THE SOUTH AUSTRALIAN ASSOCIATION FOR MENTAL HEALTH

THE TWENTIETH BARTON POPE LECTURE

ADELAIDE, 23 SEPTEMBER 1980

# MENTAL HEALTH LAW REFORM

September 1980

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

## THE BARTON POPE LECTURE SERIES

I am honoured to be the twentieth Barton Pope lecturer. The series, maintained with but one interruption since the inauguration in 1959, arises out of an idea of a distinguished and public spirited citizen, Sir Barton Pope. Sir Barton is, as all present will know, a leading industrialist who has played a major part in the expansion of secondary industry in South Australia. What began as his backyard workshop has expanded into the Pope Companies affording employment to 3,000 Australians. Sir Barton has been specially prominent in the commercial and financial life of the community. He has been an active member of the South Australian Chamber of Manufactures for many years and was President from 1947 to 1949. In 1959 his services to industry and the community were recognised by the honour of knighthood.

Apart from many interests in good causes (not least in the area of industrial relations) Sir Barton Pope has shown a special attention to a good cause which, until lately, has been something of a Cinderella among topics of social concern. I refer to the subject of Mental Health. With Dr. Bill Dibden, Sir Barton Pope was a co-founder of the South Australian Association for mental health. That Association took a leading part in the establishment of the first Chair of Psychiatry in South Australia at the University of Adelaide. Sir Barton supports this lecture series. We are privileged to have this distinguished Australian here tonight.

For some people, a lecture in an old fashioned way of communicating social concerns. The modern means of mass communication, particularly radio and television, put the public lecture at risk of irrelevance. Only the intrepid and dedicated (and frequently the already converted) will brave the physical and intellectual rigours that are

necessary to endure the 'performance'. Unlike the broadcaster, the public lecturer cannot conveniently and abruptly be switched off. Tedious passages cannot easily be escaped. But there are consolations. First, there are no commercials at least no obvious ones. Plaudits of individuals and institutions are generally advanced subliminaly or put before the audience in a tantalising but suitably modest way. I, for example, will have a few nice things to say about the Law Reform Commission. But you can ignore them if you choose.

The second consolation is more significant. Whereas the media today (particularly of the electronic variety) impose upon people with an idea to put across the rigour of doing so in as few seconds as possible, and preferably no more than 90, a public lecture permits a more thoughtful exploration of a theme. And my first point is that the Australian community urgently requires informed, public debate about very large issues that are posed for law, morality and medicine by developments in medical science and technology and by changes in the relationship between the community and its doctors.

Developments of modern medicine stretch the boundaries of the law and of medical ethics. They also test our notions of morality. Test tube fertilistion, the conduct of clinical trials, genetic manipulation, the use of foetal material in treatment of patients, patenting medical techniques and biological developments, the problems of artificial insemination by donor, sterilising, castration, human cloning, the use of surrogate mothers and so on represent some only of the problems which lie before us, and before our laws. But there are equal problems in the area of mental health: the grounds of involuntary committal to a mental hospital, the procedures to defend an individual's right to precious liberty against well-meaning but excessive medical discretion, the complete decriminalisation of suicide and the fair treatment of the criminally insane are but some of the subjects which have lately come under the lawyer's miscroscope.

In a recent case in the United States, a State Court asserted its right to determine whether chemotherapy should be given to arrest the spread of cancer in an institutionalised patient who suffered gross intellectually handicaps.[1] According to medical testimony the treatment would have involved considerable suffering and would at best have prolonged the patient's life for approximately a year. The court refused to order the chemotherapy. But it upheld the contention that it was for the law and the courts, not the hospital or doctors, ultimately to determine such a vital issue of life and death.

The decision was instantly assailed by the medical profession. It was denounced as encroaching unjustifiably on medical practice and requiring decision-making machinery

which was 'both impractical and inhumane'.[2] On the other hand, the legal profession sprang to the defence of the decision. It was contended that the rule of law required clear, specific and public pre-existing rules, openly applied and ultimately upheld and scrutinised in the courts, not left to the unreviewable decision of particular medical practitioners, however skilled or well-intentioned.[3]

Here is an illustration of a deep seated antagonism in the approaches taken by two ancient professions: the law and medicine. What the lawyers denounce as 'medical paternalism', the doctors assail as 'legal imperialism': the entry of the law into matters best left to the medical profession.

With a distinct air of 'a plague on both your houses' philosophers have now entered the fray in this United States debate. One of them has urged that neither the law nor medicine have the complete answer to the problems which arise at the interface between the two disciplines:

> Whether crucial moral decisions are routinely made in closed medical committees or in open courtrooms, it is unlikely that the results will be understandable much less acceptable, to the general public, which must live with them. Concentrating such responsibility in the hands of one or other professional group is not likely to enourage a much needed responsible public consensus. Nor is it likely to aid in the development of the public's powers of moral reasoning or its sensitivity to complex issues.[4]

I approach this lecture in the hope that my thoughts may contribute towards relevant and certainly much needed responsible 'public consensus' on some of the issues in mental health law reform. That there is a need for public understanding and debate about these topics is beyond question. Neither the medical nor the legal profession have been particularly adept in the past in enlivening that debate. This lecture series is worthwhile, if it contributes, in however small a way, to public consideration of the sensitive questions which must be resolved in fairly addressing the social consequences of mental ill health.

## AUSTRALIAN LAW REFORM COMMISSION

At this stage I should indicate the limited qualifications I have to speak on this topic. Although I am the Chairman of the Australian Law Reform Commission and although there are undoubtedly anxious debates about law reform and mental health, the Commission is limited to projects specifically given to it by the Federal Attorney-General. No project has been assigned on the subject of mental health law. Under the Australian constitutional arrangements, mental health law, outside the

Territories, is overwhelmingly a State matter. The Commonwealth certainly has social security powers[5] and one or two other concerns. By virtue of the external affairs power, for example, it represents Australia internationally and there are relevant international declarations concerning the rights of the individual generally[6] and the rights of people with mental disabilities, in particular.[7] Next year, 1981, is the Year of Disabled Persons. It is possible that the Commonwealth may take initiatives, including legal initiatives, to improve the position in Australia of handicapped people, including those with intellectual handicaps. Australian law, as it concerns the intellectually handicapped, is in need of urgent, modernising reform treatment.[8] In the Commonwealth's special area of constitutional responsibility, the Australian Capital Territory, a Mental Health Ordinance is being developed. But this development has not involved the Law Reform Commission. A revised copy of a discussion paper on the new Mental Health Ordinance for the A.C.T. was issued in March 1976.[9] The final form of the Ordinance is still awaited. In the meantime the principal law governing mental health in the A.C.T. remains the outmoded N.S.W. Lunacy Act of 1898, which was received into the Territory when it was established in 1911.[10] Of course, the 1898 Statute was repealed in New South Wales in 1958 and that State is now in the midst of a major review of the 1958 Statute. It is to be hoped that the Commonwealth's initiative in the A.C.T. will not simply adopt the reforms of the 50s when, in the 80s, a second wave of reform is now spreading across the country.

A number of reports of the Australian Law Reform Commission have referred to the legal issues posed by mental ill-health. However, they have done so in passing only and upon issues peripheral to their principal concern. For example, in a major report on the reform of the laws governing criminal investigation by federal police, the Commission identified the special problems faced in the procedures of criminal investigation by particular groups in the community.[11] Special protective provisions were recommended for suspects who were children, migrants not fluent in English and Aboriginals. The Commission identified the special problems of the intellectually handicapped. But it postponed consideration of the issue as requiring discrete attention in the future. In doing so, it referred to an anecdote in an important essay on the legal rights of the mentally retarded[12]:

> One lawyer questioned a girl for an hour and a half. She answered his questions very well, slowly and deliberately perhaps, but nonetheless she had listened to the questions and had been responsive in her answers. He felt that he had ... a complete picture of his client. Then the other lawyer (who had a retarded child) ... asked her three questions (to look up her telephone number, count some change and add 24 and 24). The girl was unable to cope at all with these questions.

The Commission concluded that a future exercise would be required if we were to deal with the general problem of crime of the mentally disturbed or retarded. Similar observations could be made in respect of the disabilities in the whole criminal justice process of many persons suffering mental illness.

The Commission's report on Criminal Investigation was made on its first reference. Its latest report, Sentencing of Federal Offenders[13], released publicly last week, contains the first major review of federal punishment and sentencing ever conducted in this country. The report refers to the need for close examination of the provision of a custodial facility in the Capital Territory to house special groups of prisoners, including those suffering from established mental illness.[14] In the Capital Territory, prisoners, whether mentally ill or not, are transferred into New South Wales institutions. So it is also, throughout the nation, in the case of offenders against Commonwealth laws, wherever convicted. Federal prisoners are received into State prisons. The Commission has foreshadowed that in its final report on Sentencing[15] it will be dealing with the provision of hospital and treatment orders, including for cases of mental illness. Such orders are available in some Australian State jurisdictions. They permit a court, instead of imposing a normal custodial sentence, to order that an offender receive specialised treatment in a hospital and be subject to specified forms of security.[16] The Australian Institute of Criminology has a current project specifically to research the development of and safeguards in hospital orders of this kind.

In default of orthodox legal provisions to make orders for hospital treatment, judges in the Capital Territory have lately turned to improvisation. For example, Mr. Justice McGregor has been persuaded to impose a common law bond on a convicted prisoner with the condition that he will voluntarily enter a mental hospital.[17] As there is no mental hospital in the Capital Territory, the result was an obligation to be discharged in another jurisdiction.[18] The sentencing and punishment problems of mentally ill offenders will be addressed in a later Commission report.

In between these two reports: one dealing with problems at the beginning of the criminal justice system and the other at its end, the Commission has delivered consultative papers on the subject of child welfare law reform.[19] In examining the direction for the reform of child welfare laws, attention has had to be paid to a conflict of professional ideals, not at all dissimilar to that which the law and lawmakers face in coping with the legal implications of mental illness. Elsewhere, I have described child welfare law reform as a study in incompatible goals.[20] Legal systems have developed two basically differing approaches to the problems of young people who come to notice by reason of minor crimes. The choice between these two

approaches, or the discovery of some compromise between them, is a matter which has been under consideration in various Australian inquiries on child welfare law reform including that conducted by the Law Reform Commission. The first approach is what might be termed the 'interventionist' or 'welfare' approach. The minor crimes are viewed as a symptom of personal and social problems. Society's response is then directed towards meeting the child's needs. This approach is, in part, a reflection of the 20th century's assumption that the government on behalf of the whole people has a special welfare responsibility for people obviously in need of help. It is said that it is typical of lawyers to deal with the superficial criminality of particular acts, whilst ignoring the underlying causes for such criminality which will not go away simply by the imposition of a specific criminal punishment.

The other approach is what may be called the 'due process of law' approach. According to this view, society should concern itself and concern itself only with clearly identified, plainly harmful and unlawful conduct. Society's response should be directed towards social control of the child's deeds rather than a bungling and usually incompetent attempt by officials to solve the child's needs. It is said that the 'child saving' philosophy of looking beyond the offence to the child's needs carries with it the danger of denying the child the protection of due process of law which the community would not think of denying to an adult. Critics of earlier juvenile procedures point out that, despite benevolent motives, intervention by courts, welfare workers, social workers, psychiatrists and others frequently resulted in coercive action and very substantial inteference with the child's total liberty for a relatively minor offence. The attempts by strangers to solve human, family and social problems which lead to juvenile crime have, so it is said, enjoyed only limited success at a price of very considerable individual oppression.

This is not a theoretical debate. It is reflected in the approaches taken to child welfare laws in a number of countries with a society similar to our own. The interventionist approach, for example, is reflected in the Scottish law. There, a 'hearing' takes the place of a formal criminal court proceeding. If a child pleads guilty he or she does not have to go to court but comes before three laymen sitting in the 'hearing'. They have more limited powers than a court. But they can order a period of supervision and even that a child reside in an institution for a time. In these 'hearings' what begins with an inquiry into why a child took this or that article from a store frequently ends up in a detailed investigtion of the child's social and moral conduct. Complaints are made by parents that the child uses lipstick, stays out late, sees boyfriends and so on. The hearings become something of an inquisition into the 'whole child'. Supporters say that is what it

ought to be. Opponents say that such a response to relatively unimportant conduct would be regarded as outrageous in the case of adults and should not be tolerated in the case of children.

In the United States, the 'due process' principle is strictly observed, chiefly for constitutional reasons. Dealing with a child on a criminal matter, it is required that the child should be given every protection of the criminal law. The efforts to establish a Children's Court countenancing a relaxation of procedural safeguards, was declared constitutionally unacceptable by the Supreme Court of the United States.[21]

I cite this issue, which is currently before the Australian Law Reform Commission, because of its obvious parallels in the law's response to mental illness. The debate has now been sufficiently identified. At its extremes it is the debate between the so-called paternalism of the healing and helping professions and the so-called 'legal imperialism' of the law, which, conscious of the fallibility of 'experts' and the frequently limited utility of their craft is always anxious, by the provision of due procedures and institutions, to safeguard individual freedom from unfair and unnecessary deprivation.

EXCESSIVE MEDICAL DISCRETION

Concern about the legal rights of those classified as mentally ill has greatly advanced in recent years. Official reports in Britain[22] and Australia[23] as well as a wealth of medical and legal writing, have addressed particular issues. Whereas the typical British solution to difficult problems is to send them to a committee, in the United States courtrooms have been used to spell out the legal rights of the mentally ill[24]. The very concept of 'mental illness' itself has been questioned and in some places vehemently criticised.[25]

Australia's mental health laws do not specifically define what is meant by 'mental illness'.[26] This lack of precision, coupled with the very great power of personal oppression which may attend the diagnosis, is the source of the lawyer's concern. A famous American judge, Mr. Justice Brandeis of the United States Supreme Court, expressed the approach which has been typical of the English common law in its dealings with people having authority over individual liberty[27]:

> Experience should teach us to be most on our guard to protect liberty when the government's purposes re beneficient. ... The greatest dangers to liberty lurk in insidious encroachment by men of zeal, wellmeaning but without understanding.

We are not dealing here with trifling numbers of our fellow citizens. More than 60,000 people enter Australian mental hospitals every year. Between 25 and 30% of this number are committed as involuntary patients. What we are dealing with, then, is the personal freedom and individual liberty of a large and probably growing section of the community. One can see the problem in better perspective if it is remembered that on average the number confined in Australian prisons at any given time is in the order of 10,000 people.[28] Rightly, we devote a great deal of the law's attention to highly detailed protective machinery, refined over many centuries, to ensure that individuals are not unlawfully or needlessly committed to prisons. A major theme of the Law Reform Commission's report on Sentencing of Federal Offenders was precisely the need to find new, effective alternatives to imprisonment so that relatively high Australian prison rates can be brought down and the community spared the costly business of incarcerating people when other, no less effective punishments would suffice.[29]

The suggestions for the greater deinstitutionalisation of criminal punishment are not specially original. They have been made by many reports. They have been followed by much legislation, including in Australia. The same forces which lead us, in the area of criminal punishment, closely to question the utility of institutional confinement require similar questions to be asked in respect of society's response to those diagnosed as 'mentally ill'. Not only are institutions extremely expensive to the community which funds them. They are frequently oppressive to the individual, destructive of self-reliance and sometimes brutalising both to the institutionalised and those who guard them. In the criminal justice area, it is recognised that some, including some mentally ill persons convicted of criminal offences, must be confined under close security. But the search is now commenced to find, for many who do not require such oppressive treatment, controls which will be less costly and which will help to instil greater self-control and appreciation of the obligations that attend living in a modern interdependent community.

Just as the criminal justice system is now questioning the numbers it consigns to custodial institutions, so, I believe, increasingly we will see the same question asked in relation to the mentally ill. And when the question is asked in Australia, it appears that, to date, comparatively little work has been done to study the utility, both for patient and for society, of confinement in mental hospitals. A study by Dr. O.V. Briscoe in New South Wales analysed 1,000 consecutive admissions to the Rozelle Admission Centre, Callan Park Hospital, in Sydney. Dr. Briscoe found that over one-half of those admitted were not suffering from 'mental illness' in any strict interpretation of the term. According to his study, most of those persons were suffering personality disorders or drunkenness or were vagrants requiring social attention or individuals displaying symptoms of instability in public.[30] Dr. Briscoe's conclusion:

> The impression given was really that almost anyone whose acute behaviour could not be controlled within the accepted norms of society either at home or in hospital might be admitted as 'mentally ill', particularly if there was known to be some medical condition as well. ... The average stay was eight days.[31]

At a Melbourne seminar a number of medical officers claimed that people in urgent need of medical attention through accident or serious illness were inappropriately certified and that one in every five patients (some claimed one in three) certified could be sent home immediately.[32] A newspaper report attributed to the Deputy Chairman of the Mental Health Authority in Victoria agreement with this claim.[33]

In what I have termed the 'first wave' of mental health law reform, important steps were taken towards liberalisation of our mental health laws in Australia. These steps were vital to provide the ground for greater community understanding of the problems and possibilities in the area of mental health. The most important innovation was probably the facilitating of voluntary admissions to mental hospitals. Such admissions now constitute the overwhelming majority of admissions into mental hospitals in Australia. Until this reform, it had generally been felt incompatible with lunacy laws that a person could form the sufficient intent to seek admission voluntarily. Such were the forbidding physical conditions and surroundings of the so-called 'lunatic asylums' that this view was perhaps understandable. When the high walls which physically guarded the 'asylums' came down, the community's attitudes to mental health began to change. Let no-one doubt that these were salutory, overdue, beneficial developments.

But at the same time as lunacy laws were repealed, their system of close legal regulation was, by and large, replaced by a system of medical discretion. The chief characteristic of the 1898 Lunacy Act in New South Wales, for example, was that persons were not involuntarily detained without a full and open inquiry by a judicial officer (a magistrate) before their admission. This inquiry was held away from the hospital itself. The involuntary loss of liberty could not occur without an appropriate judicial order, given in orthodox legal proceedings.[34] After the first wave of reform, things changed. In the N.S.W. Act in 1958 it became possible for a person to be taken to an admission centre on the certificate of one doctor alone. A very limited magisterial hearing would take place, not in a place away from the hospital itself, but at the very hospital in which the person was involuntarily detained. This remains the position in New South Wales today. And it is not atypical. It was criticised in a report of the Mental Health Act Review Committee chaired by Dr. G.A. Edwards.[35] That committee, established in 1972, reported in 1976.

The basic approach of the committee was to propose the significant reduction of some of the powers and discretions of the medical profession in order to lay greater emphasis upon the rights of the patient and the provision of machinery protective of those rights. So far as the control of psycho-surgery was concerned, the report of a Committee of Inquiry chaired by Mr. M. L. Foster Q.C. recommended restrictions considerably more stringent than those proposed by Edwards.[36] Legislation in New South Wales following these two reports and amending the 1958 Mental Health Act of that State is expected to be introduced shortly.

The change of approach signified by the 'second wave' is indicated in the Edwards Committee report. It recognised that a person suffering from mental illness (within the general sense of that term) might suffer harm other than physical harm. He might suffer social harm in the nature of embarrassment or ridicule. He might suffer harm in the nature of lost employment prospects or harm of a financial nature for himself or his family. However, it was the view of the committee that, whilst it would in some cases be appropriate for attempts to be made to persuade such a person to accept voluntary treatment, harm of a social, moral or financial nature should not justify detention without consent. In other words the approach taken suggested a much stricter requirement of 'harm' before a person should unwillingly lose his freedom. If I can say so, I believe that in this regard the Edwards Committee pointed those concerned with mental health law reform in Australia in the right direction.

In South Australia important reforms to mental health law commenced operation in October 1979 when the Mental Health Act 1976-7 was proclaimed to come into effect.[37] The Act provides a new code for the treatment and protection of persons who are mentally ill or handicapped. It expressly provides a list of objectives which the Director of Mental Health Services and the South Australian Health Commission should 'seek to attain'.[38] The first of these objectives is that patients should receive the best possible treatment and care.[39] The second is relevant to my discussion. It is:

> 9(b) To minimise restrictions upon the liberty of patients, and interference with their rights, dignity and self-respect, so far as is consistent with the proper protection and care of the patients themselves and with the protection of the public.

The Act introduces detailed machinery and procedures which are designed to achieve the stated objects. I shall revert to these shortly. In section 14 provision is made for involuntary and immediate admission and detention of a person in an approved hospital. It is required tht the legally qualified medical practitioner should be satisfied:

(a) that the person is suffering from a mental illness that requires immediate treatment;

(b) that such treatment can be obtained by admission to and detention in an approved hospital; and

(c) that that person should be admitted as a patient in an approved hospital in the interests of his own health and safety or for the protection of other persons.

The definition in the new South Australian Act is quite close to that proposed by the Edwards Committee in New South Wales, although it is somewhat wider. It leaves significant room for medical discretion in respect of what is in the 'interests of' the health of the patient. It omits the Edwards requirement that the risk to 'safety' should be 'the risk of serious bodily injury'. The reference to 'the protection of other persons' is not defined. In the context, it may, as a matter of law, exclude mere affront to other persons or upsetting susceptible and orthodox people who become offended with behaviour that is merely eccentric or unusual.

Again, I must explain the lawyer's reservations. They arise from the fact that mental illness is rarely defined, even in psychiatric textbooks.[40] The apparent faith in psychiatry is not always borne out by the results of psychiatric treatment. Many psychiatrists would surely agree with this. Within psychiatry there are differing and sometimes competing, conflicting schools of thought. Without specific criteria and a real prospect of useful curative treatment, commitment to a hospital, in a particular case, may be oppressive and even arbitrary. In the United States, Professor Kingsley Davis, as long ago as 1938, warned against the dangers of society's implicitly trusting the power of a psychiatric cure, particularly for those who do not conform to orthodox and ethical standards:

> Mental hygiene can plunge into evaluation; into fields the social sciences would not touch, because it possesses an implicit ethical system which, since it is that of our society, enables it to pass value judgments to get public support and to enjoy an unalloyed optimism. Disguising its valuational system (by means of the psycho-logistic position) as rational advice based on science, it can conveniently praise and condemn under the aegis of the medico-authoritarian mantle. ... The legitimacy of imposing one's ethical standards on others is a philosophical question of the utmost importance. ... That commitment could only be justified, if at all, in extraordinary and rare cases, is clear. I suspect that [J.S. Mill] would have abhorred the commitment of a person who merely did not match up to society's ethical standards of the day.[41]

The lack of definition of 'mental illness', the extreme consequences that may attend its diagnosis, and the growing enlightenment of the community about mental health and tolerance of individual difference has led to efforts to spell out more clearly and in a much more circumscribed way, the conditions under which diagnosed mental illness can lead to involuntary confinement. Perhaps the most celebrated recent attempt is that by the legislature and government of the Canadian Province of Ontario. Changes to the Mental Health Act of Ontario were proclaimed to commence on 1 November 1978. They followed a careful study and a thoughtful debate in the legislature. The principal aim was to clarify the legal rules governing mental health care in the Province. The reforms were introduced with a full realisation that Canadian statistics showed that a high proportion of people would, at some point of their lives, require hospitalisation because of mental disorder.[42]

In addition to citing the greater community understanding of mental illness today, a government statement on the new Act pointed out that the past quarter century had already seen changes in the delivery of mental health services. Reference was made to:

- Modern chemotherapy, including tranquilisers and antidepressant drugs
- The philosophy of treatment in the community, with hospitalisation as a last resort. This has tended to reduce the numbers of patients in psychiatric institutions in Ontario by two-thirds
- Services were developed for voluntary treatment and outpatient care
- New attention was given to rehabilitation services, day care, counselling services, residential accommodation, approved homes, sheltered workshops and volunteer programmes.

As in Australia, voluntary admissions to psychiatric hospitals in Ontario numbered 75%.[43] But the problem for the law was then stated bluntly:

> While these changes in attitude and treatment methods were taking place over the past decade, the surrounding legislation was standing still. There was also confusion about some of the terms in the legislation.

Because of the uncertainty of the 'safety' concept and the different approach taken to it by different physicians[44], the Ontario Act sought to be more specific. This is how it approaches the issue of when and why a physician may make an application for psychiatric assessment that requires that the person be taken into custody:

> Where a physician examines a person and has reasonable cause to believe that the person:

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or

(c) has shown or is showing a lack or competence to care for himself

and if in addition the physician 'is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that is likely to result in

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) imminent and serious physical impairment of the person

the physician may make application in the prescribed form for a psychiatric assessment of the person.

The Ontario criteria are much narrower than those contained in the South Australian Act. They are much narrower than those contained in any other Australian statute. The generality of the language of 'in the interests of his own health' or 'in the interests of his safety' or 'for the protection of other persons' is abandoned for a much more rigorous and specific list of criteria. These lay emphasis upon the reasonable conviction of two things. The first, as to past behaviour, lays emphasis upon bodily harm and incompetence to care for himself. The second, which is also required, is directed at future behaviour. It requires an assessment of a serious physical or bodily risk if nothing is done. It is a long way from mere affront or harmless un-orthodoxy.

An approach alternative to that adopted in the Ontario statute would be to retain language of the generality of Australian Acts and either to provide for the statutory exclusion of certain innocuous conduct or to supply machinery of external scrutiny of medical decisions which will give proper weight to the value our society traditionally puts upon liberty: including the liberty of those alleged to be mentally ill.

PROVISION OF PROTECTIVE MACHINERY

It is in this last approach that the new South Australian legislation makes important advances. Everyone concerned with mental health law reform in Australia will be studying the effectiveness of their operation.

The Mental Health Review Tribunal is established to consider whether a person should continue to be held involuntarily. It must carry out its review within two months of a person's being received into custody or detention and thereafter the circumstances of the person must be reviewed at periodic intervals, at least every six months, so long as he remains in involuntary custody.[45] In addition to statutory review, provision is made for appeal to the tribunal against detention or other orders of the new Guardianship Board. Provision is also made for an appeal to the Supreme Court from any decision or order of the Tribunal. A relative of the patient is given legal standing to institute such an appeal. Section 16 of the Act provides that patients and relatives are to be given a printed statement setting out rights of appeal and rights to representation. These are very important provisions for the law's rash assumption that everyone is intimately acquainted with its every rule is especially unreliable in predicaments of this kind. The Law Reform Commission, in the area of police interrogation, suggested a similar facility of written notices.[46] It also suggested the facility of translations, an idea happily picked up in this Act.[47]

Perhaps the most innovative provision of the new South Australian Act is section 39 which provides that in every application to the tribunal or Supreme Court the person in respect of whom the appeal is brought shall be represented by counsel. Neither the tribunal nor the court may dispense with this requirement unless it is satisfied that the person does not wish to be represented and that the person 'has sufficient command of his mental facilities to make a rational judgment in the matter'. Provision is made for a system of representation for those persons unable or unwilling to meet the costs of engaging a lawyer. I understand that in practice the scheme is administered by the Legal Services Commission. The Health Commission is to pay the costs.

So far as published material is concerned, the only report on the operation of the new scheme records that to the end of February 1980 the Guardianship Board had made over 150 orders but the Tribunal had heard only one appeal against detention and in that case the patient was unrepresented. By 18 March 1980, 5 applications for representation at appeals against detention had been lodged.[48] These figures, and later information, may indicate a growing use of the new machinery and the effectiveness of external legal review. It will be important to know whether the law's machinery can act quickly enough, sensitively enough and with an appropriate mixture of trust in professional medical judgments, on the one hand, the scepticism about claims of psychiatric diagnosis and treatment, on the other.

That there is usually a need for effective representation of the individual if external scrutiny is to be more than a placebo, is plain from

the experience gathered on the operation of other Australian Mental Health Acts. In New South Wales, the Edwards Committee recommended that a pilot scheme be implemented to investigate the desirability or otherwise of providing a legal representation service for all patients admitted involuntarily to a mental hospital. The Legal Representation Committee was established in May 1976, chaired by Dr. L. Young. Four guiding principles were accepted:

(1) That representation will be free of charge to the patient
(2) That the service would be independent of the hospital and the Health Commission
(3) That all involuntary patients would be offered representation
(4) That the patient representatives would act on the instructions of the client even though they may believe that these were not in his best interests.

In the course of the pilot project, various forms of representation were tried: a duty solicitor scheme, a full-time legal officer scheme and a full-time non-legal representative scheme. In July 1978 the committee presented a report to the N.S.W. Minister for Health:

> Statistical data collected by the committee at Rozelle Hospital indicated that the discharge rate rose from 2% of cases to 8% when the representative service was introduced, but that discharged tended to occur only after the patient had attended several hearings (i.e. had had his/her case deferred at least once). In fact the number of initial hearings that resulted in a deferment rose from 8% to 21% with the introduction of patient representation, in spite of the fact that such a course of action is not one of the options explicitly stated as being available to the magistrate in the current Mental Health Act. A further finding was that with the introduction of patient representation, magistrates were more likely than before to specify shorter committal periods. Committal orders for the maximum period allowed (six months) fell from 89% of cases to 50% and orders for committal for shorter periods rose from 3% to 29%. Survey data revealed that while some medical staff were critical of particular aspects of the representation at Rozelle, the clear majority believed that there should be some form of patient representation at committal hearings.

The N.S.W. Committee recommended a policy of providing free representation, the establishment of a service employing one lawyer, three non-lawyers who would be representatives and one administrative officer and that the scheme be implemented as a pilot project for 12 months so that its effectiveness could be judged.

Before the Young Report, the Edwards Committee had estimated that fewer than one in ten persons appearing before a magistrate for involuntary committal were legally represented. But the Young Committee noted that, having monitored over 900 cases at admission centres other than Rozelle, it could be confidently stated that the actual rate of representation was less than one in a hundred. Young also found that committal for the maximum period allowable by law tended to be made routinely by some magistrates. It cited Newcastle, Kenmore and Gladesville Hospitals as containing inmates 98% of whom were subject to six-month orders. Most cases had been dealt with on written medical evidence only: making questioning or clarification of the medical assessment difficult or inconvenient. The Young Report disclosed that medical staff attended only 3% of inquiries at Gladesville, 5% at Rydalmere and 6% at North Ryde. Attendance of relatives was also generally low. This was blamed, in part, upon the obscure nature of the form of notice given.[49]

The provision of effective, questioning, critical and independent representation of a person subject to committal to a mental hospital, as proposed by the Young Committee and as provided for in the new South Australian legislation, represents a distinct advance for liberty in our country. Although it is too soon to assess the operation of the South Australian scheme, the results are likely to be similar to those predicted by the Young Committee in New South Wales.

- Representation will rise from derisory to significant figures
- Relatives will be encouraged to participate more closely in the committal issue
- There will be fewer applications for committal and fewer committals upon them
- Committals will be for shorter periods

When the community is educated to get out of its mind stereotype pictures of people with mental health problems, these developments will come to be seen as socially desirable. It is vital that the system of involuntary admission should be recognised as second only to the criminal justice system in the impact it can have on the civil rights of the individual to liberty. Imagine what an outcry there would be if a person were sentenced to imprisonment in Australia without a trial or for a generalised purpose such as 'the protection of others'. Nowadays, few are liable to imprisonment for a crime without having had the benefit of legal representation.[50] The needs of those subject to involuntary admission to a mental hospital may even be greater than those of criminal suspects. Because of disability and medication, their capacity to present their own case may be substantially diminished. This is not a matter of forcing lawyers and other representatives on confused, disturbed or dangerous mental patients. It is a matter of

providing checks against the needless loss of freedom by people whose conduct, though it may be unusual, does not typically endanger themselves or society. The normal way the English-speaking people have provided those checks is by an adversary process which puts assertions and the claims of authority under attentive, vigorous questioning. It has been said that the very existence of this scrutiny is the reason why oppression and the interference of authority is rarer in our form of society than in most others.

With the passage and commencement of the new South Australian legislation, the debate has moved on. No longer is it about whether a universally available representation scheme should be created. The issue is now the form, quality and organisation of such representation and the effectiveness of its labours. This is not necessarily a plea for more work for lawyers. Indeed, I am sure that effective representation in some cases could be offered by a skilled laymen who had built up a detailed knowledge of procedures, relevant criteria and medical information, with which to test applications for committal. But the saving grace of the legal profession in the history of our liberties has been its independence and its persistent, sometimes obdurate, scrutiny of official acts. It is my hope that the legal profession of Australia will find relevant tasks to replace some of the functions performed by it, which are now under question. If I can say so, there is probably no function upon which lawyers have more to offer than representation of the individual when his freedom is at stake.

REFORM OF SUICIDE LAW

There are many topics of mental health and the law which have not been mentioned in this lecture. The special new problems created by drugs of addiction[51], the discrete problems of the intellectually handicapped[52], the special necessities of persons found mentally ill or incompetent before or at a criminal trial[53], how to scrutinise and review persons held during the Governor-General's or Governor's pleasure and the reform of the law relating to suicide. All of these, and many more, require attention. May I say a few words only about the law of suicide?

In New South Wales and South Australia it is still a common law misdemeanour to attempt to commit suicide. A survivor of a 'suicide pact' who kills the other party, is guilty of murder, for the common law regards such a person as having encouraged the other to commit self murder. The Criminal Codes of Queensland, Tasmania and Western Australia did not treat suicide as a form of murder. Specific crimes were created or aiding or instigating the suicide of another or of attempting to commit suicide. The crime of attempted suicide was repeated in Tasmania in 1957 and in Western Australia in 1972.

In the United Kingdom, by virtue of the Suicide Act 1961, suicide has ceased to be a crime. The Act provided simply that:

> The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated.[54]

Section 2 of the same Act created a specific offence of aiding, abetting, counselling or procuring a suicide or attempted suicide. Victoria has enacted provisions similar to those of the United Kingdom Act. Since the Crimes Act 1967 (Vic.), suicide and attempted suicide have ceased to be criminal acts. The survivor of a suicide pact (who apart from the statute itself would be guilty of murder) is now liable to be charged only with manslaughter.

The Canadian Criminal Code has no crime of attempting to commit suicide. It merely creates an offence of counselling, procuring, aiding or abetting a person to commit suicide.[55]

The Criminal Law and Penal Methods Reform Committee in South Australia, chaired by Justice Roma Mitchell, recommended that legislation should be introduced similar to that of Victoria. It pointed out that the prosecution of a person for attempted suicide was unlikely to be a deterrent either to the persons themselves or to others with a similar intention. Current practice is not to prosecute those who attempt suicide. The Mitchell Committee's investigations ascertained that there had been no prosecution for many years. The position is similar in New South Wales.

On 30 November 1978 the Legislative Assembly of New South Wales agreed to the following motion:

> That this House is of the opinion that the offence of attempting to commit suicide should be abolished provided that compassionate laws are immediately enacted to provide assistance to treatment of and support services for persons who attempt to take their own lives and provided also that the culpability for assisting a suicide or suicide attempt is maintained.

The Mitchell Committee (and the New South Wales Assembly) are surely right. No useful purpose can be served by retaining the crime of attempting to commit suicide. What utility does the maintenance of this crime serve, particularly when it is now well known that the crime is not prosecuted? Some might say that if there were a real risk of prosecution the depression of the suicide would be intensified and an additional basis provided for further and successful attempts. The road to reform here requires:

. bringing the law 'in the books' into line with the law in practice;
. abrogation of the law under which suicide or attempted suicide is a crime;
. provision that the survivor of a suicide pact who kills the deceased party is guilty not of murder but of manslaughter; and
. provision for a specific offence of inciting, counselling, aiding or abetting the suicide or attempted suicide of another.

The provision of proper support services and facilities and the amendment of the criminal law in this way would result in provisions much more closely tuned to our society's current compassionate attitude to this problem. We have come a long way since the suicide was buried at the crossroads, far from hallowed ground, and with a stake through his heart. But whilst society moves on, the law marches with it 'but in the rear and limping a little'.[56]

CONCLUSIONS

1981 will be the International Year of Disabled Persons. The Commonwealth and the States are already preparing for a vigorous participation in this enterprise. In May 1980 an Advisory Council was established in Adelaide. An Adelaide lawyer, Mr. Paul Anderson, himself a quadraplegic, is its Chairman. The aim of the year is to promote recognition of the distinctions between impairment, which is a quality of the individual; disability, which is a functional restriction due to that impairment; and handicap, which is the social consequence of the disability.

It is my hope that, in the proper concern about handicaps suffered by people with physical disabilities, Australian society will not overlook the handicaps of those with mental disabilities. Perhaps the International Year of Disabled Persons will be an unrivalled opportunity for public education. The motto of the Year should be 'Down With Stereotypes!' The medical profession, the healing professions generally and many others in society will contribute to ideas and activities during the International Year of Disabled Persons. There is no doubt that the mentally ill and the intellectually handicapped suffer additional disadvantages in the state of our law. It is my hope that lawyers, lawmakers and law reformers will play their part to improve this situation. I hope I have said enough to show that in the area of mental health, there is plenty of room for law reform.

FOOTNOTES

1. Superintendent of Belchertown State School v. Saikewicz (1977) Mass. Adv. Sh. 2461, 2495; 370 N.E. 2d. 417, 432 (1977).

2. As explained in A. Buchanan, 'Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling Saikewicz-type Cases', 5 American Journal of Law & Medicine 97 (1979).

3. In Re Quinlan 70 NJ 10, 355A. 2d. 647 (1976).

4. Buchanan, 114.

5. Australian Constitution, s.51(xxiii) and (xxiiiA).

6. The Universal Declaration of Human Rights, 1948. See also the International Covenant on Civil and Political Rights, which Australia ratified in August 1980.

7. The United Nations Declaration on the Rights of Mentally Retarded Persons, 1971.

8. T. Carney, 'Social Security and Welfare Services for Retarded People: the State of the Art.' (1979) 12 Melbourne Univ.L.Rev. 19.

9. Capital Territory Health Commission (A.C.T.), Discussion Paper on Proposals for a Mental Health Ordinance for the A.C.T., Feb. 1976, mimeo.

10. Seat of Goverment Acceptance Act 1909 (Cwlth), Seat of Government (Admdinistration) Act 1910 (Cwlth). The Inebriates Act 1900 (N.S.W.) is also relevant. Three local ordinances have been enacted namely Insane Persona & Inebriates (Committal and Detention) Ordinance 1937, Lunacy Ordinance 1938 and Mental Health Ordinance 1962. The last is not a comprehensive mental health law.

11. The Law Reform Commission, Criminal Investigation (ALRC 2) 1975, chapter 9.

12. D.E. Haggerty et al, 'An Essay on the Legal Rights of the Mentally Retarded', (1972) 6 Family LQ 59, 60. See ALRC 2, 117.

13. The Law Reform Commission, 'Sentencing of Federal Offenders' (ALRC 15) 1980 (interim).

14. ibid, 316. See also ALRC DP 10, para. 58.

15. ALRC 15 is an interim report. See ibid, 305.

16. See ALRC DP 10, para. 103. Relevant legislation includes Mental Health Act 1959 (Vic.) s.51; Mental Health Act No. 2 1976 (Qld), ss.32, 33; Criminal Law Consolidation Act (S.A.) 1935-75 s.77(a); Convicted Inebriates Rehabilitation Act 1963 (W.A.) and Mental Health Act 1963 (Tas.) s.47. See also Alcohol & Drug Dependency Act 1968 (Tas.) s.30(1).

17. R. v. Smith [1979] 3 Crim.LJ 40. Cf. R. v. Riley [1979] 3 Crim.LJ 27. See also R. v. Mooney [1978] 3 Crim.LJ 351.

18. Attention is also drawn to the need for provide for credit to be given for time served in custody in a mental institution. Cf. R. v. Wood [1977] 1 Crim.LJ 50.

19. The Law Reform Commission, 'Child Welfare: Children in Trouble' (ALRC DP 9) 1979; Child Welfare: Child Abuse and Day Care' (ALRC DP 12) 1980.

20. M.D. Kirby, 'Child Welfare Law Reform: A Study in Incompatible Goals', paper delivered at La Trobe University, 9 June 1980, mimeo.

21. Re Gault 387 US 1 (1967).

22. Report of the Committee on Mentally Abnormal Offenders (Lord Butler, Chairman), Cmnd 6244 (1975); Report on the Review of Procedures for the Discharge and Supervision of Psychiatric Patients Subject to Special Restrictions, Cmnd. 8932 (1973).

23. Criminal Law & Penal Methods Reform Committee (S.A.), Third Report, Court Procedure and Evidence; Victorian Law Reform Commissioner, Report No. 2, Criminal Procedure Miscellaneous Reforms, 1974; Mental Health Act Review Committee of New South Wales, Report (Edwards Committee) 1975-6.

24. See for example F.N. Flaschner, 'Constitutional Requirements in the Commitment of the Mentally Ill in the U.S.A.: Rights to Liberty and Therapy', 18 International Journal of Offender Therapy and Comparative Criminology 283 (1974). L.B. Kassirer, 'The Right to Treatment and the Right to Refuse Treatment: Recent Case Law', 2 Journal of Psychiatry and the Law, 455 (1974). See also now Civil Rights of Institutionalised Persons Act 1980 (Public Law 96-247) in 48 U.S. Law Week 133 (1980).

25. See for example T. Szasz, 'The Myth of Mental Illness', 1961. Cf. R.D. Laing and A. Esterson, 'Sanity, Madness and the Family' 1970.

26. See the analysis of this problem in A. Freiberg, '"Out of Mind, Out of Sight": the Disposition of Mentally Disordered Persons Involved in Criminal Proceedings' (1976) Monash Univ.LRev 134.

27. Olmstead v. United States, 277 U.S. 438, 479 (1928) (dissenting).

28. For rates of imprisonment in Australia see ALRC 15, 113. The number of adult prisoners in August 1979 was 9,993.

29. ALRC 15, Chapter 6.

30. O.V. Briscoe, 'The Meaning of "Mentally Ill Person" in the Mental Health Act 1958-1965 of New South Wales', (1968) 42 Australian LJ 207.

31. ibid, 212.

32. See Freiberg, n.26. The analysis here is drawn from Freiberg's article. Note that Victoria is reported to have a review in train, The Age, 11 September 1980, 13.

33. 'The Age' 26 August 1975.

34. Lunacy Act 1898 (N.S.W.), ss.4-8. See G.D. Woods, 'Involuntary Admissions to Mental Hospitals, Ph.D. Thesis (Syd.Uni.) 1979.

35. Edwards Committee Report. See above n.23.

36. Report of the Committee of Inquiry into Psycho-Surgery (Mr. M.L. Foster Q.C., Chairman), 1978.

37. R. Greycar, 'Legal Representation Under the South Australian Mental Health Act' (1980) 5 Legal Service Bulletin, 72.

38. Mental Health Act 1976-1977 (S.A.), s.9.

39. ibid, s.9(a).

40. T.S. George, 'Commitment and Discharge of the Mentally Ill in South Australia' (1971-72) 4 Adel.L.Rev. 330, 339. The article states the position before the 1976 Act came into force.

41. Kingsley Davis, 'Mental Hygiene and Class Structure', 1938 Psychiatry.

42. Ontario, Ministry of Health, 'Rights and Responsibilities: the Mental Health Act 1978', 1978, 4. See also G. Sharpe, The Ontario Mental Health Act 1978. A Legal Perspective (1970) 24 Canadian Journal of Psychiatry 517.

43. ibid, Ontario Ministry of Health, 4. In South Australia, the number was similar. George states that 74% of all receiving house admissions were informal in 1970.

44. Some, for example, thought that a threat to a patient's reputation, financial status or family stability provided appropriate grounds for commitment under the 'safety' concept. Others did not.

45. Mental Health Act 1976-1977 (S.A.), s.35.

46. ALRC 2, 44.

47. s.16(3).

48. Greycar, 73.

49. The telegram typically sent by the Morisset Hospital read 'A magisterial inquiry into the mental condition of ... is to be held on .... Your attendance at this inquiry is not obligatory. Mental Superintendent, Morisset Hospital'.

50. McInnis v. The Queen (1979-80) 27 ALR 449

51. T. Carney, 'Drug Users and the Law', Ph.D. Thesis, (Monash) 1979.

52. Carney, n.8.

53. Freiberg, 142.

54. Suicide Act 1961 (U.K.), s.1.

55. Canadian Criminal Code, s.224.

56. Windeyer J. in Mt. Isa Mines Limited v. Pusey (1971) 45 ALJR 88.