independent government entity),[7] has the role of advocating for the interests of people with mental health problems and their families, providing independent advice to the government, and monitoring and reporting on the implementation of the national mental health strategy.[8] Various other organizations also play a role in the mental health sector in New Zealand.[9]

A number of national strategy and policy documents on mental health services have been produced in the past twenty years.[10] Most recently, in December 2012, the Ministry of Health

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[3] *See, e.g., Health Services We Fund: Mental Health*, COUNTIES MANUKAU DISTRICT HEALTH BOARD, http://www.cmdhb.govt.nz/Funded-Services/Mental-Health/default.htm; *Mental Health and Addictions*, WAIKATO DISTRICT HEALTH BOARD, http://www.waikatodhb.govt.nz/page/pageid/2145839413; *Mental Health*, WAITEMATA DISTRICT HEALTH BOARD, http://www.waitematadhb.govt.nz/PatientsVisitors/Mentalhealth.aspx; *Mental Health*, SOUTHERN DISTRICT HEALTH BOARD, http://www.southerndhb.govt.nz/index.php?pageLoad=2671 (all last visited Feb. 5, 2013).

[4] *See* New Zealand Public Health and Disability Act 2000, pt 3 & sch 1, http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80051.html. *See also District Health Boards*, MINISTRY OF HEALTH, http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards; *see generally, Overview of the Health System*, MINISTRY OF HEALTH, http://www.health.govt.nz/new-zealand-health-system/overview-health-system (last visited Feb. 5, 2013).

[5] *Overview of the Health System*, *supra* note 4.

[6] *Id. See also Mental Health Work at the Ministry*, MINISTRY OF HEALTH, http://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-work-ministry (last visited Feb. 4, 2013).

[7] Health and Disability Commissioner Act 1994, s 9, http://www.legislation.govt.nz/act/public/1994/0088/latest/DLM333584.html. The Office of the Health and Disability Commissioner took over the functions of the Mental Health Commission in 2012. *See Background*, HEALTH AND DISABILITY COMMISSIONER, http://www.hdc.org.nz/about-us/mental-health-and-addictions/about-us/background (last visited Feb. 4, 2013).

[8] *See Monitoring and Advocacy*, HEALTH AND DISABILITY COMMISSIONER, http://www.hdc.org.nz/about-us/mental-health-and-addictions/monitoring-and-advocacy (last visited Feb. 4, 2013).

[9] *See generally, Key Health Sector Organisations and People,* MINISTRY OF HEALTH, http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people; MINISTRY OF HEALTH, OFFICE OF THE DIRECTOR OF MENTAL HEALTH: ANNUAL REPORT 2011, *available at* http://www.health.govt.nz/publication/office-director-mental-health-annual-report-2011.

[10] *See* RISING TO THE CHALLENGE, *supra* note 2, at appendix 1; *Mental Health Sector Strategy Documents*, HEALTH AND DISABILITY COMMISSIONER, http://www.hdc.org.nz/about-us/mental-health-and-addictions/mental-health-sector-strategy-documents; *Mental Health Publications*, MINISTRY OF HEALTH, http://www.health.govt.nz/ our-work/mental-health-and-addictions/mental-health-publications. There have also been a number of public investigations relating to the mental health system that have had an impact on various aspects of the system: *see* Warwick Brunton, *The Place of Public Inquiries in Shaping New Zealand's National Mental Health System*, 2(24) AUST. NZ HEALTH POL'Y (2005), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1351184/.

published a five-year mental health and addiction service development plan that sets out the challenges, vision, and priorities in this area and seeks to promote greater national consistency in service delivery.[11] This plan notes that

> [s]ince the early 1990s there has been significant transformation in the way that mental health and addiction services are provided. The focus has shifted from institutions to support and treatment in local hospitals, the community and people's homes. There has also been an increasing emphasis on early intervention and on a culture of recovery, the process of change through which people improve their health and wellness, live a self-directed life, and strive to reach their full potential.[12]

The following are some of the developments over the past two decades that are highlighted in the plan:

- A "significant increase in investment in mental health and addiction services," with total spending on this area being 9.5 percent of the government's total health budget in the 2010/11 fiscal year;[13]
- A "51 percent growth in access to specialist services;"[14]
- The "closure of the institutions and significant expansion of community-based services," with 76 percent of mental health and addiction funding going to community services in the 2009/10 fiscal year and the remainder spent on inpatient services;[15]
- The "development of a strong non-governmental organisation (NGO) sector" and "culturally specific services;"[16]
- A shift to focusing on "supporting recovery for people with the highest needs;"[17]
- Increased support for the involvement of service users and their families in service planning and delivery;[18]
- The "development of a range of primary mental health and addiction initiatives throughout the country"[19]; and
- The implementation of a national program called "Like Minds Like Mine," which aims to "counter stigma and discrimination against people with mental illness."[20]

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[11] RISING TO THE CHALLENGE, *supra* note 2, at vi and 1.

[12] *Id.* at 2.

[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] *Id.*

[17] *Id.*

[18] *Id.*

[19] *Id.*

[20] *Id. See also About Like Minds, Like Mine*, LIKE MINDS, LIKE MINE, http://www.likeminds.org.nz/ page/24-About-Us (last visited Feb. 5, 2013).

The plan sets out four overarching goals for the next five years and seeks to assist health services "across the spectrum" to collectively take action to achieve the goals. The four goals relate to more effective use of resources, enhanced integration between primary and specialist services, "cementing and building on gains in resilience and recovery" for certain groups (including those with "low-prevalence conditions and/or high needs"), and expanding access to services for certain groups, including infants, children, and youth.[21]

There are several pieces of legislation addressing the treatment of persons with mental health and addictions.[22] This report primarily focuses on the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT) Act),[23] which contains the criteria, responsibilities, and processes relating to the compulsory assessment and treatment of persons with mental disorders who are considered to be a danger to themselves or others. Information is also provided on the regulatory and accountability documents that apply to facilities offering inpatient services. The final section of this report relates to legislation or processes that seek to restrict persons accessing certain potentially dangerous items, such as cars or firearms, on the basis of mental health concerns.

II. Compulsory Assessment and Treatment Orders

A. Application of the Legislation

The MH(CAT) Act applies to persons who are considered to be "mentally disordered." This does not necessarily equate to the diagnosis of any particular "mental illness"; rather, the legislation states that "mental disorder"

> in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—
> (a) poses a serious danger to the health or safety of that person or of others; or
> (b) seriously diminishes the capacity of that person to take care of himself or herself.[24]

A separate provision prohibits compulsory assessment and treatment based solely on an individual's political, religious, or cultural beliefs; sexual preference; criminal or delinquent behavior; substance abuse; or intellectual disability.[25]

The Ministry of Health provides detailed guidance on the interpretation of the above definition and other aspects of the legislation, including the roles to be played by clinicians and certain

[21] *Id.* at 5.

[22] *See Mental Health-Related Legislation*, MINISTRY OF HEALTH, http://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-related-legislation (last visited Jan. 30, 2013).

[23] Mental Health (Compulsory Assessment and Treatment) Act 1992, http://www.legislation.govt.nz/act/public/1992/0046/latest/DLM262176.html.

[24] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2(1).

[25] *Id.* s 4.

officials in its implementation.[26] The guidance material includes information on relevant court rulings, such as those that have considered the criteria contained in the above definition. However, it notes that the interpretation of aspects of these criteria remain unsettled.[27] The Ministry also states that

> [n]o piece of legislation can be framed in such a way that all circumstances that can possibly arise are precisely covered. If there is uncertainty as to the 'correct' interpretation, any action taken should be taken in good faith, be consistent with the spirit and intent of the Act, and reflect best clinical practice. In practice, especially in urgent circumstances, situations may arise where adherence to a literal interpretation of the Act may compromise the safety and wellbeing of the individual, staff or public. If the Act can be interpreted in two ways, literally or purposively (that is, in a manner consistent with its purpose), then the purposive interpretation should be preferred.[28]

B. Compulsory Assessment Processes

The MH(CAT) Act allows "any person who believes that a person may be suffering from a mental disorder" to fill out an application form asking the Director of Area Mental Health Services for an assessment of the person.[29] Applications for assessment must be accompanied by a medical practitioner's certificate showing that the person was examined within three days before the date of the application.[30] The guidance material referred to above notes that, while anyone can make an application,

> as the application process is a complex and significant intervention, the Ministry recommends that anyone concerned about a person's mental health contact a crisis assessment team and seek the assistance of a duly authorised officer (DAO). DAOs are appointed to exercise certain powers under the Act relating to the compulsory assessment and treatment of people experiencing mental health issues in the community. The Ministry maintains a list of mental health crisis phone numbers on its website.[31]

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[26] MINISTRY OF HEALTH, GUIDELINES TO THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992 (Nov. 2012), http://www.health.govt.nz/publication/guidelines-mental-health-compulsory-assessment-and-treatment-act-1992; MINISTRY OF HEALTH, GUIDELINES FOR THE ROLE AND FUNCTION OF DULY AUTHORISED OFFICERS (Nov. 2012), http://www.health.govt.nz/publication/guidelines-role-and-function-duly-authorised-officers; MINISTRY OF HEALTH, GUIDELINES FOR THE ROLE AND FUNCTION OF DIRECTORS OF AREA MENTAL HEALTH SERVICES (Nov. 2012), http://www.health.govt.nz/publication/guidelines-role-and-function-directors-area-mental-health-services-0; MINISTRY OF HEALTH, GUIDELINES FOR THE ROLE AND FUNCTION OF DISTRICT INSPECTORS (Feb. 2012), http://www.health.govt.nz/publication/guidelines-role-and-function-district-inspectors; MINISTRY OF HEALTH, GUIDELINES FOR THE SAFE TRANSPORT OF SPECIAL PATIENTS AND SPECIAL CARE RECIPIENTS IN THE CARE OF REGIONAL FORENSIC MENTAL HEALTH SERVICES (July 2012), http://www.health.govt. nz/publication/guidelines-safe-transport-special-patients-and-special-care-recipients-care-regional-forensic-mental.

[27] GUIDELINES TO THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992, *supra* note 26, at 5.

[28] *Id.* at 1.

[29] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 8.

[30] *Id.* s 8B.

[31] GUIDELINES TO THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992, *supra* note 26, at 29.

The guidance notes that "[i]f less restrictive mental health interventions have failed, and a person appears to be mentally disordered, compulsory assessment under Part 1 of the Act may be appropriate."[32] It also states that the threshold for an initial application for compulsory assessment is lower than that for a compulsory treatment order.[33] Therefore, while a court can only impose an order where there is a mental disorder and where such an order is considered necessary, a clinician has the "capacity to compulsorily detain and assess in cases when there is some doubt, but if the assessing clinician feels it is prudent to err on the side of caution."[34]

There are several stages in the compulsory assessment process:[35] preliminary assessment;[36] first period (five days);[37] second period (fourteen days);[38] and a final period (fourteen days, unless extended) during which a court makes a determination as to whether to grant a compulsory treatment order.[39]

Once an application has been received, the patient is consulted on the place and time of the preliminary assessment, which must be conducted by a psychiatrist.[40] A written notice is provided explaining the purpose of the examination and requiring that the person attend.[41] Certificates of assessment are produced by the responsible clinician during the first two stages (preliminary assessment and first period) stating whether he or she considers that there are reasonable grounds for believing that the proposed patient is mentally disordered.[42] Statements of the legal consequences of the certificates and the ability to apply for review are also given.[43] These documents are provided to concerned parties (the patient, his or her guardian, his or her principal caregiver, the original applicant, the patient's primary doctor, and the Director of Area Mental Health Services).[44] After the first period, the findings are also provided to a district

[32] *Id.* at 27.

[33] *Id.* at 29.

[34] *Id.* at 30.

[35] A flow chart of the process is set out in the GUIDELINES TO THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992, *supra* note 26, at 31.

[36] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 9 & 10; GUIDELINES TO THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992, *supra* note 26, at 32-34.

[37] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 11 & 12.

[38] *Id.* ss 13 & 14.

[39] *Id.* s 15(1). This fourteen day period may be extended by up to one month by a court order. *Id.* s 15(2). *See* GUIDELINES TO THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992, *supra* note 26, at 36-38.

[40] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 9.

[41] *Id.* s 9(2)(c). The purpose of the examination and requirements of the notice must also be explained to the proposed patient "in the presence of a member of the proposed patient's family, or a caregiver in relation to the proposed patient or other person concerned with the welfare of the proposed patient." *Id.* s 9(2)(d).

[42] *Id.* ss 10(1) (certificate of preliminary assessment) & 12(1) (certificate of further assessment).

[43] *Id.* ss 10(4)(b) & 12(6).

[44] *Id.* ss 10(2), 10(4)(a), 12(2), & 12(5).

inspector and official visitor, who are independent persons that may assist the patient or take actions in relation to the patient's interests.[45]

Within the first, second, and final periods, the patient may be "admitted to and detained in a specified hospital for the purposes of assessment and treatment throughout" if the responsible clinician considers that the patient cannot be adequately assessed or treated as an outpatient.[46] If necessary, a DAO can request police assistance to take a proposed patient to a nominated place for the purposes of an assessment or examination.[47]

During or after any stage, a person may be released from compulsory assessment based on the determination of the responsible clinician or following a review by a judge.[48] Any of the other people who receive the certificates can apply for a review by a judge.[49]

C. Compulsory Treatment Orders

If during the second compulsory assessment period the responsible clinician finds that the patient is not fit to be released from compulsory status, he or she "must, before the expiry of the second period, apply to the court for the making of a compulsory treatment order under Part 2" of the Act.[50]

There are two types of compulsory treatment orders under the MH(CAT) Act: community treatment orders and inpatient orders.[51] Both types of order remain in force for six months,[52] unless the responsible clinician considers that the patient is fit to be released from compulsory status at an earlier point in time.[53] At the end of the six months, the responsible clinician can apply to the court for a six-month extension of the order.[54] If at the end of that six- month period the clinician considers that the order is still necessary, an application can be made for a further extension. If the court grants an extension at this point then this has effect indefinitely.[55]

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[45] *See Id.* ss 12(5)(f) and (g), 12(8)–(11). District inspectors are lawyers appointed under section 94 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. They operate independently of mental health services.

[46] *Id.* ss 11(2)(b) and (3), 13(2)(b) and (3), & 15.

[47] *Id.* s 41; GUIDELINES TO THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992, *supra* note 26, at 1 & 32.

[48] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 16; GUIDELINES TO THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992, *supra* note 26, at 38.

[49] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 11(7), 12(7), & 12(12).

[50] *Id.* s 14(4).

[51] *Id.* s 28.

[52] *Id.* s 33.

[53] *Id.* s 35.

[54] *Id.* s 34.

[55] *Id.* s 34(4).

Community treatment orders "require the patient to attend at the patient's place of residence, or at some other place specified in the order, for treatment by employees of the specified service, and to accept that treatment."[56] The order specifies the services that are authorized to treat the patient, and employees of those services are authorized to enter the patient's home for the purpose of providing treatment. There is scope within these orders for a clinician to direct the patient to be treated as an inpatient for a period of up to fourteen days, or to be reassessed to determine whether an inpatient order should be made.

Inpatient orders "require the continued detention of the patient in the hospital specified in the order" for the purposes of treatment, and require that the patient accept that treatment.[57] These orders are made only if the patient cannot be treated adequately in the community or if he or she is a prisoner.[58]

There is a preference in the MH(CAT) Act for applications for compulsory treatment orders to be heard and determined by a Family Court judge.[59] In determining whether to grant a compulsory treatment order, the relevant judge is required to personally examine the patient[60] and must consider the evidence of both the responsible clinician and "at least one other health professional involved in the case."[61] According to the Ministry's guidance material, this second person will "most often be a registered mental health nurse."[62] The patient has the right to be heard by the court[63] and the court may request a report on any relevant aspect of the patient's condition, call any witness, and receive any evidence it thinks fit, whether admissible in a court of law or not.[64] Hearings under the MH(CAT) Act are not open to the public.[65]

As noted above, an order can only be made where a patient is mentally disordered and the court considers that the order is necessary.[66]

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[56] *Id.* s 29(1).

[57] *Id*. s 30(1); *see also* s 59.

[58] *Id.* s 27; GUIDELINES TO THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992, *supra* note 26, at 40.

[59] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 17. *See Mental Health*, FAMILY COURT OF NEW ZEALAND, http://www.justice.govt.nz/courts/family-court/what-family-court-does/mental-health (last visited Feb. 4, 2013).

[60] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 18(1)–(3).

[61] *Id.* s 18(4).

[62] GUIDELINES TO THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992, *supra* note 26, at 37.

[63] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 20.

[64] *Id.* ss 21-23.

[65] *Id.* s 24.

[66] *Id.* s 28; GUIDELINES TO THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992, *supra* note 26, at 40.

The MH(CAT) Act also contains provisions relating to "special patients," who are persons detained in a hospital under other named statutes, including the Criminal Procedure (Mentally Impaired Persons) Act 2003, Armed Forces Discipline Act 1971, and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.[67] In addition, patients may be declared by a court to be "restricted patients" if they present "special difficulties because of the danger [they pose] to others."[68]

D. Patient Rights and Review Processes

Part 6 of the MH(CAT) Act sets out a list of patient rights, including rights

- to medical treatment and health care "appropriate to his or her condition";[69]
- to be kept informed about various matters;[70]
- to "receive an explanation of the expected effects of any treatment offered to the patient, including the expected benefits and the likely side-effects, before the treatment is commenced";[71]
- to company, and to seclusion, subject to certain listed provisions;[72]
- to request a lawyer;[73]
- to seek independent psychiatric advice;[74]
- to receive visitors and make telephone calls;[75] and
- to send and receive letters and posted articles.[76]

This part of the Act also requires that powers under the Act be exercised with respect for a person's culture, language, and beliefs,[77] and that the family be consulted during the compulsory assessment and treatment process (unless it is not in the best interests of the patient or proposed patient, or it is not reasonably practicable).[78]

[67] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 2(1), 44–53.

[68] *Id.* s 55.

[69] *Id.* s 66.

[70] *Id.* s 64.

[71] *Id.* s 67.

[72] *Id.* s 71

[73] *Id.* s 70.

[74] *Id.* s 69.

[75] *Id.* s 72.

[76] *Id.* ss 73 & 74.

[77] *Id.* ss 65, 5, & 6.

[78] *Id.* s 7A.

Patients are able to make complaints about breaches of these rights, and such complaints are referred to a district inspector or official visitor. The outcomes of complaints can be referred to a review tribunal for further investigation.[79]

Part 8 of the MH(CAT) contains special provisions relating to children and young persons.[80]

As noted above, during the assessment process, a patient may request a judge to review his or her condition. Once a compulsory treatment order has been issued by the court, the clinical and judicial review processes may differ depending on the nature of a patient's treatment order. The condition of restricted patients, of certain special patients, and of persons subject to compulsory treatment orders is clinically reviewed periodically.[81] Persons who receive certificates of such clinical reviews are then able to apply to a tribunal for a review of the patient's condition, and subsequent decisions about a patient's condition can also be appealed to a court in certain cases.[82] A judge of the High Court may, either on his or her own motion or following an application of any person, issue an order directing a district inspector (or others) to visit and examine a patient and report on any matter.[83]

III. Regulation of Hospitals that Provide Mental Health Services

Under the MH(CAT) Act, "hospital" means premises, or parts of premises, that "are used to provide hospital mental health care in accordance with section 9 of the Health and Disability Services (Safety) Act 2001."[84] The definition also includes premises that were previously licensed as psychiatric hospitals under earlier legislation.[85]

In addition to mental health inpatient units or teams within hospitals, and hospitals that provide mental health services as their core function, there are also several regional forensic mental health units in the country.[86] These specialist units provide mental health treatment in a secure environment for prisoners with a mental disorder who are the subject of an order under the Criminal Procedure (Mentally Impaired Persons) Act 2003[87] and for others defined as special or restricted patients under the MH(CAT) Act.

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[79] *Id.* s 75.

[80] *Id.* ss 85–90.

[81] *Id.* ss 76-78.

[82] *Id.* s 79-81.

[83] *Id.* s 84.

[84] *Id.* s 2(1); Health and Disability Services (Safety) Act 2001, http://www.legislation.govt.nz/act/public/2001/0093/latest/DLM119975.html.

[85] *Id. See also* Health and Disability Services (Safety) Act 2001, s 61.

[86] *See e.g., The Mason Clinic*, WAITEMATA DISTRICT HEALTH BOARD, http://www.waitematadhb.govt.nz/PatientsVisitors/TheMasonClinic.aspx; *Puawai: Midland Regional Forensic Psychiatric Service*, WAIKATO DISTRICT HEALTH BOARD, http://www.waikatodhb.govt.nz/page/pageid/2145839444; *Hillmorton Hospital & Cashmere Sites*, CANTERBURY DISTRICT HEALTH BOARD, http://www.cdhb.govt.nz/mentalhealth/default.htm.

[87] Criminal Procedure (Mentally Impaired Persons) Act 2003, http://www.legislation.govt.nz/act/public/2003/0115/latest/DLM223818.html.

The Health and Disability Services (Safety) Act 2001 requires that certified providers of health care services meet certain service standards.[88] Provisions in the New Zealand Public Health and Disability Act 2000 also require that the Minister of Health determine a strategy for the development and use of nationally consistent standards, quality assurance programs, and performance monitoring of health services and consumer safety.[89]

The Health and Disability Services (Safety) Standards Notice 2008 provided notification of the approved standards for providing hospital care, residential disability care, and rest home care.[90] The standards are available on the Ministry of Health's website and include general and core standards, restraint minimization and safe-practice standards, and infection prevention and control standards.[91] Some of the standards apply specifically to hospital mental health services, while others apply generally to all hospital services.

Various accountability documents also apply as part of the Crown Funding Agreements between the Minister of Health and DHBs.[92] These include performance measures and agreed levels of service coverage. There are also "nationwide service specifications" and reporting requirements for different types of health services, including the full range of mental health services.[93]

IV. Restrictions on Access to Potentially Dangerous Items

A. Driver Licensing

Under section 19 of the Land Transport Act 1998, the person in charge of a hospital must notify the Land Transport Agency that a patient is the subject of an inpatient order or has become a special patient in that hospital under the MH(CAT).[94] The patient's driver's license is then suspended by the Agency, and the license must be delivered to the person in charge of the hospital if requested and then forwarded to the Director of Area Mental Health Services. Where an order or special patient status no longer applies, the responsible clinician may still notify the Director of Area Mental Health Services that he or she considers the patient unfit to hold a

[88] Health and Disability Services (Safety) Act 2001, s 9.

[89] New Zealand Public Health and Disability Act 2000, s 9.

[90] Health and Disability Services (Safety) Standards Notice 2008,http://www.legislation.govt.nz/regulation/public/2008/0364/latest/DLM1629204.html.

[91] *Health and Disability Service Standards*, MINISTRY OF HEALTH, http://www.health.govt.nz/our-work/ regulation-health-and-disability-system/certification-healthcare-services/health-and-disability-services-standards (last visited Feb. 5, 2013).

[92] *See Accountability Documents*, NATIONWIDE SERVICE FRAMEWORK LIBRARY, http://www.nsfl.health.govt.nz/apps/nsfl.nsf/menumh/Accountability+Documents (last visited Feb. 5, 2013).

[93] *Mental Health Service Specifications*, NATIONWIDE SERVICE FRAMEWORK LIBRARY, http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/150; *Mental Health, Alcohol and Drug Sector Performance Monitoring and Improvement Report*, NATIONWIDE SERVICE FRAMEWORK LIBRARY, http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/406 (last visited Feb. 5, 2013).

[94] Land Transport Act 1998, s 19, http://www.legislation.govt.nz/act/public/1998/0110/latest/DLM433613. html.

driver's license. The license is then returned to the Agency along with a certificate to that effect. The patient may apply to the Agency for the return of his or her license.[95]

More generally, section 18 of the Land Transport Act provides that

> (1) . . . if a medical practitioner or optometrist, who has attended or been consulted in respect of a driver licence holder, considers that—
>
> (a) the mental or physical condition of the licence holder is such that, in the interests of public safety, the licence holder—
>
> (i) should not be permitted to drive motor vehicles of a specified class or classes; or
>
> (ii) should only be permitted to drive motor vehicles subject to such limitations as may be warranted by the mental or physical condition of the licence holder; and
>
> (b) the licence holder is likely to drive a motor vehicle.
>
> (2) If this section applies, the medical practitioner or optometrist must as soon as practicable give the Agency written notice of the opinion under subsection (1)(a) and the grounds on which it is based.
>
> (3) A medical practitioner or optometrist who gives a notice under subsection (2) in good faith is not liable to civil or professional liability because of any disclosure of personal medical information in that notice.[96]

The Land Transport (Driver Licensing) Rule 1999 includes provisions that allow the Agency to refuse to grant or renew a driver's license, or to place restrictions on or revoke a license, on the basis of a person's mental condition.[97]

B. Firearms Licensing

A firearms license is required for a person to legally possess a firearm in New Zealand.[98] The Arms Act 1983 and the associated regulations do not contain provisions that specifically refer to the mental condition of firearms license applicants or license holders. The New Zealand Police, in determining whether to issue or revoke a firearms license, apply a broad test of whether the applicant for or holder of a license "is a fit and proper person to be in possession of a firearm or airgun."[99] An applicant for a special license endorsement that allows the person to be in possession of a pistol, restricted weapon, or military style semiautomatic firearm, must also satisfy the Police Arms Officer that he or she is a "fit and proper person" to be in possession of that type of weapon.[100] Furthermore, a license may be revoked where there is a reasonable likelihood that the firearms or airguns of the license holder could be accessed "by any person . . .

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[95] *Id.*

[96] *Id.* s 18.

[97] Land Transport (Driver Licensing) Rule 1999, cls 42, 56, & 82, http://www.legislation.govt.nz/regulation/public/1999/0100/latest/DLM280562.html.

[98] Arms Act 1983, s 20, http://www.legislation.govt.nz/act/public/1983/0044/latest/DLM72622.html.

[99] *Id.* ss 24, 27, & 27A.

[100] *Id.* ss 30, 30A, & 30B. The applicant must also show that he or she satisfies one of the reasons for possessing these types of weapons that are listed in the Act.

who, in the opinion of a commissioned officer of Police, is not a fit and proper person to be in possession of a firearm or airgun."[101]

Under the Arms Regulations 1992, applicants for firearms licenses must provide the Arms Officer with, among other information, "the name and address of a near relative of the applicant" and "the name and address of a person (not being a near relative of the applicant) of whom inquiries can be made about whether the applicant is a fit and proper person to be in possession of a firearm."[102] The Arms Officer will conduct face to face interviews with the applicant and with the two referees in addition to their other vetting processes, which include examining information held on Police computer systems and inspecting physical storage arrangements. [103]

The Arms Manual produced by the Police states that "a fit and proper person is a person of good character who can be trusted to use firearms responsibly."[104] It then lists a number of reasons whereby a person may be considered not to be a fit and proper person, including that he or she has "exhibited signs of mental ill health."[105] The Vetting Guide used by the Police also requires that an applicant for a firearms license

> . . . advise whether he/she has ever been referred by a medical practitioner to a psychiatrist or psychologist or whether he/she has ever required treatment for or suffered from:
> - mental/emotional problems;
> - depression;
> - excess drinking/drugs;
> - fits/dizziness/blackouts;
> - head injuries[106]

If the applicant gives an affirmative answer to any of these questions, the Manual states that "his/her doctor should be contacted or the applicant must provide a statement from the doctor to determine whether the applicant is fit to be issued with a licence."[107]

The Firearms Manual also contains information about situations where an officer of the Public Trust Office makes an application for the Police to "accept the custody of a firearm belonging to any person who has been committed to a mental hospital."[108] According to the Manual, when the owner of the firearm is discharged from hospital he or she may apply for its return, at which

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[101] *Id.* s 27(1)(b).

[102] Arms Regulations 1992, reg 15(2)(f) and (g), http://www.legislation.govt.nz/regulation/public/1992/0346/latest/DLM168889.html.

[103] *See* NEW ZEALAND POLICE, ARMS MANUAL (2002) § 2.23, http://www.police.govt.nz/service/firearms/firearms_manual_2002.pdf.

[104] *Id.* § 2.29.

[105] *Id.*

[106] *Id.* § 2.32.

[107] *Id.*

[108] *Id.* § 17.19.

time there will be consideration of whether he or she is a fit and proper person to be in possession of a firearm.[109]

C. Other Licenses

Similar "fit and proper person" tests apply to the approval processes for a range of other activities and occupations in New Zealand, including the granting of licenses to possess or use explosives and the issuing of various maritime and civil aviation documents. In some cases, the relevant legislation lists criteria for these tests. For example, the Civil Aviation Act 1990 provides that an aviation document may be required for certain roles, equipment, and services.[110] The legislation requires that an applicant must not only have the necessary prescribed qualifications and experience, but also be a "fit and proper person" to hold the document.[111] The relevant authority is required to have regard to certain criteria in determining whether an applicant meets this test, including "any history of physical or mental health or serious behavioural problems."[112]

The Maritime Transport Act 1994 sets these same criteria for determining whether a person can hold various maritime documents,[113] such as those required for the owners and operators of, and seafarers on, commercial vessels.[114] Licenses are not required, however, to operate pleasure boats in New Zealand.[115]

The Environmental Protection Authority grants licenses for the possession of certain controlled substances, including explosives. Under section 95B of the Hazardous Substances and New Organisms Act 1996, the Authority must apply a fit and proper person test in determining whether to grant a license.[116] The criteria for this test are then set out in the Hazardous Substances and New Organisms (Personnel Qualifications) Regulations 2001 and include the applicant's behavioral history, any relevant court orders, and "any other information or evidence that the Authority considers relevant."[117]

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[109] *Id.*

[110] Civil Aviation Act 1990, s 7(1), http://www.legislation.govt.nz/act/public/1990/0098/latest/DLM 214687.html.

[111] *Id.* s 9. *See also Fit and Proper Person Process*, CIVIL AVIATION AUTHORITY, http://www.caa.govt.nz/Forms/FPP_Process.htm (last visited Feb. 5, 2013).

[112] Civil Aviation Act 1990, s 10(1)(d).

[113] *Id.* s 50(1)(d).

[114] Maritime Transport Act 1994, s 34, http://www.legislation.govt.nz/act/public/1994/0104/latest/DLM334660.html. *See also Fit and Proper Person Check*, MARITIME NEW ZEALAND, http://www.maritimenz.govt.nz/Commercial/Safety-management-systems/Fit-and-proper-person-check.asp (last visited Feb. 5, 2013).

[115] *See Skipper Responsibilities*, MARITIME NEW ZEALAND, http://www.maritimenz.govt.nz/Recreational-Boating/Skipper-responsibilities/Skipper-responsibilities.asp (last visited Feb. 5, 2013).

[116] Hazardous Substances and New Organisms Act 1996, s 95B, http://www.legislation.govt.nz/act/public/1996/0030/latest/DLM381222.html.

[117] Hazardous Substances and New Organisms (Personnel Qualifications) Regulations 2001, reg 6B(1) & (3), http://www.legislation.govt.nz/regulation/public/2001/0122/latest/DLM43117.html. *See also* ENVIRONMENTAL PROTECTION AUTHORITY, CONTROLLED SUBSTANCE LICENCE: CLASS 1 EXPLOSIVES AND PYROTECHNICS (July 2011), http://www.epa.govt.nz/Publications/CSL-Project-Guide-for-Applicants-Explosives.pdf.

NORWAY

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SUMMARY Norway's mental health care system, like its health care system in general, is community-based. A general practitioner may refer a patient to a district psychiatric center, which is organized into outpatient clinics, day care, and 24-hour wards. Psychiatric hospitals, often divided into specialized departments or wards to treat specific psychological disorders, handle both acute cases of mental illness and those requiring more long-term care. Four Regional Health Authorities (RHAs) oversee and also own the region's public hospitals. The health services RHA offers are organized and delivered through health enterprises owned by the RHA and through contracts with private providers. Norway also has three regional maximum security departments, a system to hold and treat people with mental disorders who are thought to pose a high risk of seriously harming other people.

In general, mental health services are provided on the basis of consent in conformity with the provisions of the Mental Health Care Act, the primary law governing mental health care in Norway, and the Patient Rights Act. A qualified physician or clinical psychologist may request a person who is seeking mental health care to consent to compulsory care for a period of up to three weeks. Such care may be provided on an outpatient or inpatient basis. Under Norway's criminal law, when deemed necessary for the protection of society, an offender is to be transferred to compulsory mental health care. Under the criminal procedure law, persons assumed to have perpetrated a crime may be committed to a psychiatric hospital or other suitable place for psychiatric observation.

Persons wishing to obtain a firearm must be "reliable" and have "sober habits" and cannot be deemed unfit to possess a weapon for any special reason. To obtain a driver's license, a person must have "the necessary physical and mental health" aside from other competencies.

I. Introduction

On Friday, July 22, 2011, twin attacks were carried out in the government district of Oslo, Norway, and at a Labour Party youth camp on nearby Utøya Island. As a result of the bombing in Oslo and the mass shootings on Utøya, 77 Norwegians died and 242 were wounded, most of them young people. The suspected murderer, Anders Behring Breivik, confessed to the bombing and the killings and claimed he acted alone.[1] In August 2012, a five-judge panel of the Oslo District Court declared Breivik was sane when he carried out the attacks and sentenced him, after two months of deliberation, to the maximum 21 years in prison, overriding the findings of a report by court-appointed psychiatrists that Breivik suffered from paranoid schizophrenia.[2]

[1] *Norway Massacre*, FT.COM, http://www.ft.com/intl/indepth/norway-massacre (last visited Jan. 22, 2013) [a collection of news items on the massacre].

[2] Mark Townsend, *Breivik Verdict: Norwegian Extremist Declared Sane and Sentenced to 21 Years*, THE GUARDIAN (Aug. 24, 2012), http://www.guardian.co.uk/world/2012/aug/24/breivik-verdict-sane-21-years; Mark Lews & Sarah Lyall, *Norway Mass Killer Gets the Maximum: 21 Years,* THE NEW YORK TIMES (Aug. 24, 2012), http://www.nytimes.com/2012/08/25/world/europe/anders-behring-breivik-murder-trial.html?pagewanted

The massacre led to amendment of the country's Mental Health Act, under consideration since 2010, and prompted a review of Norway's health care system for the violent mentally ill. The bill, "tailored to the Breivik massacre," was fast-tracked to be in force before a decision was rendered in the Breivik case and addressed "patients who may have committed grave, atrocious and offensive acts, such as mass murder." [3] Thus, the amendment that came into force on July 1, 2012, includes an entirely new fourteen-provision chapter on both safety in regional security departments and especially high security units for the mentally ill.[4]

II. Overview of the Norwegian Health Care System

A. Health Care Authorities

The Ministry of Health and Care Services (*Helse- og omsorgsdepartementet*) has overall responsibility for the health care sector.[5] The Ministry is responsible for the formulation and implementation of health policy and for public health, health legislation, and health care services, governing the latter "through comprehensive legislation, annual budgetary allocations and governmental institutions."[6]

The most important governmental institution under the Ministry is the Health Directorate (*Helsedirektoratet*) (formerly called the Directorate of Health and Social Affairs), which is the body that implements mental health policy. It is responsible for, among other tasks, monitoring conditions that affect public health and trends in health and care services; giving advice and guidance on strategies and measures aimed at authorities at the central, regional, and local levels and at health enterprises, among other stakeholders; setting national standards in certain areas and providing expertise. The Directorate's key administrative tasks include applying and interpreting laws and regulations in the health sector.[7]

Four regional hospital enterprise groups, the Regional Health Authorities (RHA), comprise over thirty local hospital enterprises and about 250 hospitals and outpatient institutions. The local and regional health enterprises are governed by boards accountable to the Minister of Health and

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=all&_r=0; Mark Lewis, *Why Norway Is Satisfied with Breivik's Sentence*, TIME (Aug. 27, 2012). http://world.time.com/2012/08/27/why-norway-is-satisfied-with-breiviks-sentence/.

[3] Esther Tran Le, *Norway Changes Health Care Laws in Wake of Breivik Massacre*, INTERNATIONAL BUSINESS TIMES (Mar. 23, 2012), http://www.ibtimes.com/norway-changes-health-care-laws-wake-breivik-massacre-429330.

[4] LOV OM ENDRINGER I PSYKISK HELSEVERNLOVEN (REGIONALE SIKKERHETSAVDELINGER OG ENHET MED SÆRLIG HØYT SIKKERHETSNIVÅ M.M.) [ACT AMENDING THE MENTAL HEALTH CARE ACT (REGIONAL SECURITY DEPARTMENTS AND UNIT WITH ESPECIALLY HIGH SECURITY, ETC.)] (issued June 22, 2012), LOVDATA, http://www.lovdata.no/cgi-wift/ldles?xdoc=/all/nl-20120622-048.html.

[5] MINISTRY OF HEALTH AND CARE SERVICES, http://www.regjeringen.no/en/dep/hod.html?id=421 (last visited Feb. 12, 2013).

[6] *General Description of the Field, Norway*, KNOWandPOL, at 1, http://koff.hiof.no/knowandpol/Description%20of%20the%20field.doc (last visited Feb. 8, 2013).

[7] *Id.*; *Norwegian Directorate of Health*, Ministry of Health and Care Services (last updated Nov. 24, 2011), http://www.regjeringen.no/en/dep/hod/About-the-Ministry/Subordinate-institutions/the-directorate-for-health-and-social-af.html?id=213297.

Care Services. Separate departments in the municipalities implement community mental health care.[8]

B. The Health Care and Mental Health Care Systems

Norway's healthcare system has been described as "a decentralized national health service . . . with universal coverage."[9] It is divided at the basic level into municipal health services and specialized health services.[10] Municipal health services are "the foundation of the Norwegian health care system,"[11] and the country's 428 municipalities are responsible for the provision of primary care.[12] These services are provided by general practitioners (GPs) and emergency clinics, as well as through public health nurses, psychiatric home care, psychological services in educational institutions, and activity centers.[13] According to a government publication, most Norwegians with mental health problems are treated by their GP, who by means of therapy and medication can provide treatment for mild psychological disorders.[14] Persons in need of psychiatric help who are unable to contact their GP can contact the local emergency clinic (*legevakt*); some of the larger cities also have a psychiatric emergency clinic.[15]

Specialized health services include the District Psychiatric Outpatient Service (DPS) (*Distriktpsykiatrisk Senter*, also referred to as District Psychiatric Centers (DPCs)) and psychiatric hospitals, as well as specialists in private practice who have agreements to work with the health authority. Patients may be referred by their GP to a DPS, which is organized into outpatient clinics (some of which treat all types of disorders at one location, while others are subdivided into specialized departments), day care, and twenty-four-hour wards.[16] For non-acute cases, there is a waiting period for admission and consultation, the length of which will vary depending on the place and the treatment institution.[17] Psychiatric hospitals, which are often divided into specialized departments or wards for treating various types of psychological disorders, handle both acute cases of mental illness and those requiring more long-term care.[18]

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[8] *General Description of the Field, Norway*, *supra* note 6.

[9] Berit Mørland, Ånen Ringard, & John-Arne Røttingen, *Supporting Tough Decisions in Norway: A Healthcare System Approach*, 26:4 INT'L J. TECHNOLOGY ASSESSMENT IN HEALTH CARE 399 (2010).

[10] MENTAL HEALTH CARE IN NORWAY, NORWAY.NO, at 8, http://www.norway.no/temaside/tema.asp?stikkord=94204 (last visited Jan. 23, 2013).

[11] Arnulf Kolstad & Haldis Hjort, *Mental Health Services in Norway, in* MENTAL HEALTH SYSTEMS COMPARED 93 (R. Paul Olson ed. 2006).

[12] Morland, Ringard, & Røttingen, *supra* note 9. The figure for the number of municipalities is as of Jan. 1, 2013. See *How many municipalities are there in Norway?*, NORWAY.NO, http://www.norway.no/oss/#a1027 (last visited Feb. 5, 2013) [scroll down the page].

[13] MENTAL HEALTH CARE IN NORWAY, *supra* note 10.

[14] *Id.* at 9.

[15] *Id*. at 10.

[16] *Id*. at 10-11.

[17] *Id*. at 11.

[18] *Id*. at 11-12.

According to the (former) Norwegian Social and Health Directorate (now the Health Directorate), the majority of admissions to psychiatric hospitals are voluntary, and the patient is free to leave at will.[19]

The RHAs are responsible for providing specialized health services for the people living in the given region. They oversee and also own the region's public hospitals, ambulance and emergency services, laboratories, and hospital pharmacies.[20] The transfer of ownership of specialized health services from local municipalities to (then) five RHAs occurred on January 1, 2002, and included all specialized mental services.[21] The health services offered by an RHA are organized and delivered through health enterprises owned by it and through contracts with private service providers. While each of the enterprises, by means of the RHA, is wholly owned by the central government, "each is also a separate legal and administrative entity rather than an integral part of the central government administration."[22]

There are also three regional maximum security departments, "established to serve general psychiatry, medium security units, and the prison system in containing and treating people with mental disorders thought to pose high risk of serious harm to others."[23]

III. Relevant Legislation

Norway's key mental health law is the Mental Health Care Act, which regulates specialized mental health care carried out in hospitals and outpatient institutions.[24] The Patient Rights Act[25]

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[19] *Id*. at 12. There are acute psychiatric inpatient units just for adolescents as well. Ketil Hanssen-Bauer, Sonja Heyerdahl, Trond Hatling, Gunnar Jensen, Pål M Olstad, Tormod Stangeland, & Tarje Tinderholt, *Admissions to Acute Adolescent Psychiatric Units: A Prospective Study of Clinical Severity and Outcome,* 5 INT'L J. MENTAL HEALTH SYSTEMS (Jan. 6, 2011), http://www.ijmhs.com/content/5/1/1.

[20] MENTAL HEALTH CARE IN NORWAY, *supra* note 10, at 9.

[21] Kolstad & Hjort, *supra* note 11, at 85. The assumption of responsibility for these services by the central government ended a more than thirty-year tradition, whereby the counties had had the responsibility under the Hospital Act (since revoked) for planning, running, and investing in hospitals and other specialist services. *Id*. at 87.

[22] *Id*. at 86.

[23] Jan Stang, Christine S. Sandli, Tron Moger, & Stål Bjørkly, *Patients Admitted to a Maximum Security Forensic Psychiatry Unit in Norway: A Case File Analysis of Demographic, Psychosocial, Clinical and Criminal Characteristics*, 8:4 INT'L J. FORENSIC MENTAL HEALTH 235-244 (2009), http://www.tandfonline.com/doi/pdf/10.1080/14999011003635597.

[24] LOV OM ETABLERING OG GJENNOMFØRING AV PSYKISK HELSEVERN (PSYKISK HELSEVERNLOVEN) [ACT ON THE ESTABLISHMENT AND IMPLEMENTATION OF MENTAL HEALTH CARE (MENTAL HEALTH CARE ACT)] (Act No. 62 of July 2, 1999, as last amended effective July 1, 2012), LOVDATA, http://www.lovdata.no/all/nl-19990702-062.html; ACT NO. 62 OF 2 JULY 1999 RELATING TO THE PROVISION AND IMPLEMENTATION OF MENTAL HEALTH CARE (THE MENTAL HEALTH CARE ACT), with later amendments [through Jan. 1, 2008], UNIVERSITY OF OSLO LIBRARY, http://www.ub.uio.no/ujur/ulovdata/lov-19990702-062-eng.pdf.

[25] LOV OM PASIENT- OG BRUKERRETTIGHETER (PASIENT- OG BRUKERRETTIGHETSLOVEN) [ACT ON PATIENT AND USER RIGHTS] (also called the Pasientrettighetsloven, Act on Patient Rights), Act No. 63 of July 2, 1999, in force on Jan. 1 & July 1, 2001 (as last amended Dec. 14, 2012, in force on Jan. 1, 2013), LOVDATA, http://www.lovdata.no/all/nl-19990702-063.html; THE ACT OF 2 JULY 1999 NO. 63 RELATING TO PATIENTS' RIGHTS (THE PATIENTS' RIGHTS ACT) (as last amended effective Sept. 1, 2004), UNIVERSITY OF OSLO LIBRARY, http://www.ub.uio.no/ujur/ulovdata/lov-19990702-063-eng.pdf (unofficial English translation).

is the most important piece of legislation regulating individual care plans and eligibility for both community health care services and specialized health care services.[26] The Health and Social Care Services Act,[27] which replaces the former Municipal Health Services Act and the former Social Services Act, governs health services in the municipalities. The Act on Specialized Health Care Services[28] regulates the RHAs and "leaves no room for doubt that the central Government has full and complete responsibility, and that it has access to direct information and to the entire range of relevant policy instruments" concerning the RHAs.[29] The Health Enterprises Act[30] (also called the Health Authorities Act) governs the hospitals that operate under the control of the RHAs.

The Health Personnel Act[31] governs professionals working in hospitals, outpatient institutions, and municipalities. It sets forth an obligation on the part of the health care professionals "to conduct work as to ensure coordination of mental health services between service levels and within different departments of the community health care."[32] Norway also has an Act on Compensation for Patient Injury.[33]

IV. Regulation of Mental Health Institutions

Institutions obligated or able to perform compulsory observations or provide compulsory mental health care, with and without inpatient stays, must be approved by the Health Directorate.

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[26] *General Description of the Field, Norway, supra* note 6.

[27] LOV OM KOMMUNALE HELSE- OG OMSORGSTJENESTER M.M. (HELSE- OG OMSORGSTJENESTELOVEN) [ACT ON HEALTH AND SOCIAL CARE SERVICES, ETC. (HEALTH AND SOCIAL CARE SERVICES ACT)] (Act No. 30 of June 24, 2011), LOVDATA, http://www.lovdata.no/all/hl-20110624-030.html. The former Act on Municipal Health Services, Act No. 66 of Nov. 19, 1982, and the Social Services Act, Act No. 81 of Dec. 13, 1991, were repealed with the adoption of this 2011 Act.

[28] LOV OM SPESIALISTHELSETJENESTEN M.M. (SPESIALISTHELSETJENESTELOVEN) [THE ACT ON SPECIALIST HEALTH SERVICES, ETC. (SPECIALIST HEALTH SERVICES ACT)], Act No. 61 of July 2, 1999 (last amended June 22, 2012), LOVDATA, http://www.lovdata.no/all/hl-19990702-061.html.

[29] Kolstad & Hjort, *supra* note 11, at 86.

[30] LOV OM HELSEFORETAK M.M. (HELSEFORETAKSLOVEN) [ACT ON HEALTH ENTERPRISES (HEALTH ENTERPRISES ACT)], Act No. 93 of June 15, 2001 (as last amended Dec. 14, 2012, in force on Jan. 1, 2013), LOVDATA, http://www.lovdata.no/all/hl-20010615-093.html.

[31] LOV OM HELSEPERSONELL M.V. (HELSEPERSONELLOVEN) [ACT ON HEALTH PERSONNEL, ETC. (HEALTH PERSONNEL ACT)] (Act. No. 64 of July 2, 1999, as last amended June 22, 2012), LOVDATA, http://www.lovdata.no/all/hl-19990702-064.html; ACT OF 2 JULY 1999 NO. 64 RELATING TO HEALTH PERSONNEL ETC. (THE HEALTH PERSONNEL ACT) (with amendments made previous to 1 July 2002), Ministry of Health and Care Services website, http://www.regjeringen.no/nb/dep/hod/dok/lover_regler/reglement/2002/act-of-2-july-1999-no-64-relating-to-hea.html?id=107079 (unofficial English translation).

[32] *General Description of the Field, Norway*, *supra* note 6.

[33] LOV OM ERSTATNING VED PASIENTSKADER MV. (PASIENTSKADELOVEN) [ACT ON COMPENSATION FOR PATIENT INJURY, ETC. (PATIENT INJURY ACT)] (Act No. 53 of June 15, 2001, as last amended effective Jan. 1, 2012), LOVDATA, http://www.lovdata.no/all/nl-20010615-053.html. For a description of the patient injury compensation system, *see for example The History of the Patient Injury Compensation Scheme*, NPE website, http://www.npe.no/en/Om-NPE/Organisasjonen-NPE/The-history-of-the-patient-injury-compensation-scheme/ (last visited Feb. 12, 2013).

"Institutions" also means departments of institutions, and separate approval for such departments is needed in those cases.[34] Approval is given to institutions that are owned by or perform services under contract to the RHAs and that meet the material and personnel requirements set forth under the Mental Health Care Regulations.[35] However, in order to maintain adequate service for patients, institutions that do not meet the material and personnel requirements for approval may be granted temporary approval for a period of up to one year.[36] A Health Directorate decision may be appealed to the Ministry of Health and Care Services.[37] Health enterprises administered by the RHAs must, like other enterprises, be registered.[38]

The Mental Health Care Act stipulates that the RHA in the region where a person transferred by court order resides is responsible for deciding which institution will take charge of the person's treatment. This competence may be transferred to another authority by the King through a regulation. The RHA is responsible for ensuring that compulsory mental health care is provided as soon as the court order is legally enforceable.[39]

The Mental Health Care Regulations stipulate that the mental health care institution must provide competent personnel decisions and appoint one or more academic administrator. Professionals responsible for decisions under the regulations should have adequate knowledge of the health care legislation, with particular emphasis on the mental health act.[40]

V. Institutionalization of Patients

The Mental Health Care Act covers the examination and treatment of patients in mental health care facilities.[41] "Mental health care" under the Act refers to the examination and treatment of persons suffering from mental illness, and the nursing and care required. "Compulsory observation" means examination, nursing, and care for purposes of establishing whether conditions are present for compulsory mental health care without patient consent. "Compulsory

[34] FOR 2011-12-16 nr 1258 Forskrift om Etablering og Gjennomføring av Psykisk Helsevern m.m. (Psykisk Helsevernforskriften [Regulations for the Establishment and Implementation of Mental Health, etc. (Mental Health Care Regulations), Regulations No. 1258 of Dec. 16, 2011] (in force on Jan. 1, 2012, as last amended Oct. 26, 2012), § 2 ¶ 1, LOVDATA, http://www.lovdata.no/for/sf/ho/xo-20111216-1258.html. A correction was made to § 46 (on supervisory commission minutes) on Jan. 16, 2012.

[35] *Id*. § 2 ¶ 2. The material requirements are set forth under § 3 of the Regulations, the staffing requirements under § 4.

[36] *Id*. § 2 ¶ 3.

[37] *Id*. § 2 ¶ 4.

[38] *See* THE BUSINESS ENTERPRISE REGISTRATION ACT [in English translation] (June 21,1985) (last updated effective Jan. 1, 2004), BRØNNØYSUNDREGISTRENE, http://www.brreg.no/english/acts/foretaksregisterlov.html; LOV 1985-06-21 nr 78: LOV OM REGISTRERING AV FORETAK [FORETAKSREGISTERLOVEN] [ACT ON REGISTRATION OF ENTERPRISES [ENTERPRISES REGISTRATION ACT], Act No. 78 of June 21, 1985] (as last amended Dec. 16, 2011), LOVDATA, http://www.lovdata.no/all/hl-19850621-078.html.

[39] MENTAL HEALTH CARE ACT, § 5-2.

[40] Mental Health Care Regulations, § 5 ¶ 1.

[41] *Id*. § 1-1a.

mental health care" refers to examination, treatment, nursing, and care without the patient's consent.[42]

Under the Mental Health Care Regulations, institutions or departments designated to provide immediate assistance have the duty to immediately receive patients for examination and treatment if the person's condition is deemed to be life-threatening or very serious, or if the patient is considered to be a significant danger to others because of his or her mental state.[43] The conditions triggering this obligation to provide immediate assistance include psychotic disorders characterized by severe hyperactivity or violence that poses a significant risk to the patient's or another person's life or health; psychotic or other conditions characterized by severe anxiety or depression, where there is considerable risk that the patient may attempt suicide or injure him- or herself or others; delirium, when detoxification is not the main issue; and psychiatric disorders in children and adolescents whose caregivers cannot cope and where help from mental health care services is urgently needed.[44]

Any person who makes decisions pursuant to the Mental Health Care Act is obliged to ensure that the patient and his or her next-of-kin are provided with information about their rights. This includes rights available under the Mental Health Care Act, the Patient Rights Act, the Public Administration Act, and the Mental Health Care Regulations. This obligation to provide guidance also applies to public authorities entitled to rights under the Mental Health Care Act.[45]

A. Consensual Treatment

In general, mental health services are provided on the basis of consent, in conformity with the provisions of the Patient Rights Act. Consent to health care is covered under Chapter 4 of the Patient Rights Act. The general rule is that the care may only be provided with the patient's consent "unless legal authority exists or there are other valid legal grounds for providing health care without consent. In order for the consent to be valid, the patient must have received the necessary information concerning his health condition and the content of the health care."[46] The patient also has the right to withdraw consent.[47]

While voluntary mental health care is in progress, the patient may not be transferred to compulsory observation or compulsory mental health care.[48] This prohibition does not apply, however, if discharge would entail the patient's constituting "an obvious and serious risk to his or her own life and health and those of others." A written account of the matter must be sent to

[42] *Id*. § 1-2, ¶¶ 1-3.

[43] *Id*. § 1 ¶ 1.

[44] *Id*. § 1 ¶ 2.

[45] *Id*. § 6.

[46] PATIENT RIGHTS ACT § 4-1 ¶ 1.

[47] *Id*. § 4-1 ¶ 2.

[48] MENTAL HEALTH CARE ACT, § 3-4 ¶ 1.

the supervisory commission in such circumstances, drawing particular attention to the fact that a transfer decision has been made.[49]

For children above age twelve who do not agree to a stay in an institution for examination and treatment, the question of application of mental health care will be brought before the supervisory commission for the area.[50] Members of the supervisory commission (*Kontrollkommisjonen*), which is composed of a physician and two other members and headed by a lawyer qualified to serve as a judge, are appointed for a given area by the Ministry of Health and Care Services for a four-year term. One of the two other members must have personally been under mental care, be a close relative of a patient, or have represented the interests of patients in his or her occupation or function.[51]

B. Compulsory Treatment

The qualified physician or clinical psychologist, who is the mental health professional responsible for making administrative decisions and deciding on other specified measures under the Mental Health Act,[52] may request a person seeking mental health care to consent to compulsory care for up to three weeks from the date the care is provided. However, treatment without patient consent and restrictions on the patient's right to have contact with the outside world[53] are not applicable under such circumstances.[54] For children under the age of 16, the parents or other persons with parental responsibility (or the child welfare service, if the child is under its care) have the right to consent to the compulsory treatment.[55]

Under the Patient Rights Act, unless stipulated otherwise, those who have the right to consent to health care include 1) persons of full legal age and legal capacity, and 2) minors over 16 years of age.[56] Competence to give consent may cease to apply completely or in part "if the patient, on account of a physical or mental disorder, senile dementia or mental retardation, is clearly incapable of understanding what the consent entails."[57] A decision on lack of competence to give consent must state the reasons for the decision, in writing and, if possible, the decision

[49] *Id*. § 3-4 ¶ 2.

[50] *Id*. § 2-1.

[51] *Id*. §§ 6-1 & 6-2. However, no one may be a member of a supervisory commission that supervises mental health care measures and institutions for which the person in question has any responsibility in his or her regular occupation. *Id*. 6-2 ¶ 3.

[52] *Id*. § 1-4, ¶ 1. The King may prescribe regulations on mental health professionals and on delegation of such persons' authority. *Id*. ¶ 2.

[53] *Id*. §§ 4-4 & 4-5 ¶ 2, respectively.

[54] *Id*. § 2-2 ¶ 1.

[55] *Id*. ¶ 2, with reference to the Patient Rights Act § 4-4 ¶ 1 (on parental and other consent) & ¶ 2 (on child welfare service consent pursuant to the Child Welfare Act).

[56] PATIENT RIGHTS ACT, § 4-3 ¶ 1.

[57] *Id*. ¶ 2.

should be presented immediately to the patient and his or her next-of-kin, or to health personnel when the patient has no next-of-kin.[58]

The responsible professional will make a decision to provide compulsory mental health care based on the available information and his or her personal examination of the patient; the decision and the grounds for it must be immediately recorded.[59] The decision may be appealed to the supervisory commission; such an appeal may be instituted for up to three months after the care has terminated.[60] Compulsory mental health care terminates after one year. To prolong it, the supervisory commission's consent is required. The commission may allow prolongation of the care by up to one year at a time, counting from the anniversary of its application.[61]

The Mental Health Care Act stipulates that "compulsory observation or compulsory mental health care may be provided on an in-patient basis in an institution approved for these purposes. The patient may be detained against his or her will and brought back if he or she escapes, if necessary by force."[62] If necessary, compulsory care may be provided on a temporary inpatient basis in a non-approved institution, but in such cases the approved institution will be responsible for the care.[63] When it would be a better alternative for the patient, compulsory observation or compulsory mental health care may be provided on an outpatient basis, with due consideration being given in the evaluation to the relatives with whom the patient is living.[64] Outpatient compulsory mental health care may only be provided under the responsibility of an institution approved for the type of treatment in question.[65]

No one may be kept under compulsory observation or compulsory mental health care unless the stipulated criteria and conditions continue to be satisfied.[66] It is up to the responsible mental health professional to evaluate whether compulsory observation or compulsory care should be continued; he or she will make administrative decisions on termination of observation or care upon finding that the criteria and conditions are no longer satisfied.[67] The patient or his or her next-of-kin may at any time request that the observation or care be terminated, and the responsible mental health professional will make a decision in such cases.[68] Decisions made by

[58] *Id.* ¶ 4. Section 4-8 of the Patient Rights Act prescribes that, in the case of patients who are not competent to give consent and who have no next of kin, a health care provider is entitled, in consultation with other qualified health personnel, to consent to the patient's health care.

[59] MENTAL HEALTH CARE ACT § 3-3 ¶ 2.

[60] *Id.* § 3-3 ¶ 3. The appeal may be made by the patient, the next of kin, or, as the case may be, the public authority who hade the request for compulsory care pursuant to section 3-6 of the Act.

[61] *Id.* § 3-8 ¶ 3.

[62] *Id.* § 3-5 ¶ 1.

[63] *Id.* § 3-5 ¶ 2.

[64] *Id.* § 3-5 ¶ 3.

[65] *Id.* § 3-5 ¶ 4.

[66] *Id.* § 3-7 ¶ 1.

[67] *Id.* § 3-7 ¶ 2.

[68] *Id.* § 3-7 ¶ 3.

the professional on continuation or termination of observation or care may be appealed to the supervisory commission by the patient, the next-of-kin, or, if applicable, the authority that requested the compulsory observation or compulsory care.[69]

Before administrative decisions are made regarding compulsory observation and compulsory mental health care, the person directly concerned has the right to state his or her opinion, applicable, inter alia, to such matters as whether compulsory observation and compulsory mental health care should be applied and which institution is to be responsible for the compulsory care. The patient's next-of-kin and any public authority directly involved in the case also have the right to state their opinions.[70] The statement of opinion must be recorded and form the basis for the decision, with particular importance attached to opinions on previous experience with the use of force.[71]

C. Implementation of Mental Health Care

The mental health care institution must formulate an individual plan for a patient who needs prolonged, coordinated services. The institution must cooperate with other service providers in drawing up the plan so that the patient may receive comprehensive services.[72] The Mental Health Care Act stipulates that "restrictions and coercion shall be limited to what is absolutely necessary, and as far as possible the patient's view of such measures shall be taken into account. Use may only be made of measures that have such a favourable effect that it clearly outweighs the disadvantages of the measure."[73]

The responsible mental health professional may make a decision to keep a patient completely or partly segregated from other patients, as well as from personnel not involved in the examination, treatment, or care of the patient, if the patient's mental state or aggressive behavior during a stay in an institution makes segregation necessary.[74] A decision to segregate must be recorded without undue delay, and the segregation may at most entail two weeks at a time. Administrative decisions on segregation and prolongation of segregation are appealable to the supervisory commission by the patient and his or her next-of-kin.[75]

The Mental Health Act stipulates that "patients under compulsory mental health care may, without their own consent, be placed under such examination and treatment as is clearly in accordance with professionally recognized psychiatric methods and sound clinical practice."[76] Examination and treatment without the patient's consent may only occur after an attempt has

[69] *Id*. § 3-7 ¶ 4.

[70] *Id*. § 3-9 ¶ 1.

[71] *Id*. § 3-9 ¶ 2.

[72] *Id*. § 4 ¶ 1.

[73] *Id*. § 4-2 ¶ 1.

[74] *Id*. § 4-3 ¶ 1.

[75] *Id*. § 4-3 ¶ 3.

[76] *Id*. § 4-4 ¶ 1.

been made to obtain his or her consent to it, or when "it is obvious that consent cannot or will not be given."[77] The Act also contains provisions governing patients' contact with the outside world;[78] inspection of rooms and possessions and bodily searches;[79] seizure of medications, intoxicants, escape aids or dangerous objects;[80] and collection of urine samples.[81]

The Act stipulates that coercive means may only be applied to patients in institutions for inpatients "when this is absolutely necessary to prevent him or her from injuring himself or herself or others, or to avert significant damage to buildings, clothing, furniture or other things," and only when milder methods "have proved to be obviously futile or inadequate."[82] An administrative decision made by the responsible mental health professional is necessary in order for such action to be taken, unless otherwise provided by regulations.[83] Patients subjected to coercive means must be kept under continuous surveillance by the nursing staff.[84]

D. Transfer of Criminal Offenders to Mental Health Care

The General Civil Penal Code stipulates that, when deemed necessary for the protection of society, an offender shall be transferred to compulsory mental health care. The transfer decision will be made by a court judgment, and may only be effected when certain conditions have been met.[85] One condition is that "the offender has committed or attempted to commit a serious violent felony, sexual felony, unlawful imprisonment, arson or other serious felony impairing the life, health or liberty of other persons, or which may expose these legal rights to risk," and there is also deemed to be an imminent risk of the offender again committing a serious felony. Alternatively, if the offender has just committed or attempted to commit a less serious felony of the same nature as the felonies listed above and has also previously committed or attempted to commit such a felony, it must be presumed that a close connection between the prior felony and the one now committed exists and that there is a particularly imminent risk of relapsing into a new serious felony which may pose a threat to other persons. [86]

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[77] *Id*. § 4-4 ¶ 3. The provision goes on to state that unless it is clearly impossible, consideration should be given as to whether other voluntary measures might be offered as an alternative to examination and treatment undertaken without the consent of the patient.

[78] *Id*. § 4-5.

[79] *Id*. § 4-6.

[80] *Id*. § 4-7.

[81] *Id*. § 4-7a.

[82] *Id*. § 4-8 ¶ 1.

[83] *Id*. § 4-8 ¶ 5. The decision to use coercive means must be recorded without delay. The decision may be appealed to the supervisory commission by the patient or the next-of-kin. *Id*.

[84] *Id*. § 4-8 ¶ 4.

[85] THE GENERAL CIVIL PENAL CODE, Act No. 10 of May 22, 1902 (as last amended by Act No. 131 of Dec. 21, 2005), § 39, UNIVERSITY OF OSLO LIBRARY, http://www.ub.uio.no/ujur/ulovdata/lov-19020522-010-eng.pdf; ALMINDELIG BORGERLIG STRAFFELOV (STRAFFELOVEN) [THE GENERAL CIVIL PENAL CODE] (PENAL CODE)], Act No. 10 of May 22, 1902 (as last amended June 22, 2012), LOVDATA, http://www.lovdata.no/all/hl-19020522-010.html.

[86] *Id*.

Termination of the sanction is governed by section 39b of the General Civil Penal Code.[87] The provision states that compulsory mental health care may be continued only if the condition relating to a risk of repetition continues to be fulfilled.[88] The convicted offender, the next-of-kin, or the person professionally responsible at the responsible treatment institution may apply for remission of the sanction. The prosecuting authority shall submit the case to the district court, which will make a judgment on remission. Hearings of such cases are to be accelerated.[89] An application for remission of the sanction may not be made until one year after the transfer judgment or a judgment denying remission is legally enforceable.[90] The prosecuting authority may at any time decide to remit the sanction; however, no later than three years after the passage of the last legally enforceable judgment, the prosecuting authority must decide whether to remit the sanction or to bring the case before the district court, which will decide whether the sanction should be continued.[91]

Under article 167 of Norway's Code of Criminal Procedure, persons assumed to have perpetrated a crime may also be committed to a psychiatric hospital or other suitable place for purposes of forensic psychiatric observation. In such cases, the roles of the health care personnel are different from those who provide health assistance, because the person being observed is not viewed as a patient (unless he or she needs health care during the observation period). The observers' findings are not to be documented in the regular patient records. They must be kept separate, in another documentation system.[92]

E. Tightened Security Measures in 2012

Amendments to the Mental Health Care Act were adopted in June 2012 to strengthen security measures related to particularly dangerous patients. The amendments add an entirely new chapter, 4A, on safety in regional security departments, including the unit in these departments that have especially high security. The stated purpose of the new provisions in the chapter is to provide adequate security for patients, their fellow patients, and staff in such departments and units; it also aims to address protection for society from the dangerous patients.[93] Regional security departments are departments at the regional level that handle and study patients who have or are suspected of having severe mental illness and pose the risk of serious violent behavior.[94] A unit with especially high security refers to an entity in a regional security

[87] *Id.* § 39 ¶ 2.

[88] *Id.* § 39b ¶ 1.

[89] *Id.* § 39b ¶ 2. Determination of who is the convicted person's next-of-kin must be made pursuant to § 1-3, ¶ 2, of the Mental Health Care Act. THE GENERAL CIVIL PENAL CODE, *Id.*

[90] *Id.* § 39b ¶ 3.

[91] *Id.* § 39b ¶ 4.

[92] M. Sigurjónsdóttir & B. Østberg, *Hospital-Based Forensic Psychiatric Observation Pursuant to Section 167 of the Criminal Procedure Act*, 20 TIDSSKRIFT FOR DEN NORSKE LEGEFORENING 2297-2299 (Oct. 30, 2012), http://tidsskriftet.no/article/2896823/en_GB. The article is in English.

[93] MENTAL HEALTH CARE ACT, § 4A-1.

[94] *Id.* § 4A-2 ¶ 2.

department that can accommodate patients when particularly heightened security is required to guard against the risk of escape, hostage taking, violent behavior, or severe attacks against the patient himself, fellow patients, or personnel.[95] The Ministry of Health and Care Services decides whether such a unit should be established in a regional security department.[96]

In order to ensure safety in regional security departments, investigations of the patient and of his or her room and belongings can be undertaken when he or she is admitted and before and after outings to prevent the introduction of dangerous objects, drugs, intoxicants, or escape aids, including mobile phones or other means of communication.[97] A health care professional may conduct a body search if there is "a reasoned and strong suspicion" that a patient is concealing such objects or substances upon his or her person.[98] Decisions to undertake such post-admission investigations must be recorded without delay and justified. The patient or his or her next-of-kin may appeal the decision to the supervisory commission.[99] In regard to contact with the outside world, patients have the right to receive visitors, use the telephone, and send and receive letters and packages, but the responsible professional may restrict such rights for up to four weeks if there is the risk of such potentially harmful incidents as a patient escape, serious violence, etc.[100]

The regional security department requires all persons who perform or will perform work in the department to submit a regular criminal record certificate, in accordance with the Police Registry Act.[101] Those who work or will work in a unit with especially high security must also present a criminal record certificate.[102] The certificate must not be more than three months old.[103] Persons whose certificate bears a remark cannot be added or transferred to or work at a regional security department or especially high security unit if the remark could call into question the person's suitability for the work.[104]

The responsible professional in charge at a regional security department can decide that a patient should be transferred to a unit with especially high security in special cases where there is a particular risk of escape, hostage taking, violent behavior, or severe attack against the patient himself, fellow patients, or staff.[105] A transfer decision must be recorded without delay and

[95] *Id*. § 4A-2 ¶ 3.

[96] *Id*. § 4A-2 ¶ 4.

[97] *Id*. § 4A-4 ¶ 1.

[98] *Id*. § 4A-4 ¶ 3.

[99] *Id*. § 4A-4 ¶ 4.

[100] *Id*. § 4A-6 ¶¶ 1 & 2.

[101] *Id*. § 4A-7 ¶ 1.

[102] *Id*. § 4A-7 ¶ 2. For the criminal record certificate form, *see* Application for Criminal Record Certificate, Politiet [National Police Force] website, https://www.politi.no/vedlegg/skjema/Vedlegg_2017.pdf (last visited Feb. 19, 2013).

[103] MENTAL HEALTH CARE ACT, § 4A-7 ¶ 3.

[104] *Id*. § 4A-7 ¶ 5.

[105] *Id*. § 4A-8 ¶ 1.

justified, and can only be applied for a time period of up to six months.[106] The patient or his or her next-of-kin may appeal the decision to the supervisory control commission.[107] Patients in the especially high security units must be kept separate from patients in lower security units.[108]

The new security measures established a new National Coordination Unit (*Nasjonal koordineringsenhet*) for decisions on compulsory mental health care. This unit is tasked with developing and updating guidelines to ensure the necessary coordination and follow-up between health care services and the courts; guiding health authorities in the choice of the treatment location; and conducting administrative oversight of prosecuted and convicted persons consigned to compulsory mental health care.[109]

VI. Psychiatric Restrictions on Obtaining Firearms, Drivers', and Pilots' Licenses

The Firearms Act stipulates that anyone intending to buy or otherwise acquire a firearm or firearm parts must have permission from the police commissioner of the place of residence of the applicant.[110] According to the Act, "[p]ermission may only be given to reliable persons of sober habits who need or have other reasonable grounds for possessing firearms, and who can not be deemed unfit to do so for any special reason."[111] The applicant must also provide a written statement stating why he or she wants a firearm.[112]

According to the Road Traffic Act, whoever drives a motor vehicle must have a driver's license and a valid certificate of competence for the given type of vehicle.[113] Whoever has a driver's license must be sober, and there must not be any other mark on his or her record.[114] The person must have adequate vision and mobility and the necessary physical and mental health, and must have passed the driving test.[115] A guide to health requirements for a driver's license prepared by the (former) Directorate of Health and Social Affairs states that persons with psychological problems seeking to drive a vehicle must document their need to drive by obtaining a certificate

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[106] *Id*. § 4A-8 ¶ 3.

[107] *Id*. § 4A-8 ¶ 4.

[108] *Id*. § 4A-9 ¶ 1.

[109] *Id*. §§ 5-2a, 5-2b.

[110] LOV OM SKYTEVÅPEN OG AMMUNISJON MV. [VÅPENLOVEN] [ACT ON FIREARMS AND AMMUNITION, ETC. (FIREARMS ACT)] (Act No. 1 of June 9, 1961, as last amended June 19, 2009, in force Dec. 28, 2009), § 7, ¶ 1 & 2, LOVDATA, http://www.lovdata.no/all/hl-19610609-001.html; ACT NO. 1 OF 9 JUNE 1961 RELATING TO FIREARMS AND AMMUNITION [English translation based on the Act as amended in 1990], LOVDATA, http://www.ub.uio.no/ujur/ulovdata/lov-19610609-001-eng.html.

[111] *Id*. § 7, ¶ 3.

[112] Simon Tisdall, *Norway's Gun Laws Prove Easy to Ignore*, GUARDIAN.CO.UK (July 24, 2011), http://www.guardian.co.uk/world/2011/jul/24/norway-strict-gun-laws-circumvented.

[113] LOV OM VEGTRAFIKK (VEGTRAFIKKLOVEN) [ACT ON ROAD TRAFFIC (ROAD TRAFFIC ACT), Act No. 4 of June 18, 1965] (last amended June 22, 2012), § 24 ¶ 1, LOVDATA, http://www.lovdata.no/cgi-wift/wiftldles?doc=/app/gratis/www/docroot/all/nl-19650618-004.html&emne=vegtrafikklov*&&.

[114] *Id*. § 24 ¶ 4.

[115] *Id*. § 24 ¶¶ 5 & 6.

from the doctor or specialist responsible for their care.[116] Under the Regulation on Driver's Licenses, when special health circumstances of the applicant make it necessary, driving rights may be limited to driving a motor vehicle of a particular group or type. If necessary, such vehicle use may require specified equipment, specific identifiers, a shorter-than-normal period of validity, or a combination of these restrictions.[117] Other forms of restrictions, including geographic ones, may be applied in combination with the restrictions.[118]

According to the Regulation on Physician Notification That the Holder of a Pilot's License or Driver's License Does Not Meet the Health Requirements, a physician is obliged to warn the holder of a pilot's license if the doctor finds, through an examination, that the person's continuing to provide service requiring a pilot's license is indefensible for health reasons. The warning is to be given in writing, and notification of issuance of the warning shall also be given to the Civil Aviation Administration.[119] A physician similarly has the duty to warn a driver's license holder if, through an examination, the physician finds it indefensible for health reasons that the person continue to drive a motor vehicle.[120]

[116] DIRECTORATE OF HEALTH AND SOCIAL AFFAIRS, HELSEKRAV TIL FØRERKORT -EN VEILEDNING [HEALTH REQUIREMENTS FOR A DRIVER'S LICENSE—A GUIDE] 7 (Apr. 2007), http://www.helsedirektoratet.no/publikasjoner/forerkort-helsekrav-til-forerkort-en-publikumsveiledning/Publikasjoner/forerkort-helsekrav-til-forerkort-en-publikumsveiledning.pdf.

[117] FOR 2004-01-19 nr 298: Forskrift om Førerkort m.m. [Regulation on Driver's Licenses etc., Regulation No. 298 of Jan. 19, 2004] (as last amended Jan. 11, 2013, with effect from Jan. 19, 2013), § 4-3 ¶ 1, LOVDATA, http://www.lovdata.no/for/sf/sd/xd-20040119-0298.html#map011.

[118] *Id*. ¶ 2.

[119] Forskrift om leges melding om at innehaveren av flysertifikat eller førerkort ikke fyller helsemessige krav [Regulation on Physician Notification That the Holder of a Pilot's License or Driver's License Does Not Meet the Health Requriements] (July 13, 1984, as amended Dec. 19, 2002), § 1, LOVDATA, http://www.lovdata.no/cgi-wift/wiftldles?doc=/app/gratis/www/docroot/for/sf/ho/ho-19840713-1467.html&emne=flysertifikat*&.

[120] *Id*. § 2 (1) ¶ 1.

RUSSIAN FEDERATION

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SUMMARY Mental health care is a low priority within the Russian health care system, and institutionalization of patients remains the main form of treatment. The federal Law on Psychiatric Care is a framework act that regulates the provision of mental health care and defines basic guarantees for the protection of patients' rights. Mental health treatment is subject to patient's informed consent. The Law stipulates situations when involuntary treatment and institutionalization can be applied. In such cases, court review of the validity of a hospitalization is required; however, such a review cannot be requested by the hospitalized patient. The time frame for periodic evaluations of hospitalized patients, which are required to make a decision on the continuity or termination of treatment, is established by law. All conclusions of psychiatric evaluations can be challenged in court. Professional and other restrictions can be imposed on people suffering from mental illnesses. People who are diagnosed with a mental disease typically cannot acquire and possess firearms or apply for driver's, boating, and certain other licenses. Proof of mental fitness is required, and medical certificates confirming the mental health of an applicant must be submitted when applying for such licenses.

I. Background

Under Russian law, mental health care is a form of specialized medical assistance, which includes monitoring an individual's mental health, diagnosing their mental illness, prescribing treatment, and providing social rehabilitation.[1] The provision of mental health care and the fulfillment of related legal requirements by physicians and government authorities is a contentious issue.[2] In the Soviet Union, psychiatry was used as a political instrument and the "authorities [got] political dissenters to be declared mentally unstable and then [had] them put into mental institutions."[3]

The situation appeared to be changing following efforts by the authorities of the newly independent Russia to establish legal protections for psychiatric patients. In 1992, a law addressing the issues of providing psychiatric care was passed. This law, which remains in force today, was intended to grant mental patients guarantees of legal representation and to subject them to involuntary commitment only on the order of a court. It provided for the right of patients to live in the community as much as possible.[4] However, mental health remains a low

[1] Law of the Russian Federation on Psychiatric Care and Legal Guarantees for Citizens who Receive Psychiatric Assistance of July 2, 1992 (hereinafter Law on Psychiatric Care), art. 1, VEDOMOSTI S"EZDA NARODDNYKH DEPUTATOV ROSSIISKOI FEDERATSII I VERKHOVNOGO SOVETA ROSSIISKOI FEDERATSII [BULLETIN OF THE PEOPLE'S DEPUTIES CONGRESS OF THE RUSSIAN FEDERATION] (then the official gazette) 1992, No. 33, Item 1913.

[2] *Health*, ENCYCLOPEDIA OF SOVIET LAW 353 (Ferdinand Feldbrugge ed., 2d rev. ed. 1985).

[3] *Id.*

[4] Kim Murphy, *Speak Out? Are You Crazy?*, LOS ANGELES TIMES (May 30, 2006), http://articles.latimes.com/print/2006/may/30/world/fg-psychiatry30.

priority within the Russian health care system, and the "resources to support the system's modernization have been insufficient."[5] Presently, the mental health care system is funded from the federal budget through allocations by provincial authorities, and according to a World Health Organization report, "funding of mental health services is based on the existing number of hospital beds and bed occupancy rate, which in turn determine staff levels and other inputs."[6]

Despite a number of reforms, the Russian mental health system remains hospital-centered, and the institutionalization of patients continues to be the most widely accepted form of treatment. While the establishment of community-based services for psychiatric care patients was identified as a priority in the Federal Program for Psychiatric Care Network Reorganization,[7] this system is still underdeveloped. Mental illnesses in Russia continue to be stigmatized[8] and "Russian psychiatrists are pressing the legislature to return the Soviet-era law on psychiatric assistance that allowed doctors to independently detain and treat people."[9] According to media reports, amendments eliminating judicial control over the process of institutionalization and the termination of periodic evaluations required to extend the hospitalization of patients have been proposed by professional organizations of psychiatrists in response to several recent mass shootings perpetrated by mentally unstable people.[10]

II. Current Legislation on Mental Health Care

The provision of mental health care and the legal rights of people with mental disabilities are regulated by numerous federal normative acts covering varied aspects of legal relationships. Key among them are the Federal Law on Fundamentals of Health Care Protection of Citizens in the Russian Federation,[11] the Civil Procedural Code,[12] the Law of the Russian Federation on Psychiatric Care and Legal Guarantees for Citizens Who Receive Psychiatric Assistance (Law on Psychiatric Care),[13] and implementing regulations issued by the federal government and the Ministry of Health Care and Social Protection.

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[5] Rachel Jenkins et al., *Mental Health Reform in the Russian Federation: An Integrated Approach to Achieve Social Inclusion and Recovery*, 85(11) BULLETIN OF THE WORLD HEALTH ORGANIZATION 858, 864 (Nov. 2007), http://www.who.int/bulletin/volumes/85/11/06-039156.pdf.

[6] *Id.*

[7] Order of the RF Ministry of Health Care No. 98 of March 27, 2002, *available at* http://bazazakonov.ru/doc/?ID=1507076 (in Russian).

[8] *Russia's Mental Health Revolution*, BBC WORLD SERVICE (June 28, 2003), http://news.bbc.co.uk/2/hi/health/3026648.stm.

[9] Paul Goble, *Russia Considering Restoring Soviet-Era Law on Psychiatry, Opening Door to Political Abuse*, EURASIA DAILY MONITOR (Nov. 13, 2012), http://www.jamestown.org/single/?no_cache=1&tx_ttnews%5Btt_news%5D=40100.

[10] *Id.*

[11] SOBRANIE ZAKONODATELSTVA ROSSIISKOI FEDERATSII [SZ RF] [COLLECTION OF THE RUSSIAN FEDERATION LEGISLATION] (official gazette) 2011, No. 48, Item 6724.

[12] SZ RF 2002, No. 46, Item 4532.

[13] Law on Psychiatric Care, *supra* note 1.

The 1992 Law on Psychiatric Care is the framework document and serves four major purposes: (1) defending the right of mental health care patients to be free from unjustified intervention in their lives, (2) protecting them from social discrimination, (3) securing the society from possible dangerous acts committed by mentally ill people, and (4) defining the rights and obligations of medical personnel involved in the provision of mental health care. According to Russian lawyers who are experts in the field,[14] this Law follows the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care,[15] and requires that mental health care is provided according to principles of legality, humane treatment, and preserving the individual's rights and liberties.[16]

The Law states that psychiatric assistance must be provided when a patient requests such assistance voluntarily or consents to receiving mental treatment. In regard to minors under the age of fifteen, treatment must be requested by the minor's parents or legal representatives. Forcible treatment can be applied to mentally ill people pursuant to a court ruling if they might commit socially dangerous acts or if their health situation is worsening.[17]

The government guarantees to people suffering from psychiatric diseases emergency, outpatient, and hospital mental health care; psychiatric evaluations; employment assistance; social assistance (e.g., providing placement in government-run nursing homes); legal assistance; help in resolving guardianship-related issues; and psychiatric assistance in the event of catastrophes and emergencies.[18] The federal social security system manages homes for people recognized as permanently mentally ill and schools, including boarding schools, for children with mental illnesses and developmental disabilities. The Law guarantees that each citizen may receive free mental health care in state psychiatric and psychotherapeutic institutions. However, persons are not prohibited from seeking assistance from private physicians licensed to practice in the field of psychiatry.[19]

Basic guidelines and regulations for mental health care are developed by the federal Ministry of Health Care and Social Protection. Based on these regulations, provincial health care authorities establish their own psychiatric care programs, which are implemented by local and municipal authorities, with responsibility for the delivery of health care services, including mental health care.

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[14] GRIGORII USOV & MARINA FEDOROVA, PRAVOVOE REGULIROVANIE PSIHIATRICHESKOI POMOSHCHI [LEGAL REGULATION OF PSYCHIATRIC CARE] 24 (Moscow, 2006).

[15] G.A. Res. 46/119, U.N. Doc. A/RES/46/119 (Dec. 17, 1991), http://www.un.org/documents/ga/res/46/a46r119.htm.

[16] Law on Psychiatric Care art. 1.2.

[17] *Id*. art. 4.

[18] *Id*. art. 16.

[19] *Id*. art. 17.

III. Mental Health Institutions and Involuntary Institutionalization

Outpatient psychiatric assistance is usually provided in special clinics called "dispensaries" in the locality where the patient permanently resides. The nationwide network of dispensaries provides consultative and medical assistance to mental patients and monitors their health situation. Decisions on initiation and cancellation of one's registration at a dispensary must be made by a commission consisting of psychiatrists and based on the conclusions resulting from a psychiatric evaluation of the patient. This evaluation can be conducted upon the request of the patient, his/her legal representative, or guardianship authorities. The commission's decision is appealable to a court.[20]

In the most severe cases, psychiatric care is provided through 279 psychiatric hospitals and 101 inpatient departments of general hospitals, each serving a population of approximately 25,000. In 2007 (the latest data available), these hospitals had a capacity of 161,000 beds, which equated to about 113.2 per 100,000 population. These figures made Russia the European leader in the number of psychiatric beds per capita.[21]

The reasons for placing a mental patient under hospital care are stated in articles 28 and 29 of the Law on Psychiatric Care: presence of a severe and dangerous mental illness, an inability to treat an individual outside of a hospital, and the recommendation of a treating psychiatrist or court order. The need to conduct a forensic psychiatric evaluation may also be a reason for institutionalizing an individual. An individual can be forcibly institutionalized before a court order is issued if this is required by his or her health condition.

Involuntary hospitalization is a long, multistage process, which consists of the following:

- A recommendation by the treating psychiatrist at the dispensary or by the emergency care physician.
- A decision on admission by the hospital's physician on duty.
- Psychiatric evaluation of the admitted patient within forty-eight hours after arrival to the hospital, to decide if hospitalization is required.
- If the hospital's evaluation confirms the necessity of institutionalization, materials must be forwarded to the court within the first forty-eight hours after the patient's admission to the hospital.
- After the decision on involuntary hospitalization has been made, it must be sanctioned by a judge; a request for court hearings must be submitted by the hospital administration.
- A court hearing must be conducted within five days after a judge is informed about a case of involuntary hospitalization.
- If the court approves involuntary hospitalization of a patient, monthly evaluations must be conducted during the first six months of treatment in order to decide on the need to continue

[20] *Id*. art. 27.

[21] Jenkins, *supra* note 5, at 860.

treatment; if a patient remains in the hospital, evaluations are conducted once every six months.

- Required court hearings to decide on extensions of involuntary institutionalization are conducted after the expiration of the first six-month period following one's admission to the hospital and annually thereafter, if needed.[22]

Decisions to release from mental institutions those who were forcibly placed there are made by the commission of psychiatrists who perform periodic evaluations of patients or by the court.[23] Court decisions regarding involuntary hospitalization in mental institutions are not published on courts' websites because they contain private medical information that is not subject to public disclosure.

In conducting involuntary hospitalization, medical authorities rely on police assistance. The Russian Federal Law on Police requires police officers to ensure the security of medical personnel and take necessary measures if a patient needs to be taken into custody.[24]

IV. Patient's Rights and Review Process

Mental patients have the right to refuse medical assistance unless their involuntary treatment was ordered by a court.[25] Additionally, the Law provides for the following rights of patients: the right to be informed about their health situation and methods of treatment; the right to request medical and other information from the head of the medical establishment where the patient is institutionalized; the right to submit complaints to government bodies, the police, courts, and the prosecution without censorship; the right to meet with an attorney and a member of the clergy in private; the right to perform religious rites; the right to receive correspondence and subscribe to periodicals; and the right to participate in educational and employment programs conducted by the medical institution.[26]

Article 38 of the Law on Psychiatric Care provided for the creation of a government service tasked with the duty to defend the rights of those patients hospitalized in mental institutions. According to the Law, this service is to be independent from medical authorities. Members of the service would represent patients and discuss their complaints with the hospital administration and government institutions. However, this service has not yet been established.

Psychiatric care institutions are controlled by authorized executive branch agencies and state attorney's offices. Nongovernment organizations representing concerned citizens and professional organizations of psychiatrists can be involved in monitoring activities of mental care institutions.[27]

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[22] USOV & FEDOROVA, *supra* note 14, at 78–90.

[23] Law on Psychiatric Care art. 40.

[24] Federal Law on Police, art. 12.12, SZ RF 2011, No. 7, Item 900.

[25] Law on Psychiatric Care art. 12.2.

[26] *Id*. art. 37.

[27] *Id*. arts. 45, 46.

The Psychiatric Care Law (art. 34) and the Code of Civil Procedure (sec. 35) provide procedural guarantees for a fair judicial review. They include mandatory participation by a state attorney, representatives of the hospital administration, and the patient's attorney in court hearings. In cases where the patient has no legal representative, the court appoints a public defender to represent the interests of the hospitalized patient. While these provisions are in compliance with tests and requirements established by the landmark case of *Winterwerp v. The Netherlands*, resolved by the European Court of Human Rights (ECHR) in 1979,[28] some other provisions of the Russian Law on Psychiatric Care remain contradictory to the ECHR decision.

The Law does not allow institutionalized patients to request judicial review of the validity of their hospitalization. This right is reserved to hospital administrators only. According to Russian legal scholar Anton Burkov, the fact that a hospitalized person cannot challenge the legality of his or her hospitalization in a court violates article 5(4) of the European Convention on Human Rights. He suggests that institutionalized patients should have the right to request judicial review of their hospitalization independently from the hospital administration.[29] Another problem is that cases on illegal hospitalization are reviewed under the rules of civil procedure, which place the burden of proof on the patient to convince the court that there were insufficient reasons for hospitalization. In 1999 the Constitutional Court of the Russian Federation stated that rules for resolving disputes regarding the legality of actions undertaken by government institutions must be changed but no implementing legislation has yet been passed.[30]

Implementation of the norms established by the Law on Psychiatric Care is problematic.[31] Reportedly, courts rarely look into all aspects of cases under their review. As a rule, they base their decisions on conclusions of psychiatric commissions. Judges often say that they do not understand medical matters or trust physicians. Typically, witnesses who can testify in support of a hospitalized patient are not admitted and court decisions are made when a patient's representative or the patient him or herself are absent. Even though the Law requires that all parties be present in the court room, hearings on the legality of hospitalization are often conducted *in absentia*.[32] These flaws in Russian law were emphasized in the case *Rakevich v. Russia*. In this case, the ECHR stated that Russian law does not provide patients of psychiatric institutions unrestricted access to an effective legal defense, making them dependent on the good will of the same authorities that institutionalized them.[33]

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[28] Winterwerp v. The Netherlands, App. No. 6301/73 (ECHR, Oct. 24, 1979), http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-57597.

[29] Anton Burkov, *Prinuditelnaia Gospitalizatsiia Dushevnobolnykh v Rossiiskoi Federatsii v Sootvetstvii so Statyei 5 Evropeiskoi Konvenstsii o Zashchite Prav Cheloveka I Osnovnykh Svobod* [*Forceful Hospitalization of Mentally Ill in the Russian Federation and Compliance with Article 5 of the European Convention on Human and Fundamental Rights*], PRAVOVEDENIE, 2012, No. 2, at 130.

[30] Ruling of the Constitutional Court of the Russian Federation No. 9-p of May 28, 1999, SZ RF 1999, No. 23, Item 2890.

[31] Burkov, *supra* note 29, at 132.

[32] *Id*.

[33] Rakevich v. Russia, App. No. 58973/00 (ECHR, Oct. 28, 2003), http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-61414.

A court order approving involuntary hospitalization can be appealed within ten days by the patient, his or her legal representative, the head of the psychiatric institution, or an organization created for the purpose of defending the rights of individuals. Submission of an appeal is not a reason to terminate hospitalization.

V. Legal Restrictions and Licensing-related Evaluations

Legal restrictions for people with mental health problems are listed in article 6 of the Law on Psychiatric Care. Article 6 states that, because of his or her mental illness, an individual can be recognized as temporarily incapable of performing specific professional or other activities if doing so could cause an increased public danger. Such decisions must be made by a medical commission established by the local government agency in charge of providing health care services and can be appealed. Such decisions are initially made for a period of up to five years and can be extended. Additionally, all employees working in high-risk jobs are subject to mandatory psychiatric evaluations conducted every five years. A list of medical reasons that prevent an individual from performing specific job functions was approved by the government in 1993 and is periodically updated.[34]

The acquisition and possession of firearms, including those for self-defense, hunting, or sports activities, requires a license issued by local police departments in the area where an applicant permanently resides. In order to obtain a firearms license, an individual must submit with his or her application a medical certificate proving mental fitness to deal with firearms. A similar certificate must be provided by those who apply for licenses to possess guns given to them as an award, gift, or inheritance.[35]

Mental illnesses are included in the list of medical reasons preventing an individual from acquiring and having firearms. According to the Rules on Circulation of Civilian and Service Weapons and Munitions on the Territory of the Russian Federation, a license cannot be issued to those who have chronic or lengthy psychiatric illnesses. A license must be terminated if a person who owns firearms is diagnosed with a psychiatric disease. With regard to people who have borderline mental health conditions, decisions are made on a case-by-case basis.[36]

Legislative proposals to expand restrictions related to mental conditions to those who own shotguns and traumatic weapons are pending.[37]

A similar application process that includes a psychiatric evaluation is prescribed for those who apply for driver's, boating, and certain other licenses.[38]

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[34] Regulation of the RF Government No. 377 of April 28, 1993, SZ RF 2000, No. 31, Item 3288.

[35] Federal Law of the Russian Federation on Weapons, art. 13, SZ RF 1996, No. 51, Item 5681.

[36] Government Regulation No. 847 of Dec. 30, 2005, SZ RF 2005, No. 50, Item 5304.

[37] IULIIA ARGUNOVA, PRAVA GRAZHDAN S PSIKHICHESKIMI RASSTROISTVAMI [RIGHTS OF CITIZENS WITH MENTAL ILLNESSES] 162 (Moscow, 2010).

[38] Federal Law of the Russian Federation on Traffic Safety art. 23.1, SZ RF 1995, No. 50, Item 4873.

A medical evaluation for licensing purposes is conducted upon an applicant's request at a general medical institution where primarily medical needs of an individual are served. The evaluation must be conducted by the applicant's primary care physician and a group of specialists, including a psychiatrist, ophthalmologist, and substance abuse specialist. The presence of all three specialists is required.[39] When reviewing a licensing application, the police are not allowed to request additional information on an applicant's mental health from psychiatric dispensaries. In 2003, the Supreme Court of the Russian Federation stated that such requests are illegal.[40]

[39] Order of the Russian Federal Ministry of Health Care and Social Protection No. 344 of Sept. 11, 2000, ROSSIISKAIA GAZETA [ROS. GAZ.] (official publication), Oct. 18, 2000.

[40] Supreme Court of the Russian Federation, Ruling of July 24, 2003, ROS. GAZ., Jan. 23, 2004.

SOUTH AFRICA

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SUMMARY South Africa's mental health regulatory regime consists of two key laws—the Mental Health Care Act (MHCA of 2002) and its subsidiary legislation, the Mental Health Care General Regulations (MHCAR). Although permitted, the approval and management of involuntary care, treatment, and rehabilitation (CTR) of mental health patients is subject to various oversight mechanisms. A person can be committed into involuntary CTR only if two mental health care practitioners who examined him agree that there is a need for it. The health care establishment then has seventy-two hours to assess the person and further involuntary CTR requires the approval of a Review Board. When a proposal for CTR is approved, the head of the health care establishment must assess the patient periodically and report to the Review Board on the need to continue the involuntary CTR. All decisions of Review Boards in favor of involuntary CTR are subject to judicial oversight.

Mental health fitness is a condition for obtaining a firearms license or permit in South Africa. An applicant for a firearms license must be a "fit and proper person" and have no tendencies for violence or substance-abuse problems. The Registrar of Firearms may investigate an applicant to determine if he meets these requirements. Particular events that occur in the applicant's life may trigger an investigation; for instance, a suicide attempt within five years preceding the application or the loss of a job within two years preceding the application. During the investigation, the Registrar may require the applicant to submit mental health reports.

Mental health fitness is also a requirement for obtaining/holding a learner's or a driver's license. Authorities have the power to require an applicant or a holder of a license to submit to a mental health fitness examination for the purpose of determining the person's competence.

I. Background

Mental health has become a serious public health issue in South Africa. A 2007 study found that 16.5% of South Africans suffered from common mental disorders, the most widespread being agoraphobia, major depressive disorder, and alcohol dependence.[1] This is slightly higher than

[1] D.R. Williams et al., *Twelve-month Mental Disorders in South Africa: Prevalence, Service Use and Demographic Correlates in the Population-based South African Stress and Health Study*, 38(2) PSYCHOL. MED. 211, 215 (Feb. 2008), *available at* the National Institutes of Health (NIH) website, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2718686/pdf/nihms108979.pdf; CRICK LUND ET AL., MENTAL HEALTH POLICY DEVELOPMENT AND IMPLEMENTATION IN SOUTH AFRICA: A SITUATION ANALYSIS: PHASE 1. COUNTRY REPORT 14 (Mental Health & Poverty Project, Jan. 31, 2008), *available at* the World Health Organization website, http://www.who.int/mental_health/policy/development /SA%20Country%20Report%20-%20Final%20Draft%20Jan%202008.pdf; Jonathan Kenneth Burns, *The Mental Health Gap in South Africa – A Human Rights Issue*, 6 EQUAL RTS. REV. 99, 103 (2011), http://www.equalright strust.org/ertdocumentbank/ERR06_special_Jonathan.pdf.

the global average, which stands at 14%.[2] South Africa also has a high suicide rate of 15.4 per 100,000 people and is ranked twenty-second in the world in terms of suicides.[3] Mental health is the third highest contributor to the country's burden of disease following HIV/AIDS and other infectious diseases.[4]

South Africa's current mental health regulatory framework consists of a number of laws,[5] but only two of them appear to be directly relevant to this project**:** the Mental Health Care Act (MHCA)[6] and its subsidiary legislation, the Mental Health Care General Regulations (MHCAR).[7]

The MHCA replaced a 1973 mental health law.[8] Safeguarding the rights of mental health patients was not the driving motive for the 1973 legislation, which was said to have been developed in response to the assassination of the country's Prime Minister, Dr. Hendrik French Verwoerd, in 1966.[9] The primary focus of the legislation was ensuring "patient control and treatment" and the "welfare and safety" of society; it was also reportedly at times used for political purposes:

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[2] I.O. Jack-Ide et al., *A Comparative Study of Mental Health in Two African Countries: South Africa and Nigeria*, 4(4) INT'L J. NURSING & MIDWIFERY 1 (May 2012), http://www.academicjournals.org/ijnm/PDF/pdf 2012/May/ Jack-Ide%20et%20al.pdf.

[3] Burns, *supra* note 1, at 104.

[4] Catherine E. Draper et al., *Mental Health Policy in South Africa: Development Process and Content*, 24 (5) HEALTH POL'Y & PLAN. 342, 343 (June 26, 2009), http://heapol.oxfordjournals.org/content/24/5/342.full.pdf+ html?sid=6982c08d-b6cd-42c8-adf4-b9959f77eb24.

[5] These include the South African Constitution (Act No. 108 of 1996); Basic Conditions of Employment Act No. 75 of 1997; Labour Relations Act No. 66 of 1995; Promotion of Access to Information Act 2 of 2000; Employment Equality Act No. 55 of 1998; National Health Act No. 61 of 2003; Health Professionals Act No. 55 of 1974; Allied Health Professionals Act No. 63 of 1982; Nursing Act No. 50 of 1978; Pharmacy Act No. 53 of 1974; Dental Technicians Act No. 19 of 1979; Medical, Dental and Supplementary Health Services Professions Amendment Act No. 18 of 1995; Medical, Dental and Supplementary Health Services Professions Amendment Act No. 89 of 1997; Chiropractors, Homeopaths, and Allied Health Service Professions Amendment Act No. 40 of 1995; Chiropractors, Homeopaths, and Allied Health Service Professions Amendment Act No. 91 of 1997; and the Traditional Health Practitioners Act No. 35 of 2007. ABR Janse Rensburg, *A Framework for Current Public Mental Health Care Practice in South Africa*, 10(4) AFR. J. PSYCHIATRY 205, 206 (Nov. 2007).

[6] Mental Health Care Act No. 17 of 2002 (MHCA), 449 REPUBLIC OF SOUTH AFRICA GOVERNMENT GAZETTE [GG], No. 24024 (Nov. 6, 2002), *available at* the South African Department of Justice website, http://www.justice.gov.za/legislation/acts/2002-017_mentalhealthcare.pdf.

[7] Mental Health Care Act, 2002 (Act. No. 17 of 2002) General Regulations (MHCAR), No. R. 1467 GOVERNMENT NOTICE [GN], No. 27117 (Dec. 17, 2004), to be read together with the MHCA, 2002 (Act No. 17 of 2002) Correction Notice to the General Regulations, No. 98, GN, No. 27236 (Feb. 11, 2005), http://www.info.gov .za/view/DownloadFileAction?id=62653.

[8] Mental Health Act No. 18 of 1973, 94 GG, No. 3837 (Apr. 4, 1973).

[9] *Hendrik Frensch Verwoerd*, SOUTH AFRICA HISTORY ONLINE (SAHO), http://www.sahistory.org.za/ people/hendrik-frensch-verwoerd (last visited Feb. 4, 2013); Natalie Latoya McCrea, *An Analysis of South Africa's Mental Health Legislation*, THE NAT'L L. REV., *available at* http://digitalcommons.wcl.american.edu/cgi/ viewcontent.cgi?art icle=1006&context=stusch_winners.

> (i) it only required a reasonable degree of suspicion [in order for a patient] to be certified to a mental institution; (ii) individuals could be denied their freedom and placed in a mental facility based on prejudices and vendettas. In fact, finding someone mentally incapable was sometimes utilized solely for political means in the apartheid era. Freedom fighters were often silenced by being placed in a mental facility; (iii) once deemed mentally ill and certified, patients went without the assistance of the law, and could spend a considerable amount of time in the mental institutions against their will; and (iv) patients did not have a significant right of appeal or representation.[10]

With the enactment and implementation of the MHCA, South Africa moved to a more patient-friendly system. This was mainly because the political and legal landscape under which the 1973 legislation was enacted had completely changed by the time the current legislation was drafted and enacted. In the early 1990s South Africa ended apartheid and entered a transition into a democratic system of government.[11] In 1996, it enacted a democratic Constitution incorporating a Bill of Rights.[12] Therefore, the MHCA was intended to reflect the human rights protections envisaged in the new Constitution and accordingly put an end to the discriminatory and excessively intrusive provisions of the 1973 Act.[13]

This report describes the process and procedures for involuntary CTR of mental health care users in South Africa. It also discusses laws that require mental health evaluations as a condition for obtaining certain permits or licenses, specifically a license to possess a firearm and a learner's or driver's license.

II. Involuntary Care, Treatment, and Rehabilitation

A. Application and Examination

The law requires that a "mental health care user"[14] (user) be committed for involuntary care, treatment, and rehabilitation (CTR) as an inpatient or outpatient if an application is made to the head of the relevant health establishment and

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[10] McCrea, *supra* note 9, at 2.

[11] *See* South Africa Profile, BBCNEWSAFRICA http://www.bbc.co.uk/news/world-africa-14094918 (Dec. 20, 2012).

[12] S. AFR. CONST., ch. 2, §§ 2–39, http://www.info.gov.za/documents/constitution/1996/96cons2.htm.

[13] McCrea, *supra* note 9, at 2 & 3; I.O. Jack-Ide et al., *supra* note 2, at 51.

[14] "Mental health care user" is defined broadly by MCHA § 1 as

> a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, State patient and mentally ill prisoner and where the person concerned is below the age of 18 years or incapable of taking decisions, and in certain circumstances may include –
>
> I. Prospective user;
>
> II. The person's next of kin;
>
> III. A person authorized by any other law or court order to act on that person's behalf;
>
> IV. An administrator appointed in terms of this Act; and
>
> An executor of that deceased person's estate and "user" has a corresponding meaning.

- there is a reasonable belief that the user's mental illness is such that he is a danger to himself or others, or that involuntary CTR is necessary for his financial interests or reputation; and
- the user is not capable of making an informed decision on and is unwilling to submit to CTR.[15]

An application for involuntary CTR may only be made by a spouse, next of kin, partner, associate, parent, or guardian of the user.[16] If the user is under the age of eighteen, only his parent or guardian can make the application.[17] In all cases, if the person eligible to make an application is unable or unwilling to do so, a health care provider may make the application.[18] None of the individuals eligible to make an application for involuntary CTR can do so unless they have seen the user not more than seven days before the date of the application.[19] An application for involuntary CTR can be withdrawn at any time.[20]

Involuntary commitment does not automatically follow the filing of an application. Having received an application, the head of the relevant health care establishment is required to have the user examined by two mental health care practitioners, none of whom can be the applicant and at least one of whom should have the qualifications to conduct a physical examination.[21] After completing their examination, the two practitioners are required to submit a written report to the head of the health care establishment regarding the presence of the above-stated justifications for involuntary CTR of the user.[22] If the findings of the examiners differ from one another, the head of the establishment is required to appoint another health care practitioner to examine the user, and only if two practitioners agree on a diagnosis can he then approve the application.[23]

B. Seventy-two Hour Assessment

If the head of the health care establishment approves the application for involuntary CTR, he is duty-bound to make sure that the user receives the necessary CTR.[24] He must have the physical and mental status of the user examined by a medical practitioner and another mental health care practitioner for seventy-two hours.[25] He is also required to ensure that the practitioners determine whether the involuntary CTR must be continued, and if so, whether it must be

[15] MHCA § 32.

[16] *Id.* § 33.

[17] *Id.*

[18] *Id*.

[19] *Id.*

[20] *Id.*

[21] *Id*.

[22] *Id*.

[23] *Id.*

[24] *Id*. § 34.

[25] *Id*.

provided to the user on an inpatient or outpatient basis.[26] The head of the establishment must make the results of the assessment available to the applicant within twenty-four hours from the expiration of the assessment period.[27]

The head of the establishment, depending on the outcome of the assessment, must then take one of three possible courses of action. If he is of the opinion that involuntary CTR is unnecessary, the user must be immediately released unless he agrees to voluntary CTR.[28] If he finds that the need for further involuntary CTR on an outpatient basis is in order, he must immediately discharge the patient subject to the applicable requirements and procedure and inform the Mental Health Review Board (the Review Board) in writing (*see* section C below).[29] A finding of a need for further involuntary CTR on an inpatient basis is subject to additional scrutiny. In this instance, the head of the establishment is required, within seven days of the expiration of the seventy-two-hour assessment period, to submit a request to the Review Board to approve further involuntary CTR.[30] This request must include a copy of the initial application for involuntary CTR, a copy of the notice provided to the applicant on the decision to commit the user for involuntary CTR, and the basis for the request.[31]

C. Review Boards and Judicial Oversight

Review Boards are provincial bodies established to provide oversight of decisions to commit users to involuntary CTRs. A Review Board's principal function is to safeguard users' rights from abuse or neglect.[32] They are established at the provincial level for every health establishment that provides mental health care CTR.[33] A Review Board may consist of three to five members with at least one mental health care practitioner, one magistrate or attorney, and one member of the community.[34]

The law grants Review Boards broad oversight powers/obligations with regard to decisions made by the head of a health establishment regarding involuntary CTRs. They are authorized/required to

(1) consider appeals against decisions of the head of a health establishment;

(2) make decisions with regard to assisted or involuntary mental health care, treatment, and rehabilitation services;

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[26] *Id*.

[27] *Id*.

[28] *Id.*

[29] *Id*.

[30] *Id.*

[31] *Id*. § 33(8).

[32] S. Ramlall, *The Mental Health Care Act No. 17 – South Africa. Trials and Triumphs: 2002–2012*, 15(6) AFR. J. PSYCHIATRY 407, 409 (Nov. 2012); McCrea, *supra* note 9, at 3.

[33] MHCA § 18. There may be more than one Review Board in each province. *Id*.

[34] *Id.* § 20.

(3) consider reviews and make decisions on assisted or involuntary mental health care users;

(4) consider 72-hours assessment made by the head of the health establishment and make decisions to provide further involuntary care, treatment and rehabilitation;

(5) consider applications for transfer of mental health care users to maximum security facilities; and

(6) consider periodic reports on the mental health status of mentally ill prisoners.[35]

Specifically, as noted above, when the head of a health care establishment, after having conducted a seventy-two-hour assessment of a user, decides that there is a need for further involuntary CTR, his decision, in order to stand, needs Review Board approval.

In addition to its routine oversight function, a Review Board also hears appeals against decisions made by heads of health care establishments on involuntary CTR. A decision of the head of a health care establishment can be appealed to a Review Board by a user, his spouse, his next of kin, his partner, or his guardian within thirty days from receiving notification from the head of a health care establishment about a decision regarding involuntary CTR and before a Review Board approves such decision as part of its routine review process.[36]

All decisions of a Review Board, both as part of its routine review function over decisions of heads of health care establishments or as part of its appeals function, in favor of involuntary CTR are subject to judicial oversight. In both instances, if a Review Board upholds a decision of the head of a health care establishment to commit a user to involuntary CTR, it is required by law to automatically submit its decision and all documents involved to the High Court for review.[37] The High Court is required to consider the matter within thirty days of receiving the documents from the Review Board and may seek additional information from anyone.[38] The High Court must then order that the user either be immediately discharged or committed for further involuntary CTR.[39]

A decision by the High Court to commit a user to involuntary CTR does not confer on the head of the health care establishment unfettered discretion to institutionalize a user. The head of the health care establishment is required to commission an initial six-month review of the involuntary CTR and annual reviews thereafter regarding the mental health status of the user.[40] Every periodic review must

[35] *Id*. § 19.

[36] *Id.* §§ 33(8), 34(8), & 35.

[37] *Id*. §§ 34 & 35.

[38] *Id*. § 36.

[39] *Id.*

[40] *Id.* § 37.

a) state the capacity of the mental health care user to express himself or herself on the need for care, treatment and rehabilitation services;

b) state whether the mental health care user is likely to inflict serious harm on himself or herself or other people;

c) state whether there is other care, treatment and rehabilitation services that are less restrictive or intrusive on the right of the mental health care user to movement, privacy and dignity; and

d) make recommendations regarding a plan for further care, treatment or rehabilitation service.[41]

The head of the health care establishment is required to submit a summary of all the periodic reports to the Review Board, which decides whether the involuntary CTR should continue.[42]

III. Psychiatric Evaluation as Condition for Licensing

A. Firearms Licenses

The Firearms Control Act (FCA) requires that an application for a firearm or firearm-related activities be accompanied by a competency certificate.[43] A first-time application for a competency certificate may be granted only if, among other things, the applicant

- is a "fit and proper person" for the license he or she is seeking;
- is stable and does not have a proclivity for violence;
- does not have a substance-abuse problem; and
- has not "become or been declared unfit to possess a firearm" under the FCA or the 1969 Arms and Ammunition Act within the five years preceding the application.[44]

The FCA Regulations impose additional requirements. For instance, they require anyone who provides a recommendation on behalf of any applicant to attest that the applicant

[41] *Id*.

[42] *Id.*

[43] Firearms Control Act No. 60 of 2000 (FCA), *as amended*, § 6, 3 BUTTERWORTHS STATUTES OF THE REPUBLIC OF SOUTH AFRICA [BSRSA] (rev. ed. 2011). No online source for the current version of the FCA was located. The text of the original Act can be found on the website of the South African government, http://www.info.gov.za/view/Download FileAction?id=68229, along with the text of Firearms Control Amendment Act 43 of 2003, http://www.info.gov.za/ view/DownloadFileAction?id=68021. The text of Firearms Control Amendment Act No. 28 of 2006 is available on the website of the South African Gunowners' Association (SAGA), http://www.saga.org.za/FCA%20Amendments %20ACT%202006% 20gaz%2030210%2020070822.pdf; *see also Application for a New Firearm License*, SOUTH AFRICA GOVERNMENT SERVICES, http://www.services.gov.za/services/content/Home/ServicesForPeople/Dealing with thelaw/firearms/firearmlicence/en_ZA (last visited Jan. 28, 2013).

[44] FCA § 6; FCA 2000: Firearms Control Regulations (FCA Regulations) § 14, No. R. 345, GG, No. 26156 (Mar. 26, 2004), http://www.info.gov.za/view/DownloadFileAction?id=161734, *as amended by* FCA, 2000: Amendment of the FCA Regulations, 2004, No. R. 696, GN, No. 27781 (Sept. 16, 2005), http://www.info.gov.za/view/Dowload File Action?id=161672.

- is a fit and proper person to be issued a competency certificate, license, permit, or authorization;
- has a stable mental condition and does not have a propensity for violence; and
- does not suffer from a substance-abuse problem.[45]

Upon receiving an application for a competency certificate, the designated regulatory authority—the National Commissioner of the South African Police, which is also the National Commissioner of Registrar of Firearms (the Registrar)—may launch an investigation for the purpose of determining whether the applicant is a fit and proper person, is in stable mental condition, or has a tendency for violence or a substance-abuse problem. An investigation is launched if, in the five years preceding the application, the applicant, among other things,

- has been served with a protection order or accused of domestic violence, necessitating a police visit to his or her residence;
- has been denied a license, permit, or authorization for a firearm;
- has attempted suicide, suffered major depression or emotional problems, or had a substance-abuse problem;
- has been diagnosed or treated for depression, substance abuse, or behavioral or emotional problems;
- has been reported to the police or social services for threatening or attempting violence or other conflict anywhere;

or if, in the two years preceding the application, the applicant

- went through a divorce or separation from a partner in which violence was alleged; or
- was fired or laid off from his or her job.[46]

In the course of investigating an applicant for a competency certificate, the Registrar may require the applicant to submit a doctor's certificate regarding the applicant's dependence on intoxicating or narcotic substances[47] and/or a report compiled by a psychiatrist or psychologist on the applicant's mental condition or propensity for violence.[48]

B. Driver's Licenses

Mental health fitness is a requirement for obtaining a learner's or a driver's license. A person who suffers from "any form of mental illness to such an extent that it is necessary that he or she

[45] FCA Regulations § 13.

[46] *Id*. § 14; FCA § 124.

[47] FCA Regulations § 14.

[48] *Id.*

be detained, supervised, controlled, and treated as a patient in terms of the Mental Health Act, 1973 (Act No. 18 of 1973)"[49] may not obtain or hold a learner's or a driver's license.[50] If the holder of a learner's or a driver's license is disqualified for not being mentally fit, the concerned authority is required to cancel his license.[51] If the holder of a learner's or a driver's license would be a danger to the public by driving on a public road, the authority may cancel or suspend his license.[52] For the purpose of determining whether a person is qualified to hold a learner's or a driver's license or whether he would be a danger to the public if he were to drive on a public road, the authority may require him to submit to a mental fitness examination.[53]

Mental fitness is also a requirement for registration as a driving instructor. A person may not be registered to act as an instructor unless he is "mentally or physically fit to act as an instructor, and was medically examined to ascertain such fitness."[54]

[49] Note that most of the provisions of the Mental Health Act No. 18 of 1973 were repealed and replaced by the MHCA in 2002. MHCA § 73.

[50] National Road Traffic Act No. 93 of 1996, §15, 25 BSRSA (rev. ed., 2011). No online source for the current version of the NRTA was located. The text of the original Act can be found on the website of the South African government, http://www.info.gov.za/gazette/acts/1996/a93-96.htm.

[51] *Id.* § 25.

[52] *Id.*

[53] *Id.*

[54] *Id.* § 28B.

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SUMMARY This bibliography contains recent, English-language publications on mental health law. It includes works of a comparative and international nature and those providing an overview of European Union law, as well as works on the domestic legislation and court systems of Australia, Cambodia, Canada, Chile, England and Wales, Ireland, Japan, Nigeria, New Zealand, Scotland, and Sweden.

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