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ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

19TH ANNUAL CONGRESS PERTH

11 OCTOBER 1982

LAW REFORM, POLITICS AND MENTAL HEALTH

The Hon. Mr. Justice M.D. Kirby
Chairman of the Australian Law Reform Commission

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THE LAW REFORM COMMISSION, MEDICINE AND MENTAL HEALTH

I have titled my address to you 'Law Reform, Politics and Mental Health'. I do have qualifications to speak about law reform. Of mental health law, I can claim no special qualifications. Of politics, I must be most circumspect. The new Master of the Rolls in England, successor to Lord Denning lately retired, once said that a judge looks on politics as a monk looks on sex. With embarrassment for early indiscretions. With nostalgia for opportunities missed. And with a sneaking suspicion that he could better at it than the current practitioners.

The Australian Law Reform Commission is a permanent national institution. It was established by the Federal Parliament in Australia to report to Parliament on the review, modernisation and simplification of Federal laws. Some of the most distinguished lawyers in our country have been appointed as Commissioners. Sir Zelman Cowen, now Provost of Oriel College Oxford was, for a period, a part-time Commissioner. So was Sir Gerard Brennan, now Justice of the High Court of Australia. Mr John Cain the new Premier of Victoria was one of the initial Commissioners. Judges, silks, solicitors and law teachers have made up the Commission since it was established seven years ago.

The Commission cannot roam unchecked of any area of the law it may choose to address. Unlike some other law reform bodies, it is not free to choose its own program. It is for the Federal Attorney-General to assign to the Commission, tasks to be examined by it. Some the tasks we have received have been relevant for the interface between law and medicine.

. Human tissue transplants. Most notable was our inquiry into the law on human tissue transplants. The report on that topic has been internationally acclaimed. More to the point, the draft legislation attached to the report is now working its way through the State and Territory parliaments of Australia. The legislation, dealing with tissue transplanation and the definition of death in terms of brain function, has already been adopted in three jurisdictions of Australia. Legislation in three others is being prepared. Reform can be achieved.

. Criminal investigation examinations. In an early report on criminal investigation, the Commission made recommendations relating to medical procedures to be followed in a criminal investigation which involves intimate personal searches of the subject. The proposals in that report are substantially adopted in the Criminal Investigation Bill 1981 now before Federal Parliament.

. Breathalysers and drug intoxication. In a report on breathalyser laws for the Australian Capital Territory, the Commission had to examine the rights and duties of medical practitioners in relation to one group of citizens committing anti-social acts by reason of intoxication by alcohol or other drugs. The extent to which it was reasonable to impose compulsory law enforcement obligations on medical practitioners, otherwise than in treatment of a consenting patient, had to be considered. The general issue of the balance between social protection and individual human rights had to be weighed in considering whether a system of random breath tests should be introduced. Legislation based on the Commission's report was accepted by the Federal Government and has been enacted.

. Child welfare and child abuse. A recent report on child welfare law considered the difficult problem of child abuse: a species of the circumstances of a child in need of care and protection by the law. The Commission had to the consider the extent to which it was acceptable and efficacious to impose on medical practitioners (whose primary professional and ethical duty is to help the patient) the obligation to report to the authorities suspected cases of child abuse.

The Commission is presently working on other projects that bring us into contact with the medical profession. For example, we are examining the question of whether class actions should be introduced in Federal courts in Australia. Class actions are a form of legal procedure for aggregating similar legal claims and for using the law and the courts as a means of achieving major social changes. In the United States,

class actions have been used by some critics of the psychiatric profession.[1] We are also currently examining the laws of evidence in Federal courts. One of the issues raised in this project, which may seem esoteric but is of direct and practical concern to your profession, relates to the problem of professional legal privilege. To what extent should a legal privilege against having to give evidence be extended to a patient to refuse access by a court to intimate confidences shared with medical practitioners generally and psychotherapists in particular. Only in some States of Australia does the law presently provide protection against a subpoena seeking the confidences of a patient.[2] An issue before the Law Reform Commission is whether a privilege akin to that generally enjoyed by a client in relation to his lawyer should be extended generally in the Federal courts to the confidences of a patient. If this privilege should be extended should it be available to medical practitioners at large or confined to psychiatrists — because of the special intimacies of the information typically shared? A third current project is one upon which we have already had assistance from this College. It is, in fact, in some ways related to the issue of medical privilege. But it is wider. I refer to our current inquiry into the law governing privacy protection in Federal jurisdiction. This great subject, upon which we hope to report early in 1983, involves many issues of lively concern. One is bound up with a topic which I see you will be addressing during this Conference, and which is identified in the Conference theme namely, the growing use of computerisation in personal medical records. To what extent should the data subject (in this case the patient) have restricted or unrestricted access to medical and psychiatric data about himself? To what extent could a general right of access be applied to the special cases of persons under a disability? Such disabilities may include those of tender age or advanced senility. But they may also include the case of persons who are not mentally competent to make an informed, free and knowing decision on their own behalf.

I catalogue these instances of the work of the Law Reform Commission for three reasons. First, to show you that law reform and the general profession of medicine are in a constant dialogue. Times are changing. The law cannot be static. Technology alone requires major adjustments in the law. The process of law reform is permanent and ongoing. It affects my profession. But it also affects yours.

Secondly, the work of the Law Reform Commission, and of its State counterparts with which it is co-operating closely, is not simply academic business. I hope that our work is done to high intellectual standards. Certainly we secure the assistance of interdisciplinary teams of experts drawn from the top talent in our country and beyond.

But the object of the exercise is essentially a political one. It is the improvement of old laws and the developments of suitable new laws. Most of the reports of the Australian Law Reform Commission have either passed into law or are under active current consideration by the Federal Government and its agencies. I mentioned the State law reform bodies. After this session with you I will be going to the Law Reform Commission of Western Australia which is working on a project for State laws for privacy protection, in co-operation with the Federal Commission. Each State has a law reform agency and none is more distinguished than the Law Reform Commission of this State.

The third reason for listing the past and current projects of the Australian Law Reform Commission is to acknowledge from the outset that we have not yet been afforded an opportunity to examine directly mental health laws. Under the Australian Constitution, the subject matter of mental health legislation is basically a responsibility of the several States. The Federal concern is limited to its plenary power of the Commonwealth in the Australian Territories. There is, in fact, a somewhat overdue effort to reform the mental health laws of the Australian Capital Territory proceeding at this very time. I say it is overdue because my understanding is that the project actually began in 1932. Sometimes law reform cannot be hurried. The result of this delay is that in the Australian Capital Territory (A.C.T.) the substantive mental health law is the New South Wales Lunacy Act of 1898, inherited as part of the law of the Capital Territory, when it was severed from the State of New South Wales in 1912. The fact that the Lunacy Act, with its perjorative language and antique procedures has long since been abandoned in New South Wales has not affected the continuing operation of the legislation in that jurisdiction of Australia which is sometimes rashly described as the Australian 'hothouse of legislative experimentation'. In the business of mental health law reform, the 'hothouse' has been content to persist with a faded, aged plant — a kind of Victorian aspidistra of a law. Although the Law Reform Commission has at various times proposed to the Federal Attorney-General that mental health law reform (and in particular the law governing mental retardation) would be appropriate matters for law reform treatment — no such reference has been given by the Attorney-General to the Commission. Instead, the reform project has proceeded substantially within the Capital Territory Health Commission. I am assured that the 1898 Lunacy Act will be repealed in its application to the A.C.T. before the time comes for its centenary celebrations.

LAWS OLD AND NEW

The mental health law of the A.C.T. 1898 and all is, however, positively fresh and green if it is compared to the mental health laws operating in many parts of the world. Many of you will know of the splendid conspectus published by the World Health Organisation 'The Law and Mental Health: Harmonising Objectives'.[3] A copy of it

was handed to me by Professor W.J. Curran when I met him at Harvard University last month. It points out that in many parts of the world the mentally disordered are still an underprivileged minority, denied the means of daily living, scorned and mocked by fearful fellow humanity excluded from their social group, and without access to any modern effective treatment. In so far as there are laws to deal with the mentally ill, they are the laws of the village, the laws of prejudice or, in some parts of the world, laws as old as the Koran and like religious texts. Even in terms of modern legislation, France is still functioning under the law of 1838.[4] Australia's general laws on mental health on the other hand trace their origins to England.

The first step towards the establishment by law of a general independent body to supervise standards of care for psychiatric patients was taken in England with the appointment in 1744 of Commissioners in Lunacy. They had the responsibility of licensing and inspecting private 'mad houses' in London. The Commissioners consisted of five positions elected annually by the Royal College of Physicians. In 1828 they were replaced by a body of Metropolitan Commissioners comprising 15 members appointed by the Home Secretary. Significantly, only five of these were positions were reserved for medical practitioners. Most of the rest were lay-members of parliament. Their power included (with respect to London) the supervision of 'subscription hospitals for the insane' in addition to private mad houses. One exception was Bethlem, commonly called Bedlam — the Hospital of St Mary of Bethlehem which was established in 1247 - the first public asylum for the mentally ill in Europe. It was chartered by King Henry VIII on the south bank of the Thames in 1547. I wonder how many of you have visited the modern fabric of Bedlam in London? It is now, as most of you would know, the Imperial War Museum. Where locked cells once existed, now a coffee bar services the visitors. The chains and bars are replaced by other silent monuments of man's cruelty to man: the V2 rockets and the bric a brac of countless imperial wars and conflicts.

The problem of striking the right balance between the medical profession's perceptions of madness and lay scepticism did not terminate with the reforms of 1828. The Lunatics Act of 1845 replaced the Metropolitan Commissioners by Lunacy Commissioners appointed by the Lord Chancellor.[5] For the first time a permanent full-time inspectorate was established. The powers of inspection included the right to visit the insane in whatever institution they were confined. The Lord Chancellor could order special visits, including also a visit the Bethlem. Here at last was the endeavour of the law, lawyers and lawmakers to assert the general voice of scepticism and the value of protecting individual liberty which has been such an important feature of those legal systems

that trace their origins to England. This English legislation of the 19th century was copied throughout the old British Empire and in some places — such as Ghana, and to a large extent the Australian Capital Territory, that legislation lives today. It was changed in England by reforms in 1913 and virtually eliminated in 1959. What conclusions emerge from this history of law and psychiatry? Professor Curran points out in his review:

> There are fashions and cycles in mental health legislation just as there are in any other area of law. The cycles do not affect all countries uniformally nor at the same time. However, certain trends affecting many countries can be detected. Most of the commitment laws stressing judicial or police involvement were enacted in the middle of the 19th century. Emphasis on formal structures and court revue continued during the asylum era. The mentally ill and retarded were segregated and generally lost their legal capacity and civil rights. Significant changes in treatment methods and in public attitudes towards the mentally ill did not tend to have an effect upon law until the middle of the current century. Mental health legislation of many countries was significantly revised after 1950. The last two decades have seen more varied and even more piecemeal changes in response to the greater complexity of the mental health systems themselves and the lesser concentration upon long term hospitalisation of the chronically ill.[6]

This diagnosis of cycles or 'waves' in mental health law reform can certainly be applied to Australia. A superficial examination of the popular media and learned journals over the past year or so show that there are many topics that could be considered in a serious review of mental health law reform. In New Zealand, for example, even more than in Australia, there has been a lively debate about legal controls on electro-convulsive therapy. Commentators have urged the introduction of legislation posing legal restrictions on the use of ECT as in California. Yet psychiatrists have illustrated the difficulties that can arise in complex clinical situations by imposing too rigorous an insistence upon the law's general criterion for medical intervention, namely the informed consent of the patient.[7] In a vivid phrase T.G. Gutheil suggested that by exclusively emphasising civil rights, judgments of the United States courts and laws enacted by the legislators have ignored the need for treatment and left patients needlessly to suffer from treatable psychiatric illnesses.

> The physician seeks to liberate the patient from the chains of illness, the judge from the chains of treatment. The way is paved for patients to 'rot with their rights on'.[8]

THE HINCKLEY VERDICT: INSANITY ON TRIAL

The issue of the Hinckley trial was still very much a matter of lively concern throughout the United States when I was there last month. Hinckley, as you will recall, was declared not guilty by reason of insanity, though it was never disputed that he shot the President of the United States and two aides. Sitting alone in his prison cell awaiting what he and everyone else thought would be the verdict of guilty, John W. Hinckley Jr penned his apologia:

> On March 30 1981, I was asking to be loved. I was asking my family to take me back and I was asking Jodie Foster to hold me in her heart. My assissination attempt was an act of love. I'm sorry love has to be so painful.[9]

The jury decision followed an eight week trial replete with conflicting psychiatric testimony, avidly reported throughout America and the world. The competing evidence fanned, I believe the anti-psychiatry brigade's contempt and cynicism concerning the psychiatric 'science'. The demand for law reform followed immediately on the jury's verdict and from the United States Attorney-General - down. According to Judge Irving Kaufman:

> Outrage over the verdict was immediate and intense. Numerous government officials called for changes in the laws concerning the insanity defense. The United States Senate Subcommittee conducted hearings to consider amending the relevant Federal statutes, summoning five of the jurors in the Hinckley case to testify. .. And among the general population there was widespread anger and resentment.[10]

The fact that the insanity defence rarely succeeds, either in the United States or in Australia, does little to abate the public concern about this apparently bizarre and unacceptable result in a trial with the highest possible public profile. It has been estimated that the insanity defence is invoked in the United States in no more than 1.5% of all felony indictments. It fails in three quarters of the cases in which it is raised. Australian figures are probably lower still. But to many Americans and Australians the verdict in the Hinckley case was yet another sign that something was wrong with the law and the courts. Some of the criticism rubbed off onto psychiatry. A leading cartoonist depicted blindfolded justice on a psychiatrist's couch, the sword by her side, the Hinckley verdict in her hands telling an unflattering reproduction of a psychiatrist on rollerskates, 'I think I am going nuts! '.

Yet Judge Kaufman and others warn that the principle behind the insanity defence — that individuals may sometimes take actions for which they cannot justly be held criminally responsible — should not be abandoned thoughtlessly.[11] The problem is one of finding procedures and satisfactory evidence and criteria upon which the decision of insanity can be made by a lay jury confronted by conflicting 'expert' testimony of apparently reputable, trained, professional psychiatrists.

Psychiatrists themselves acknowledge, as they must, the need of their profession to play its part in protecting the institutions of justice from charlatans willing to sell evidence to the highest bidder and unacceptably imprecise psychiatric evidence:

> The psychiatric profession has the obligation to continue to refine its concepts so that the testimony it presents is more useful to the court which is ultimately responsible for weighing all relevant factors and determining blameworthiness.[12]

It is also suggested that law reforms may be needed to redefine the insanity defence, provide a more expert tribunal than jury or to 'come to view mental illness as but a mitigating circumstance in criminal behaviour, rather than one that results in [complete] exoneration' of the accused.[13] But whatever the direction of reform, it is plain that more attention is needed including in Australia to the laws and procedures governing mentally ill offenders both in and out of custody. In June 1982 a major seminar on this topic was held by the Australian Institute of Criminology. Earlier in the year a useful Australian book 'Mental Health and the Law' was published by John O'Sullivan. A specific call for a reference on mental illness and the law to be given to the Australian Law Reform Commission is contained in a further book published by Ivan Potas, 'Just Deserts for the Mad', which became available in recent months.[14] Much background work has been done. What is now needed is a well organised national project — conducted with interdisciplinary expert and public participation — to consider mental health law in general and the laws governing the mentally ill offender, in particular.

PATIENTS RIGHTS AND CYCLES OF REFORM

The criminally insane represent only a small proportion of the large numbers whom we presently classify as mentally ill. My brief excursus into the history of mental health law shows that efforts to provide better protection for the mentally ill are not the recent discovery of this generation of law reformers. As you would know, the very concept of 'mental illness' itself has been questioned and sometimes vehemently criticised.[15] I am sure I am not breaking the bad news to you by telling you that

there are many articulate writers, both within the legal discipline and outside, who are very dubious about the claims of psychiatry. A correspondent in New Zealand recently sent me a new book 'Psychiatry: A Confused Profession' by Dr Wayne Innes — trenchantly critical of what he sees as the disorderly expansion of an imprecise, inexpert, malleable and largely bureaucratic profession:

> Psychiatry has always been a minor servant of governments because of its eagerness to deal with nuisances. Moreover it has shown itself willing to shift its definitions of mental illness in response to public and/or political demands. This is not surprising because the majority of psychiatrists in the world are employment directly by governments: In communist countries, all psychiatrists are employed by the government; in European and Commonwealth nations, at least two thirds; and even in the U.S.A., approximately one half. It would be wrong, therefore, to think that psychiatry is a profession which earns its living on the basis of private contracts with consenting individuals. Most psychiatric services are provided by government for the presumed benefit of their population. And since the government is paying, it may think that some of these services should also be for its own benefit. Even the apparently harmless talkback therapists employed in private practice encourage conformity to the political system.[16]

I do not read this passage to you to suggest approbation of everything Innes says. But I think the psychiatric profession, as with the legal profession, must squarely face its critics and take occasions such as this congress to indulge in efforts of healthy and practical self-criticism. Cases such as the Hinckley case and reports of the misuse of psychiatry in the Soviet Union, even the news in recent days that the Buckingham Palace intruder Fagan, acquitted by a jury, has now been committed indefinitely to a mental hospital, arouse in the community at large reservations about psychiatry. At least is this so in psychiatry's interaction with the legal process. These reservations produce, in turn, continuing and even cyclical efforts to define more closely the boundaries within which psychiatry will operate when not fully consensual and the checks and balances that will be provided as an assurance to the patient, his relatives and the community at large against any oppressive use of great powers. Australia's mental health laws do not specifically define what is meant by 'mental illness'.[17] This lack of precision, coupled with the loss of liberty, dignity, reputation and other valued rights that may sometimes attend the diagnosis of mental illness, is the source of the lawyer's concern that is now being reflected in the current cycle of

mental health law reform evidenced in a number of jurisdictions in Australia. It is important never to forget that we are not dealing with trivial numbers of our follow citizens. More than 60 000 people enter Australian mental hospitals every year. True, between 70% and 75% of this number are committed as voluntary patients. This figure is roughly the same as demonstrated by English and Scottish percentages (70% and 67% respectively).[18] It contrasts with the position in France where 37% only of admissions are voluntary. In the United States as a whole, the corresponding rate is only 10%. The growth in voluntary admissions and the deinstitutionalisation of psychiatric treatment are two of the very important and I believe beneficial developments of psychiatry that have marked recent years in Australasia.

But even allowing this, we are dealing with the personal freedom and liberty of a significant and probably growing section of the community. Remember that a smaller number, 10 000 is confined in Australian prisons. The law, rightly, pays a great deal of attention to the provision of detailed procedural and institutional checks against the unlawful or unjustifiable deprivation of the liberty of such prisoners. The law should be no less tender in its concern for people who have committed no criminal offence. The loss of liberty is equally the concern of a free society, whether it occurs in the case of a criminal accused or a person said to be mentally unwell.

Comparatively little work has been done on the utility, both for society and for the patient, of confinement in Australian mental hospitals. In 1968, Dr Briscoe analysed 1000 consecutive admissions at the Rozelle Admission Centre, Callan Park Hospital Sydney. He found that over one half of those admitted were, at least in his view, not suffering from 'mental illness' in any strict interpretation of that term.[20] According to his study, most of the persons admitted were suffering from personality disorders or were chronic alcoholics or were vagrants requiring social attention or individuals displaying symptoms of instability in a public place.

The worldwide wave of mental health law reform of the 1950s was reflected in most parts of Australia, other than the A.C.T. The most important innovation was probably the facilitation of voluntary admissions, which has been successful in reducing the number of persons involuntarily committed by judicial order. Changes in the forbidding physical conditions of mental hospitals in the 1950s and 1960s were symbolic of changes that occurred within those places. When the high walls which physically guarded the 'lunatic asylums' came down, the community's attitudes to mental health law reform also began to change.

A further turn of the cycle commenced in October 1979 with the proclamation of the South Australian Mental Health Act 1976—7. The Act provided the latest approach to the treatment and protection of persons who were mentally ill or handicapped. It listed objectives which the Health Commission were direct by Parliament to 'seek to attain'. The first was the best possible treatment and care. The second listed objective was the minimisation of restrictions upon the liberty of patients and with their rights, dignity and self respect. Detailed prerequisites were laid down for involuntary admission. And a Mental Health Review Tribunal was established with statutory obligations of periodic review, precisely to guard against people 'langishing with their rights on' in mental hospitals. Possibly the most innovative provision of the South Australian Act was s.39 which provided that in every application to the Tribunal or to the Supreme Court on appeal, the person in respect of whom the appeal was brought is to be represented by legal counsel. In practice the representation is arranged by the Legal Services Commission and the Health Commission pays the costs. The success of the representation scheme remains to be reported and assessed.[21] Since the South Australian reforms, there have been moves in most of the Australia jurisdictions of Australia. I have already mentioned the belated efforts to reform the law in the Australian Capital Territory. A draft Ordinance is currently before the House of Assembly and the Human Rights Commission. In Victoria, the Consultative Council on Review of Mental Health Legislation produced a major report with 26 principal recommendations. Amongst these was the establishment of a right to an independent review tribunal in the case of the detention of an involuntary (formal) admission with appeal to the Supreme Court. Legal representation is also to be provided free of charge. There is to be a right of second opinion to any proposed psychiatric treatment program. The administration of of ECT treatment to involuntary patients and psychosurgery are to be controlled by strict pre-conditions. Periodic reviews of formal patients were also provided for.[22] In April 1982, the Minister for Health of Queensland announced a major review of the Queensland mental health legislation. It seems that Queensland Cabinet has already approved the principles of the review which include automatic review of all patients by mental health review tribunals, complete separation of the legislation governing the intellectually handicapped from that dealing with the psychiatrically ill and the establishment of consultative committees to issue guidelines in respect of particular forms of treatment such as ECT.[23]

At about the same time as the Queensland and Victorian announcements, the New South Wales Minister for Health forshadowed an overhaul of the Mental Health Act of that State, including more detailed provision for the definition of 'mentally ill persons'. This, it was said, would specifically indicate that a person cannot be declared mentally ill

by reason only of his politics, religion, sexual preferences, promiscuity, immorality, illegal conduct, drug taking or developmental disabilities.[24] As in the other announced reforms periodic review, legal representation and controls on psychosurgery and ECT are features of the New South Wales proposals As the Minister for Health of Western Australia told the Congress the new Western Australian Act was passed last year and will be proclaimed to commence shortly.

THE POLITICS OF REFORM

This catalogue of the changes that are occurring in the general mental health laws of Australia says something about the politics of mental health law reform in a federation. Indeed, we can see at once both the advantages and disadvantages of the federal system of government. The advantage is principally that one jurisdiction (in this event South Australia) can introduce legislation, whose operations can be observed and, if found acceptable, adopted, with variations, elsewhere. In communities with roughly similar traditions, a common language, a generally integrated legal system and like economic and social conditions, federalism can encourage experimentation and law reform developments, where a central unitary system might postpone reform, for fear of offending this or that minority.

But the disadvantage may be that undue caution and delay in introducing reforms, long since enacted elsewhere, may cause injustice or inefficiencies in one part of the country that would not be tolerated in another. Furthermore, there is the problem of expensive duplication of time consuming inquiries when precisely the same topics are re-explored by equally distinguished committees going over the same ground and often reaching the same conclusions, years or even decades apart. This is not a problem confined to mental health law reform. It is the general problem of uniform law reform in Australia. Unlike the United States and Canada, two other great English speaking federations, with societies like our own, we in Australia have not yet developed an efficient national machinery for regular large scale uniform law reform.

I mentioned undue caution. In reform, of course, in a subject such as mental health law reform, there is always the risk that elected political officers will shy away from the obligations of reform because of the fear that minority groups (for example, so called 'law and order' defenders or people with strong religious views) will be offended. This tendency to timorousness is exacerbated in Australia because of the short parliamentary terms of our legislatures — nominally three years but usually little more than two. Because we are all too often in a constant and heady electoral atmosphere, it is frequently hard to get the parliamentary process to address complex, sensitive and controversial issues which upset some, disturb many and attract votes from few.

A classic illustration of the difficulty which stands at the gate of reform achievement can be found in the tardy moves towards reform of the law of suicide in Australia. In New South Wales and South Australia is is still a common law misdemeanour to attempt to commit a suicide. A survivor of a so called 'suicide pact' who kills the other party is guilty of murder, for the common law regards such as person as having encouraged the other to commit self murder. The crime of attempted suicide was repealed in Tasmania in 1957 and in Western Australia in 1972. Victoria has enacted provisions similar to those of the United Kingdom 1961 reform and amended the Victorian Crimes Act 1967. In August 1982 the South Australian Government introduced a Bill into the Parliament of that State seeking to remove the crime of attempted suicide and to have the matter dealt with instead as a problem of mental illness. To this day the position remains unchanged in New South Wales. In November 1978 the Legislative Assembly agreed to a motion calling for abolition of the offence of attempting to commit suicide. The Attorney-General stated that he would take steps to introduce legislation. So far, no legislation and no reform.

Does this tale of slow reform reflect credit on the law and lawmaking institutions of our country? Should it have required the Suicide Act 1961 in the United Kingdom to initiate the moves for Australian reform of such a medieval law? Should it have taken more than a decade to secure similar reforms in most of the Australian States? Is the absence of reform legislation in New South Wales, where the Parliament so recently failed to agree on homosexual law reform (though a majority wanted reform of some kind) an indication of the institutional inadequacy or even the breakdown of the modern parliament's ability to cope with the pressures of law reform today?

If parliaments cannot cope, the pressure will be there (because the problems do not go away) for other institutions to provide the reform answers. The Executive Government through its agencies, such as prosecutors and police may provide the answers by not prosecuting survivors in a suicide or homosexual offenders or others though the letter of the law is left unreformed. This course is unacceptable because it leads to the unequal application of the law of the land and it gives rise to opportunities for corruption and idiosyncratic police or bureaucratic decisions.

The other solution is that which is used so often in the United States. The courts provide the answers. Judges are asked, in the midst of a busy work day and with little opportunity of expert consultation and no opportunity of public debate, to provide solutions to complex social issues. I am sure many of you are familiar of the literature in the United States which points to the frequent inadequacy of the solutions which, not surprisingly, judges in such situations can offer.

And this leads me to my concluding point. The true democrats amongst us will seek to ensure that the representative parliament, rather than the elite judiciary or the opinionated bureaucracy, provide the important law reforms including on such community problems as mental health law. Yet unless the representative parliament and the community it reflects can be assisted, it is likely to postpone difficult and controversial problems to another time. And that is precisely where bodies such as the Law Reform Commission come in. We do not shirk controversial issues when they are assigned to us by the Attorney-General. We provide a mechanism for bringing together some of the best and most talented experts from all parts of the country. We put forward before the whole community an identification of the problems that exist in the law and tentative suggestions for the improvement of the law. We conduct public hearings at which the expert and the ordinary citizen can come forward to be heard in an informal setting as they analyse or personalise the problems in the law. We do not retreat from the obligation of communicating through the mass media of communication, the problems of law reform, even in sensitive and highly charged issues such as mental health law can sometimes be. We produce our report with draft legislation. And the procedure works as the recommendations on so many sensitive topics will illustrate.

If our democratic institutions are to survive and are to be more than a cliche in our system of government, it is important that we should vigorously develop support machinery that will assist the legislative process to address promptly and systematically the needs of legal renewal in Australia. The science of psychiatry is not static. It is developing constantly and it needs refinement. The implications of the development and refinement for the law will need to be considered. Even in this brief talk, I hope I have indicated to you that there are many areas where the law, as it touches mental health, may itself be in need of treatment. The chief message I bring to this congress is therefore a political one. We should all be concerned as citizens about the capacity of our law making institutions to cope with the pressures for change in today's world. As democrats we should seek to enhance the decisiveness and effectiveness of the representative organs of government. These lofty aims will not be easily achieved. The delays and years of neglect in mental health law reform illustrate the impediments. They also illustrate the fact that the last word is rarely spoken and that cycles and fashions of change come and go. If the law is to be kept in tune with the time, we must find and utilise to the full institutions that can help our parliaments to cope. I hope I have said enough to suggest to you that in Australia the Law Reform Commission is one such helping institution.

Footnotes

1. See e.g., Wyatt v. Stickney 344 F Supp 373 (MDA la 1972) and Donaldson v. O'Connor 390 US 971 (1969). These cases are mentioned in P.E. Deitz, 'Social Discrediting of Psychiatry: The Potasis of Legal Disfranchisement', Am J Psychiatry 134; 12, December 1977, 1356.

2. The Law Reform Commission, Discussion Paper No. 16, Reform of Evidence Law, 1980, 5.

3. W.J. Curran and T.W. Harding, 'The Law and Mental Health: Harmonizing Objectives' World Health Organisation, Geneva, 1978.

4. ibid., 10.

5. This history is set out in greater detail in R. Blueglass, 'Towards a New Mental Health Act: Mental Health Commissions for England and Wales'.

6. Curran and Harding, 21. See also Law and Mental Disorder, Editorial, The Lancet, 7 April 1979, 759.

7. P.R. Byrne and R.H. Gerner, 'Legal Restrictions on the Use of ECT in California: Clinical Impact on the Incompetent Patient, J. Clin Psychiatry 42: 8, August 1981, 300.

8. T.G. Guthiel, In Search of True Freedom, Editorial. Am J Psychiatry 137: 327, 328, 1979.

9. I.R. Kaufman, 'The Insanity Plea on Trial', The New York Times Mazagine, 8 August 1982, 16.

10. ibid.

11. id., 17.

12. S. Rachlin, 'The Inanity of Insanity: Some Improper Applications of the Insanity Defense', Hospital and Community Psychiatry, Vol. 32, No. 7, September 1982, 642, 643.

13. ibid.

14. I. Potas, Just Deserts for the Mad, Australian Institute of Criminology, 1982, 60.

15. T. Szasz, The Myth of Mental Illness (1961). Cf. R.D. Laing and A. Esterson, Sanity, Madness and the Family, 1970. H.M. van Praag, 'The Scientific Foundation of Anti-psychiatry', Acta Psychiat. Scand (1978) 58, 113.

16. W. Innes, Psychiatry: A Confused Profession, Auckland NZ, 1981, 122.

17. See e.g., A. Freiberg, 'Out of Mind, Out of Sight' Monash Uni Law Rev, 1976: 134.

18. Curran and Harding, 11.

19. ibid.

20. O.V. Briscoe, 'The Meaning of "Mentally Ill Person" in the Mental Health Act 1958—1965 of New South Wales' (1968) 42 Aust Law J 207. See now the report of the Study of Melville Clinic, Melbourne by Lenora Lippman reported in the Age, 3 September 1982, 5.

21. R. Greycar, 'Legal Representation Under the South Australian Mental Health Act' (1980) 5 Legal Service Bulletin 72. See also W. Hall and B. Flaherty, 'Getting Lawyers into the Act: Legal Representation in the New South Wales Mental Act', New Doctor, March 1982, No. 23, 31.

22. Victoria, Report of the Consultative Council on Review of Mental Health Legislation, December 1981.

23. Statement by the Hon. Brian Austin, Queensland Minister for Health, mimeo, Brisbane, 20 April 1982.

24. As report Sydney Morning Herald, 18 March 1982, 3.