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WHO ARE THE 'MENTALLY ILL'?

Concern about the legal rights of those classified as mentally ill has greatly advanced in recent years. Official reports in Britain[1] and Australia[2], 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[3]. The very concept of 'mental illness' itself has been questioned and in some places vehemently criticised.[4]

Australia's mental health laws do not specifically define what is meant by 'mental illness'.[5] 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.

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 is in the order of 10,000 people.[6] 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.

The same forces which lead us, in the area of criminal punishment, to question closely the utility of institutional confinement and to search for effective alternatives, require similar questions to be asked in respect of society's response to those diagnosed as 'mentally ill'. Institutions are not only 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.

It appears that, to date, comparatively little work has been done to study the utility, both for patient and for society, of confinement in Australian mental hospitals. A study by Dr. O.V. Briscoe 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.[7] 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.[8] A newspaper report attributed agreement with this claim to the Deputy Chairman of the Mental Health Authority in Victoria.[9]

THE 'FIRST WAVE'

Moves to ameliorate the treatment of the mentally ill can be traced to Biblical times. In recent Australian history, however, the 'first wave' of mental health law reform occurred in the late 1950s and early 1960s with the passage in all States of Mental Health Acts, replacing 19th century lunacy laws. Important measures were taken towards liberalising the mental health laws of 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 that it was incompatible with lunacy laws for a person to 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 enlarged 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.[10] After the 'first wave' of reform, things changed. For example, in the N.S.W. Act of 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. It is not atypical. It was criticised in a report of the N.S.W. Mental Health Act Review Committee chaired by Dr. G.A. Edwards.[11] 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 Dr. Edwards.[12] Legislation in New South Wales following these two reports, amending the 1958 Mental Health Act of that State, has been foreshadowed.

THE 'SECOND WAVE'

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 what constitutes 'harm', before a person should unwillingly lose his freedom.

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.[13] The Act provides a new approach to 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'.[14] The first of these objectives is that patients should receive the best possible treatment and care.[15] The second is:

(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. In section 14 provision is made for involuntary and immediate admission and detention of a person in an approved hospital. It is required that 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, although, 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.

The lawyer's reservations stem from the fact that mental illness is rarely defined, even in psychiatric textbooks.[16] 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 or even 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. There are obvious dangers in society's implicitly trusting the power of a psychiatric cure, particularly for those who do not conform to orthodox social and ethical standards.[17]

ONTARIO REFORMS : SPELLING OUT THE CRITERIA

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 unorthodoxy and individual differences 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 notable 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 in their lives, require hospitalisation because of some form of mental disorder.[18]

As in Australia, voluntary admissions to psychiatric hospitals in Ontario numbered about 75%.[19] Rehabilitation services, outpatient care, counselling services and volunteer programs have all been increased. But the problem for the law remains. While these changes in professional and community attitudes 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[20], the Ontario Act was drawn up to be much more specific.

> 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 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, in the mind of the physician, 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 is to retain language of the generality found in relevant Australian Acts and either to provide for the statutory exclusion of certain innocuous conduct or to supply machinery providing external scrutiny of medical decisions which will ensure proper weight is given 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.

A 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.[21] 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.[22] 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.[23] 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, and 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. 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 cases 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.[24]

When the community is helped by education 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.[25] 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.

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[26], the discrete problems of the intellectually handicapped[27], the special necessities of persons found mentally ill or incompetent before or at a criminal trial[28], 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. I address only the issue 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.[29]

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 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. But lasting reform is not achieved by reliance on a prosecutor's discretion.

On 30 November 1978 the Legislative Assembly of New South Wales agreed to a motion calling for abolition of the offence of attempting to commit suicide. It proposed that compassionate laws be immediately enacted to provide assistance to treatment of and support services for persons who attempted to take their own lives. No reform has yet occurred.

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 even 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 society's 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 and medicine move on, the law marches with them 'but in the rear and limping a little'.

DOWN WITH STEREOTYPES!

1981 will be the International Year of Disabled Persons. The Commonwealth and the States are already preparing. In the proper concern about handicaps suffered by people with physical disabilities, Australian society should 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. In the area of mental health, there is plenty of room for law reform.

FOOTNOTES

* A revised version of the author's 20th Barton Pope Lecture, delivered in Adelaide on 23 September 1980, for the South Australian Association for Mental Health.

** Chairman of the Australian Law Reform Commission.

1. 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).

2. 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.

3. 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).

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

5. 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.

6. For rates of imprisonment in Australia see The Australian Law Reform Commission, Sentencing of Federal Offenders (ALRC 15) (Interim) 1980, 113. The number of adult prisoners in August 1979 was 9,993.

7. 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.

8. See Freiberg, n.4. 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.

9. 'The Age' 26 August 1975.

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

11. Edwards Committee Report. See above n.2.

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

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

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

15. ibid, s.9(a).

16. 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.

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

18. 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.

19. ibid, Ontario Ministry of Health, 4.

20. 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.

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

22. Provision is made for translations. See ibid, s.16(3).

23. Greycar, 73.

24. 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'.

25. But see McInnis v. The Queen (1979-80) 27 ALR 449

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

27. T. Carney, 'Social Security and Welfare Services for Retarded People : The State of the Art' (1979) 12 Melbourne Univ. Law Rev. 19 and D.E. Haggerty, et al 'An Essay on the Legal Rights of the Mentally Retarded', (1972) 6 Family LQ 59.

28. Freiberg, 142.

29. Suicide Act 1961 (U.K.), s.1. See also the Canadian Criminal Code, s.224.

30. Mr. Justice Windeyer in Mt. Isa Mines Limited v. Pusey (1971) 45 Australian L.J. Reports 88.