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INSTITUTE OF CRIMINOLOGY
SYDNEY UNIVERSITY LAW SCHOOL

Proceedings of a Seminar on

MEDICAL AND LEGAL ASPECTS OF CURRENT MENTAL HEALTH LEGISLATION

Convenor: Mr T. S. Davidson, Q.C.

CHAIRMAN:
Mr T. S. Davidson, Q.C., President, Mental Health Tribunal

17 September 1986
State Office Block, Sydney

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FOREWORD

T. S. Davidson, Q.C.,
President, Mental Health Tribunal,
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Criminology.

The *Mental Health Act 1983,* and related provisions of the *Crimes (Mental Disorder) Amendment Act 1983,* represent the end results of a process of debate and discussion which has continued for over eleven years, including two seminars conducted by this Institute.[1]

For many psychiatrists this legislation represents a further and unwarranted interference into matters which they regard as being essentially of medical concern; for some lawyers it represents a long overdue statutory recognition of the rights of the mentally ill to be free of the risk of involuntary incarceration and non-consensual treatment for mental illness except in circumstances rigorously defined and limited by considerations of necessity in the public interest.

Although the selection of two psychiatrists and two lawyers to present the major contributions to this seminar seems to emphasize and reflect this apparent polarisation of concerns, it is really an oversimplification of a complex set of problems involving many contentious issues. Nevertheless, although this polarity exists only at a superficial level, it serves to provide a convenient framework for debating the issues dealt with in the legislation.

The provisions of the *Crimes (Mental Disorder) Amendment Act 1983,* and Part VII of the *Mental Health Act 1983,* dealing with the defence of insanity and the question of fitness to be tried, address problems which are only to a very limited extent the direct concern of psychiatrists. On the other hand, these problems have much to do with the failure of the legal profession and the bureaucracy to stimulate earlier effective reform in areas of the common law. We should not have tolerated for so long, and with such apparent equanimity, the fact that persons *acquitted* on the ground of mental ill health were incarcerated without provision being made for formal automatic and periodic review of their cases with a view to release if this would not be contrary to the public interest. Nor should we have accepted for so long the fact that persons *unfit to be tried* should have been incarcerated indefinitely, sometimes for periods longer that the maximum possible sentence which might have been imposed after a conviction. It remains to be seen, as Mr Harrison's paper suggests, whether the introduction of automatic periodic review and of the "special hearing" and the "limiting term" will provide a satisfactory redress, but at least the initiative has been taken.

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[1] Syd. Inst. Crim. Proc. No. 22, *Proposed Amendments to the N.S.W. Mental Health Act 1958* (N.S.W. Govt. Printer, 1975); Syd. Inst. Crim. Proc. No. 34, *Rights of the Mentally Ill: Representing Patients at Mental Health Act Hearings* (N.S.W. Govt. Printer, 1978). *See also* Syd. Inst. Crim. Proc. No. 1, *Fitness to Plead* (N.S.W. Govt. Printer, 1967).

The approach which the mental health advocate takes in representing a patient whose capacity to give instructions may be in question in the proceedings, seems to raise problems essentially for the lawyer and, in particular, whether he should invariably adopt the "strict instructions" approach or whether on occasions it is proper for him to adopt the "best interests of the patient" approach. Some psychiatrists, however, from time to time, express anxiety, and occasionally even resentment, at the intrusion of the advocate. The prospect of a psychiatric opinion being challenged and being tested in cross-examination by one who is not likely to be qualified by training or experience to do so, and canvassing, in the presence of the patient, matters which may tend to undermine confidence in the psychiatric advisor, are matters commonly raised. Suggestions are made that the psychiatrist who gives evidence before a magistrate or a Mental Health Review Tribunal should be represented in order to counter the overzealous approach of the patient's advocate eager to get to the bottom line in a field, as much art as science, in which certainty may be unachieveable. This in turn raises the question whether proceedings of this sort should be essentially adversarial or inquisitorial in nature. Mr. Wallach in his paper stresses the necessity of providing patients with legal representation, not only for the purpose of protecting their rights, but also for the purpose of exposing mistakes and maladministration in the institutions in which the mentally ill are incarcerated. Whilst this may not entirely placate psychiatric concern there are few, it is submitted, who would disagree with these objectives.

The legislation seeks to reconcile the public interest in maximising freedom of citizens, even if mentally ill, with that of ensuring safety from physical harm of the mentally ill and of other members of the community by limiting the category of persons who may be involuntarily detained as such to those who are "mentally ill persons" as that term is closely defined in the Act. Each sub-category of "mentally ill person" must, as so defined, be suffering from a "mental illness", but that term is not itself defined. Nor has it been defined in the predecessors to the 1983 Act. What is "mental illness" is a matter of vital concern to all psychiatrists—even, presumably, to those who assert that mental illness does not exist. Psychiatric definitions of "mental illness", however, tend naturally to leave out of account non-medical considerations of the broad public interest and lack the necessary qualifications which legislators and lawyers, especially judges, insist should exist so as to ensure that people who do not want to be treated, and who are not dangerous to themselves or others, are not involuntarily detained for that purpose. The term "mental illness", therefore, has had to be redefined by the courts, and has become a legal rather than a medical term. As such it may be too narrowly defined for psychiatric purposes. In any event the definition of what is essentially a medical term by the courts is of questionable necessity now that we have the close definition of "mentally ill person" in the Act, giving expression to those matters of public interest which the Legislature is of the view ought to limit the liability of citizens to compulsory detention and treatment because they are "mentally ill". Nevertheless, Dr Shea in his paper opts for what he describes as a pragmatic approach, in lieu of the existing statutory definition. This involves the formulation of a list compiled by a committee of psychiatrists, lawyers, etc. of what are commonly agreed to be mental illnesses, with definitions of each to be either adopted in the legislation or simply circulated as a statement of departmental policy. The definition of "mental illness" is likely to be of central importance in determining how the 1983 legislation will operate and Dr Shea's paper, as well as Dr Durham's contribution, will help to stimulate further debate

on a matter which is unlikely to be regarded as put at rest by the statutory definition.

Both as a general notion in the context of recommendations by the Mental Health Review Tribunal as to "forensic patients", and in particular forms of it appearing as part of the limiting requirements for a "mentally ill person", the issue of "dangerousness" is of basic concern. Again this issue involves a number of areas of controversy, one of which is whether the mentally ill are any more prone to have this potentiality than others. Assuming that some persons suffering from mental illness are prone to be dangerous, the question then arises how this potentiality is to be assessed and on the basis of what sort of evidence. Dr Sainsbury, in discussing these issues, gives a characteristically frank "no" to the proposition whether, in general and without any special experience in the matter, psychiatrists are any better equipped than any others may be to assess the matter and give expert evidence on the issue. However this may be, lawyers are infinitely less well-placed and I, for one, am happy to look to the assistance of Dr Sainsbury and his colleagues on this all important issue.

It is impossible to deal in a foreword such as this with all of the contributions made to the debate and discussion beyond acknowledging them and extending my thanks and those of the Institute to all those who made them. The object of a seminar such as this is to provide a platform for the canvassing of available points of view, for the promotion of discussion and for the identification of salient issues. I trust that at least in these respects the seminar was a success.

FORENSIC PATIENTS 1986

FOR BETTER OR WORSE

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The aim of this paper is to examine briefly problems which have been identified in the operations of the *Mental Health Act (1958)* and to consider how these problems have been addressed in the *Mental Health Act (1983)* and the *Crimes (Mental Disorder) Act 1983.* This examination concentrates on persons alleged/found unfit to be tried and how these persons will fare as a consequence of the innovations of the "special hearing" and the "limiting term".

Background

The principle that persons who are of unsound mind should not be subject to the full force and effect of the criminal process is a principle embodied in the agreed concepts of fair play and justice.

An accused must be capable of defending himself, that is making a full answer and defence to the charge/s being laid. He must be able to understand the nature or object of the proceedings against him; for example, does he know what he has been charged with and what the consequences of a conviction will be, does he know the purposes of the trial and the roles of the various personnel in the courtroom, does he appreciate what pleas are available to him and the consequences thereof; is he able to instruct counsel or to defend himself.[1]

In Hale's *Pleas of the Crown*[2] the principle was stated as follows:

> If a man in his sound memory commits a capital offence and before his arraignment becomes absolutely mad, he ought not by law to be arraigned during such his phrensy, but be remitted to prison until that capacity be removed, *the reason is because he cannot advisedly plead to the indictment* . . . (my emphasis)

As Lord Reading stated in *Regina v. Lee Kun*[3] the accused's presence in the courtroom must be mental as well as physical.

The legislative provisions which have applied in this State since 1958 in relation to persons alleged to be unfit to plead or mentally ill at the time of the offence are embodied in the *Mental Health Act (1958),* as amended ("the 1958 Act") particularly ss. 23, 24 and 26. It is not necessary to set out these provisions in full other than to note that s. 23 sets out a procedure where persons charged with offences are found to be mentally ill by a jury or acquitted on the ground of being mentally ill; s. 24 deals with persons certified as mentally ill before trial and s. 26 sets out a procedure whereby the Attorney General can order the removal of a person from a hospital to a prison to facilitate a trial of the issue of fitness to plead, where such an issue has been raised.

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[1] See for example, *R.* v. *Dashwood* (1942) AER p. 586 at 587.
[2] Hale, *Pleas of the Crown*—Vol. I (pp. 34–5).
[3] (1916) 1 K.B. 337.

Despite some amendments to the 1958 Act in 1964, expanding the powers given to Mental Health Tribunals set up under that Act, a number of inadequacies within the legislation have been identified.

The Problems

In 1967 the Institute of Criminology within the Sydney University Law School organised a seminar on Fitness to Plead.[4] In one of the papers presented, Mr R. P. Roulston, the Senior Lecturer in Law at that Law School, saw the provisions of Part VII of the Mental Health Act 1958 as appearing to provide a comprehensive code for the disposition of persons indicted for or convicted of an offence who are mentally ill or otherwise unfit to plead. He nevertheless raised a number of difficulties with the relevant legislative provisions.[5]

The issues identified at that time were the proliferation of authorities and powers under ss. 23, 24 and 26; the machinery by which the Attorney General could be persuaded to make the appropriate orders under s. 26; and the inadequate definition of mental illness.

Other problems have been identified as follows:

(a) A person found unfit to be tried (formerly referred to generally as unfit to plead) by a jury, might languish indefinitely in custody until such time as examination proved his/her fitness to be tried. Having regard to the presumption of innocence, this might well be regarded as an extreme injustice.

(b) Similarly, a person who had successfully set up a defence of mental illness under the M'Naghten Rules, and had obtained from a jury a verdict of "not guilty" on that ground, might nevertheless be incarcerated for a longer period than if he had been convicted of the offence with which he was charged. Furthermore, unless his/her case was kept under regular review he/she might be kept in custody for a period which was neither just nor necessary.

(c) A further problem arose in relation to persons, either on remand in custody awaiting trial or serving a sentence following upon a conviction, who had become mentally ill during the period of incarceration in a prison. Such persons might be transferred against his/her will from prison to a mental hospital and detained there for care and treatment.[6]

In 1972 Dr G. Edwards, the Medical Superintendent of Parramatta Psychiatric Centre was given the task of chairing a Committee of experts to look at certain parts of the 1958 Act. The Committee consisted of Dr Edwards; Mr S. Davis from the School of Health Administration, University of New South Wales; Dr G. Woods, Senior Lecturer in Law at the University of Sydney Law School; Dr W. Lucas, Senior Lecturer in Forensic Psychiatry at the same Law School; and Dr P. Houston, Medical Superintendent of the Prison Medical Service.

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[4] Syd. Inst. Crim. Proc. No. 1 *Fitness to Plead*, 1967, N.S.W. Government Printer.
[5] *ibid* pp. 84–86.
[6] The "Forensic Patients" Provision of the *Mental Health Act (1983)* and Parts XIA and XIB of the *Crimes Act*, T. S. Davidson, Q.C. President of the Mental Health Review Tribunal; February 1986.

The first report of the Edwards Committee was produced in 1974. This was subsequently published as a public document and was the subject of detailed examination at a seminar held by the Institute of Criminology in 1975.[7]

Between 1976 and 1982 the original recommendations, which had commenced as a redrafting of various provisions of the 1958 Act, had been superceded by the recommendations of an Interdepartmental Committee set up to sort out differences of approach which existed between the Health Department and the Attorney General's Department.

Particularly between 1980 and 1982 the idea of detailed amendments to the 1958 Act was abondoned in favour of a completely new Act which would to a large extent repeal the 1958 Act.

The new Act, the *Mental Health Act 1983,* ("the 1983 Act") and cognate Acts, were presented to the Legislative Assembly on 24 November, 1982 by the then Minister for Health, Mr L. Brereton. The most important of the cognate Acts was the *Crimes (Mental Disorder) Amendment Act, 1983.* The Minister addressed the issues involved in relation to fitness to plead as follows:

> It is a well-established and fundamental principle of our criminal justice system that a person cannot be tried for an offence unless he is in a condition to defend himself, that is, unless he is fit to plead. As this concept has developed, it has encompassed all persons who, for whatever reason, are unable to understand clearly the course and nature of the proceedings of the trial so as to make as proper defence, or to challenge a juror or to communicate adequately with a lawyer. Although the original concept of fitness to plead was developed in regard to persons who were clearly insane, the notion of fitness to be tried has come to be understood as covering all persons who from whatever cause are unable to plead, understand the proceedings or communicate with others. In 1936 in the case of *Pritchard,* Baron Alderson in addressing the jury in a trial relating to a prisoner who was deaf and dumb, said:
>
> > Upon the issue, therefore if you think that there is no certain mode of communicating the details of the trial to the prisoner, so that he can clearly understand them, and be able properly to make his defence to the charge, you ought to find that he is not of sane mind. It is not enough that he may have a general capacity of communicating on ordinary matters.
>
> At present, if an accused person is found unfit to plead, the trial judge, in virtually all cases, will order that the accused be kept in strict custody in such place and manner as the judge thinks fit. This means detention in a mental hospital or prison. The major weakness in the present system is that a person may be detained indefinitely without having had an opportunity to present a defence case. In particular, if a person is mentally retarded, he or she may become fit in the future so as to come before a court for trial. He or she may never get out, in effect.

[7] Syd. Inst. Crim. Proc. No. 22, *Proposed Amendments to the N.S.W. Mental Health Act (1958),* 1975, N.S.W. Government Printer.

> Other deficiencies in the existing system can be summarized as follows: the onus of proof rule in fitness to plead hearings is not clear; the nature of fitness proceedings is not clear, for example, whether they are adversary proceedings or not; no procedure exists for compelling the Crown law authorities to indicate whether it is intended that charges will not be proceeded with against a particular person, and there is no review by an independent tribunal of the necessity for continued detention of a person detained as unfit.[8]

The Solutions

The deficiencies identified above are sought to be remedied, insofar as forensic patients (that is, patients who are unfit to be tried or who have been found not guilty at trial on the grounds of mental illness) are concerned, by the *Crimes (Mental Disorder) Amendment Act* and Part VII of the 1983 *Mental Health Act.*

Whilst the main purpose of this paper is to examine and comment upon the establishment of the concept of a special hearing and a limiting term, there is one issue raised which requires comment initially.

The Crimes Act Amendment inserts a new Part XIA in the *Crimes Act.* It is a Part entitled "Unfitness to be tried for an offence". It should first be noted that the old concept of "fitness to plead" has been done away with. As can be seen from the various issues raised earlier in this paper, the question of a person's fitness to plead is only a small part of the total concept of a criminal prosecution of which the Court has to be satisfied the person has a proper understanding. Issues such as challenging the jury, instructing counsel, understanding the evidence are all part and parcel of the understanding required of a person facing trial. The term "fit to be tried" is now used both in England and New Zealand.

The Part is divided into two chapters, Chapter I referring to proceedings in the Supreme or District Courts and Chapter II to other proceedings. In Chapter II, s. 428U provides that the Chapter applies to criminal proceedings in respect of summary offences or indictable offences triable summarily, being proceedings before a magistrate, but does not apply to committal proceedings.

When the Edwards Committee approached the question of fitness to be tried in summary matters, they did so with some diffidence. There is clearly an inconsistency in requiring a jury to try such an issue in the Supreme and District Court but allowing a magistrate to make a similar order in summary proceedings. In New Zealand, for example, the use of juries to try issues of fitness has been abolished and there is therefore no distinction between the jurisdictions. The Edwards Committee finally came down in favour of the retention of juries on the basis that it afforded "some protection which the public believes ought to be retained".[9]

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[8] *Hansard,* Wednesday, 24th November, 1982, pp. 2987–3008.
[9] Syd. Inst. Crim. Proc. No. 22 *supra* p. 63.

Chapter II therefore does not empower the magistrate to make a finding on the question of the person's fitness to be tried but allows the magistrate to make orders as to that person's continued detention or otherwise and as to treatment.

As a consequence, one area which is specifically excluded from either Chapter I or Chapter II is that of committal proceedings. It is acknowledged that a defendant in such an instance is not facing trial. Nevertheless the consequences of a committal for trial order are not to be ignored. What is a magistrate to do if, during committal proceedings it becomes apparent that the defendent may be mentally ill and unable to understand the nature of the procedings? As Part XIA does not apply, one must assume that the magistrate has to continue with the committal hearing. How is Part IV of the *Justices Act* to be complied with? Section 36 (3) of the *Justices Act* grants to a defendant the right to "make full answer and defence, and . . . give evidence himself, and . . . examine and cross examine the witnesses giving evidence . . . ". What are the consequences for a defendant who is unable, by means of mental illness, to comply?

By way of example s. 36 (4) requires that the deposition of every witness shall be recorded. In *Mekarzel* v *The Attorney General for New South Wales*[10] Lusher J. ruled that the committal proceedings were rendered void because the statutory requirements of s. 36 (4) had not been complied with. In *R* v *Cordell and Parquet*[11] committal proceedings were declared void where the defendants had been committed for trial after a committal hearing in which they thought they were represented by a solicitor. In fact the solicitor was appearing *amicus curiae* and did not see his role as extending to cross examination of prosecution witnesses. In delivering judgment Enderby J. said in relation to the defendants: "They did not understand that it meant they would be denied opportunities to test the evidence led against them. They were also denied the opportunities to make submissions and call evidence or perhaps to obtain the services of someone who would do those things for them".[12]

What then, are the consequences for the defendant who is mentally ill at committal and unrepresented or represented and unable to give proper instructions? It would appear that the magistrate would commit for trial if "a *prima facie* case" is made out. If the prosecution case is uncontroverted through the lack of involvement of the defendant, the magistrate would be most unlikely to find, under s. 41 (6) that a jury would not be likely to convict the defendant of an indictable offence.

Is the defendant to seek an order quashing the committal, assuming for the purposes of this argument that he is now in receipt of legal advice, which he may or may not understand. Should the order of committal be quashed the defendant remains in limbo. As the offence is indictable the prosecution would be entitled to lay fresh charges and recommence committal proceedings. What if no action is taken?

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[10] New South Wales Supreme Court, unreported, 23rd September, 1985.
[11] 1983 10 A. Crim. R. 475.
[12] *ibid* p. 480.

If the defendant is in custody as may well be the case if the defendant is considered a danger to self or to society, a considerable period of incarceration may ensue before the proper procedures are implemented.

Part XIA, ss. 428A *et seq*, proceed to determine who may raise an issue of unfitness to be tried, that is, any party to the proceedings or the Court, and fixes the burden of proof as being on the balance of probabilities.[13]

One of the major issues in the old fitness to plead trials is thereby resolved. Clearly where the evidence was overwhelmingly in favour of or against a finding of fitness there was little difficulty in practice. However considerable difficulties arose where there was a real conflict. In England the matter was partially resolved by the Court of Criminal Appeal in *R* v. *Podola*.[14] There the Court held that when the issue was raised by the defence the onus was upon the defence and was on the balance of probabilities. Where the issue was raised by the prosecution, then the onus was on the prosecution. Unfortunately the Court was silent as to the standard of proof in the latter event.

It appears that, in New Zealand, where the trial of the issue of fitness is reserved to a judge alone, the burden of proving unfitness remains on the prosecution to be established beyond reasonable doubt.[15]

As Judge Goran pointed out to this Institute in 1975, since there was "no question of guilt involved in a trial of fitness, there should be no question of proof beyond reasonable doubt".[16]

This view is now clearly enshrined.

The Act provides that an inquiry into a person's fitness shall not be conducted in an adversary manner.[17] However where there is a real dispute this rule may be more often broken than not. At present, fitness trials usually involve each side calling a consultant psychiatrist to give evidence as to the accused's mental state. If there is a conflict between the two experts, for example, if the Crown evidence favours fitness and the defence evidence, assisted by the views of the instructing solicitor, favours unfitness then there will be imparted into the trial, whether proper or not, a degree of conflict. An arbitrary rule that the "inquiry shall not be conducted in an adversary manner" is of no real assistance to the trial judge, especially when there is no sanction involved.

It is not my intention to go through all the subsections of s. 428 nor to refer in detail to the role of the Mental Health Review Tribunal. These are set out in the second reading speech and more particularly in the pamphlet produced by the President of the Mental Health Review Tribunal in relation to "Forensic Patients".[18] There are however a number of provisions which call for particular comment.

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[13] s. 428D *Crimes Act*.
[14] (1959) 3 AER 418.
[15] Commentary on *R* v. *Tindall*, in 1986 10 Crim L.J. p. 108.
[16] Syd. Inst. Crim. Proc. No. 1 (*supra*) p. 101.
[17] s. 428H *Crimes Act*.
[18] *supra* footnote 6.

Section 428E enables the Attorney General to determine whether an inquiry should be conducted, before the hearing of the proceedings for the actual offence, where the question of a person's fitness to be tried has been raised. Whilst the Attorney General may determine that an Inquiry not be held,[19] it seems that this would only be likely to occur in cases where it appears that the question has not been raised *bona fide*.[20]

Section 428F (5) provides that the court may determine not to hold an inquiry and may dismiss the charge and order the person's release where the court feels it is inappropriate to proceed further, due to the trivial nature of the charge or offence, the nature of the person's disability or any other matter which the court thinks proper to consider. This gives to the court powers which it has not held in the past and may lead to interesting arguments as to what criteria the court should apply in deciding whether or not to inquire or dismiss.

Should the Attorney General or the court direct that an inquiry be held, the question of fitness shall be resolved by a jury especially empanelled for that purpose.[21] Where a person is found fit to be tried the criminal proceedings shall then continue before another jury.[22] Where a person has been found unfit to be tried after an initial inquiry, the Court must refer that person to the Mental Health Review Tribunal.[23]

The Tribunal, as soon as practicable thereafter, has to determine whether the person, during the ensuing twelve months will be fit to be tried.[24]

Where the determination is that the person will become fit to be tried then the Tribunal must also determine whether that person is suffering from a mental illness or a treatable mental condition. The latter distinction is relevant to a decision as to how the person will be dealt with thereafter, as the court has the power, on receiving the Tribunal's decision, to allow bail or order detention in a hospital or place other than a hospital, which one assumes would include a prison.[25] That person then becomes a forensic patient subject to regular review under the 1983 Act. Should the Tribunal after further review find that the person has become fit to be tried the Attorney General has to be notified and may thereafter request a further inquiry as to the person's unfitness or direct no further proceedings.[26]

The consequences of a finding by the Tribunal under s. 428K (4) that a person will not become fit to be tried in the ensuing twelve months and a finding by a further inquiry under s. 428S (1) that a person remains unfit to be tried, are not dissimilar.

After a s. 428K (4) determination, the Attorney General may direct that a special hearing be held or direct no further proceedings. After a s. 428S (1) finding, the Court shall order a special hearing where the person has been detained for at least twelve months, and may order such a hearing in any other case or return the person to custody or hospital.

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[19] s. 428E (2) *Crimes Act*
[20] *ibid* s. 428F (2)
[21] *ibid* s. 428G (1)
[22] *ibid* s. 428G (4)
[23] *ibid* s. 428I (2)
[24] *ibid* s. 428K (1)
[25] *ibid* s. 428L
[26] *ibid* s. 428S (1)

As both sections are aimed at ensuring that a person found unfit to be tried is not detained indefinitely in relation to an offence of which he/she may not be guilty, it is logical to assume that in the majority of such cases the next step would be the holding of a special hearing.

The Special Hearing

The concept of a special hearing needs to be looked at very carefully. As the Minister for Health said in the second reading speech:

> I am aware that some members of the legal profession may be a little puzzled by the special Inquiry *(sic)* notion, involving as it does a significant departure from the principle that a mentally incompetent person should not be put in jeopardy of criminal punishment. This is an excellent principal, but in practice it is capable of operating very unjustly, particularly against mentally retarded persons . . . They may be locked up forever on a mere accusation. Although the special Inquiry *(sic)* procedure may appear to be somewhat novel, it is designed to obviate such possible injustice . . .[27]

Let us look then at what is so "novel" about the special hearing. Section 428O provides that a special hearing shall be conducted as nearly as possible as if it were a trial of criminal proceedings. The person shall be legally represented and the finding of unfitness is presumed not to be an impediment to such representation.

The accused person is deemed to have pleaded not guilty; the rights of jury challenge may be exercised; the accused person may raise any defence and may give evidence or make an unsworn statement.[28]

The jury is to be told that the accused is unfit to be tried, what that means, the purpose of the special hearing, the verdicts that are available and the consequences thereof.[29]

Section 428O (5) is framed on the basis that the following verdicts are open to the jury:

(a) not guilty;

(b) not guilty on the ground of mental illness;

(c) that the accused committed the offence, or an alternative offence charged, on the limited evidence available.

Where the person is found not guilty of the offence charged, the person is entitled to be dealt with thereafter as if there had been an acquittal at a normal criminal trial.

Where a verdict of not guilty of the grounds of mental illness is returned, that is deemed to equate to a like verdict at a normal trial. The court is empowered to act accordingly and make appropriate orders.[30]

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[27] *Hansard (supra)* p. 3006.
[28] s. 428O (3) *Crimes Act.*
[29] *ibid.* s. 428O (4).
[30] *ibid.* See sections 428O (6) and 428P (5).

Where the offence (or an alternative) is found to have been committed by the accused then that finding constitutes a qualified finding of guilt (whatever that means) but does not constitute a conviction for the offence.[31] Nevertheless such a finding is essentially a bar to further proceedings, may be appealed against and enables an application for compensation to be made.

The purpose of the special hearing is stated to be "ensuring, notwithstanding the unfitness of the person to be tried in accordance with the normal procedures, that the person is acquitted unless it can be proved to the requisite criminal standard of proof that, on the limited evidence available, the person committed the offence charged or any other offence available as an alternative to the offence charged".[32]

It will be very interesting to see how the courts and legal practitioners cope with this "Claytons" trial.

The rationale behind the concept is logical. Once one accepts that it is unfair to subject a mentally ill patient to a criminal trial the present consequences are that such a person will be detained indefinitely, with a trial perhaps permanently withheld. The irony is that this withholding of trial is justified on the basis that the person must be treated fairly.

Under the proposed "special hearing" regime, the specific provisions mentioned earlier have been implemented in an attempt to assist the person's defence. But there are other problems which are not so easily overcome. The particular mental disability may have lessened if not totally destroyed a person's ability to give evidence, to remember what may have happened at the time of the offence (e.g. an alibi or self defence) or to properly instruct counsel. The latter will certainly be the case as this is one of the specific criteria which will have been addressed in the earlier fitness to be tried hearing.

Clearly a special hearing is preferable to unlimited detention with the issue of guilt never addressed beyond the prima facie level which resulted in the original committal for trial.

However provisions allowing the person to raise any defence and to give evidence or make an unsworn statement, really go no way to ensuring that the person receives a fair "special hearing".

The reference to "limited evidence" clearly contemplates the problem of the person being unable to give a relevant account of events.

If the defence is simply a question of putting the prosecution to strict proof, then that can probably be achieved in a special hearing. However in the majority of normal trials the defence goes beyond that threshold point. The defence may be an alibi, an assertion of self defence, or of duress or accident, or a denial of intent, or as occurs in many cases an allegation that the alleged admissions which point to guilt were either fabricated or induced or both.

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[31] *ibid.* s. 428O (7) (a).
[32] *ibid.* s. 428M (2).

How is a mentally incompetent person to raise such issues? While the Act provides that the person shall be legally represented unless the court otherwise allows, how is the legal representative to gain instructions? A provision in these terms: "the fact that the person has been found unfit to be tried for an offence shall be presumed not to be an impediment to the person's representation"[33] is really meaningless. A presumption that there is no impediment does not remove the impediment.

If the person is unfit to be tried, having failed the tests as to understanding of the nature of the proceedings and in particular having been shown as unable to properly instruct his legal representatives, what sort of defence/s can possibly be raised under s. 428O (3) (c)? The answer must clearly be—very few. Is the legal representative to appear, to cross examine witnesses as to their veracity, to raise defences, without instructions?

An explanation to the jury that the person is "unfit to be tried in accordance with the normal procedures, the meaning of unfitness to be tried, the purpose of the special hearing, the verdicts available and the legal and practical consequences of those verdicts"[34] is clearly essential but will it achieve a fair hearing? Will not juries faced with persons unable to assist their counsel, and thereby assist the jury, be unlikely to return verdicts of not guilty? Will not the tendency be for the special verdict of not guilty on the ground of mental illness be a more attractive alternative, despite all proper and earnest exhortations of defence counsel and the trial judge?

It is possible for example that the person may be unfit to be tried, sane at the time of the offence but mentally ill at the time of the trial. Is a jury of lay persons going to be able to group the intricacies of such a combination of factors? How is the trial judge to sum up in such circumstances? In the hypothetical situation suggested, the various "states of mind" might be legally distinguishable but will they be factually so? Is it not more often the case than not that the evidence of the person's state of mind at the time of the offence is in fact not known but only inferred from the various circumstances of the case?

It remains to be seen whether the high ideals behind the special hearing can be approached let alone reached.

Nevertheless it must be acknowledged that for many persons under detention as unfit to plead, even a qualified finding of guilt will be an improvement on the present position. What can now be an indeterminate period of detention will be replaced by a further innovation.

The Limiting Term

Where a qualified finding of guilty is made, the court is required to indicate if it would have imposed a sentence of imprisonment or penal servitude for the offence found to have been committed. If the court would have imposed a sentence then the court shall nominate a term called a "limiting term" being the best estimate of the head sentence which would have been appropriate if it had been a normal trial.[35]

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[33] *ibid* s. 428O (2).
[34] *ibid* s. 428O (4).
[35] *ibid.* s. 428P (1).

The Tribunal is to be notified accordingly and to make a determination as to whether the accused is suffering from a mental illness or a treatable mental condition.[36] The court thereafter is empowered to order the detention of the accused in a hospital or another place,[37] assumedly for the period of the limiting term.

The qualified finding of guilt does "not constitute a basis in law for any conviction for the offence to which the finding relates".[38] Problems spring to mind immediately. What if the court would not have fixed a head sentence but would have deferred sentence? It cannot do so, on my reading of the Act. As indicated in the hypothetical case suggested earlier, the person at the time of the "verdict" may be unfit to be tried and/or mentally ill. If the person is unfit and no head sentence is appropriate, how is the court to deal with the person? The Act is silent as to what the court should do in such circumstances.

Surely the person is not to be further disadvantaged by the court having to fix a limiting term to enable the remaining provisions of s. 428P to be brought into effect.

The consequences of the fixing of a limiting term would seem to be, as far as the person is concerned, that the person after referral to the Tribunal can be detained by court order either in hospital or prison for no longer than the period of the limiting term. During that period of time the person's case will be reviewed regularly by the Tribunal.

Certainly under s. 117 of the 1983 Act the first review will be within fourteen days. The Tribunal's role at the first review is to ascertain if the person has now become fit to be tried, and whether the safety of the person or of the public would be seriously endangered if the person was released. It would seem unlikely that the person would have become fit to be tried when a similar review some short time earlier (a review which led to the special hearing procedure being implemented) had answered the same question in the negative.

Nevertheless if the subsequent review by the Tribunal reveals that the person has become fit to be tried, the Tribunal must notify the Attorney General who will presumably then direct that arrangements be made for trial or will direct no further proceedings.

One obvious consequence is that the Crown is thereupon put to the expense and the Crown witnesses are put to the inconvenience, of taking part in a second "trial" within a short time of an almost identical earlier hearing. Or is it to be suggested that the Attorney General would exercise his discretion to direct no further proceedings in a more liberal fashion than at present, on the basis that the earlier hearing has satisfied the rights of the victims as to compensation and has lead to a qualified finding of guilty in relation to the particular offence.

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[36] *ibid.* ss. 428P (2) and (3).

[37] *ibid.* s. 428Q.

[38] *ibid.* s. 428O (7).

Where the Tribunal arrives at a negative conclusion as to fitness but is satisfied that the person may safely be released, the Tribunal is to make such a recommendation to the Minister for Health who shall notify the Attorney General accordingly. If the Attorney General does not object within thirty days of notification, the prescribed authority may order the person's release. The Attorney General may object on the basis that the person has served insufficient time in custody or under detention; or because the Attorney General intends to proceed with criminal charges against the person. In either such case the prescribed authority shall not order the person's release.[39]

What then, is the effect of the limiting term. Clearly it is not intended to be binding or even persuasive on the Tribunal as the criteria the Tribunal must abide by under s. 117 (3) are clearly set out and the length of the limiting term is not amongst them. Is the limiting term then to be set as an indication to the Attorney General when he exercises his mind as to whether to object to the person's release? Clearly there the limiting term is of relevance. But how far must or should the Attorney General be bound by that term? Is the Attorney General entitled to say, in effect, that the person is not to be released until the expiry of the whole of the limiting term? Clearly that entitlement exists on a simple reading of the section.

The limiting term is clearly not intended as in any way setting a minimum period for detention or otherwise. The rationale is that the limiting term sets the maximum length of time during which the person may be detained as a forensic patient.

Consider this however. Under the provisions of the *Probation and Parole Act* (1983) every person convicted of an offence and sentenced to a term of imprisonment is "entitled" to certain specified remissions upon both the head sentence and non parole or non probation period.

What then of the forensic patient?

Is the Attorney General entitled, in the exercise of his discretion, to ignore the effect that remissions would have had on the limiting term if it had not been a head sentence after a proper trial? The Act does not address itself to such an issue, an issue which one might consider vital to the interests of the person. If the Attorney General says, in effect "you are to be detained for the full period of the limiting term", as he is clearly entitled to do, then the person is at a disadvantage in relation to competent accused who have been tried and sentenced for like offences and thereafter given the benefit of release by remissions.

The competent accused who has served a period in custody prior to conviction and sentence is also entitled to have that period taken into account, either by a "reduction" in the head sentence or more appropriately by the backdating of the head sentence and non parole/non probation period. Is the presiding judge, in fixing a limiting term, to allow a similar discount when it comes to setting the "best estimate" of what the head sentence would have been?

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[39] s. 117 *Mental Health Act 1983.*

Likewise how can one justify the power as to release/non release vesting in the Attorney General when it is effectively in his name that the prosecution has originally been brought. The idea of the prosecutor also being the arbiter of the length of "sentence" is a novel concept with far reaching ramifications.

The Attorney General's second option is to indicate an intention to proceed with criminal charges against the person. I fail to comprehend the logic of this provision. The premise upon which the Attorney General's views are sought is that the person is still unfit to be tried. On what basis then would the Attorney be contemplating criminal charges?

Is it that s. 117 (6) (b) contemplates a future event? Is it to enable the Attorney General to say: "this person may become fit to be tried within the next six months. He will then be reviewed by the Tribunal. If he is found fit to be tried, I can then continue the criminal proceedings. I will not allow his release until I see what happens"?

That would clearly be a proper consideration to take into account. However a deferral for six months may lead to a further deferral for six months and so on, if there is a continuing possibility that the person may become fit.

What must not be lost sight of here is that the person has not been found guilty of any criminal offence. There has been no conviction. The "limiting term" is not a term of imprisonment. What then is the need for the provisions in s. 117 (6)? Is it to provide a statutory alternative or substitute for the present system of release by the Governor on the advice of the Executive Council?

The practical problem facing the Minister and the Attorney General is that the person may have been subject to a qualified finding of guilt in relation to what may have been a most horrific and therefore sensational offence. The political consequences of permitting such a person to be released shortly after a special hearing may well carry weight in the decision which is made under s. 117 (6).

It should be noted that the decision of the Tribunal under s. 117 (3) that the person is/is not in a condition to be released, can be the subject of an appeal, by way of rehearing, to the Supreme Court. There is no such right of review in relation to the Attorney General's decision under s. 117 (6).

The person detained under a limiting term ceases to be a forensic patient once the limiting term has expired; upon unconditional release following a recommendation of the Tribunal; where the release was conditional, upon the expiry of the conditions; upon the person being classified by the Tribunal as a continued treatment patient.[40]

The consequences therefore are that the person is likely to have been released, either conditionally or unconditionally during the course of the limiting term. Where the person is suffering from such a mental disorder as to be a danger to self or society then the person, at the completion of the limiting term, would be reclassified and a continued treatment patient. Thereafter the person would come within Part V of the 1983 Act, which relates to the involuntary admission of person to hospital, and thus outside the scope of this paper.

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[40] s. 127 (1).

Conclusion

No longer will an accused person be detained indefinitely solely on the grounds that he/she is unfit to be tried and it is therefore improper for the question of guilt to be addressed.

The innovative alternatives, the special hearing and the limiting term, will go some way to establishing whether that person should be detained as a consequence of the offence and, if so, what is the maximum permissable period of detention.

Whether these innovations are effective will depend to a large degree on the good graces of the legal representatives of the Crown and the person. The provisions in both Acts referred to are complex. A strictly legalistic approach will not be to the benefit of the accused person. Whether another style of approach is appropriate and, if so, whether it is successful in achieving the humane considerations which underlie the legislative action undertaken, only time will tell.

PRESENTATION OF PAPER

N. A. Harrison

I should preface my remarks by saying at the outset that whilst this paper was written by me and my title is Deputy Solicitor for Public Prosecutions, you would appreciate that the views expressed therein are totally mine. I must admit to having had some trepidation when I was asked by the Chairman to prepare a paper for this seminar. It is very difficult to decline when you have a brawny Scot on the other end of the phone asking you nicely. The following day the Chairman confirmed that what I was to speak on was a critical analysis of the *Crimes Mental Disorder (Amendment) Act* as well as the forensic patients provisions of the *Mental Health Act* and how they interlock. At first blush I thought I would be here for several hours and the paper would probably run to some hundred pages. What he did do then, which caused me even greater consternation, was to produce three weeks later a "pamphlet" entitled "The Forensic Patients Provisions of the *Mental Health Act 1983* and Parts XIA and B of the *Crimes Act*". In a sense he took the wind from my sails and I ended up writing a paper concentrating mainly on the innovative parts of the *Crimes Mental Disorder (Amendment) Act,* the Inquiry, the Special Hearing, and the Limiting Term.

I would like to take up a couple of the issues that I have raised in the paper and elaborate on them.

It can be seen from a detailed examination of both the Acts and from a reading of my paper there has been little change in the treatment of persons unfit to be tried, insofar as that relates to the proceedings which have to be followed prior to the inquiry into the person's fitness. Under the old *Mental Health Act* what was called a fitness to plead trial was conducted after a direction by the Attorney-General under s. 26 (3) of that Act. Under the new Act a fitness to be tried inquiry can be commenced by order of the Attorney-General or by order of the court and may be commenced at the instigation of any party to the proceedings. So there is some slight variation. So far as persons who are unfit to be tried are concerned the essential innovative features of the new Acts relate to their disposition after findings of unfitness to be tried. The assessment of such persons and the subsequent reviews are two of the major roles of the new Tribunal.

Perhaps if I can turn briefly to look at the composition of the Tribunal. It consists of members appointed by the Governor and includes a President and one or more Deputy Presidents. The other members of the Tribunal are to be barristers or solicitors of at least five or seven years' standing respectively, as well as psychiatrists and persons having other suitable qualifications or experience. Both the President and any Deputy President must also be barristers or solicitors of the stated standing. Except in the case of the President or the Deputy President both of whom must be appointed full time, members may be appointed on a part-time basis. They must include one or more women, and one or more persons of ethnic background. They are not subject to the *Public Service Act* and they may be removed only for inability, misbehaviour, or failure to comply with the terms and conditions of appointment. I am not sure in the present climate who is going to remove them. You might require a special complaints division.

What I want to point out to you is you have a Tribunal with very wide experience. As most of you will realise the two persons appointed as President and Deputy President are both senior counsel with extensive forensic experience with particular emphasis on the criminal law.

The Tribunal itself has a wide range of powers not just in relation to forensic patients with which my paper deals. It has powers under ss. 95 and 97 of the *Mental Health Act* to determine whether temporary patients are mentally ill and to make orders for the classification and detention of those persons. Under s. 102 of the same Act it is empowered to make determinations in relation to continued treatment patients. Under s. 428K of the *Crimes Act (as amended)* the Tribunal has to determine whether on balance the person referred to it by the court or trial will become fit during the next twelve months and certain consequences follow. Under s. 428S of the *Crimes Act,* where there has been an earlier finding of unfitness to be tried, the Tribunal is to form an opinion as to whether that person is now fit. In such cases the Attorney-General has to be notified and the Attorney may then require a further inquiry into the person's fitness to be tried or he may direct no further proceedings. Of course, as you will see from a reading of the *Mental Health Act* there are provisions there in relation to appeals from any of the determinations, orders, directions, or decisions of the Tribunal.

The point I want to make is that you now have established a Tribunal consisting of persons experienced in the criminal law, in psychiatry, and of persons who are to reflect the community interest in the proper treatment of persons found unfit to be tried or found to be mentally ill. There is clearly a role, in my view, for this Tribunal to play a far greater part in the disposition of persons found unfit to be tried.

What I would like to suggest for future consideration is that the concept of a fitness to be tried inquiry being held before a judge and jury should be looked at most critically. I point out in my paper that in New Zealand the use of juries to try issues of fitness has been abolished. The Edwards Committee (see page 13) finally came down in favour of the retention of juries on the basis that it afforded some protection which the public believed ought to be retained. In retaining trial by jury of such an issue, that is the issue of whether a person is fit to be tried, you are relying on twelve lay persons who will almost certainly have no experience of persons with any sort of mental illness or mental condition. Such persons will find it difficult to give due regard to any cultural factors which are relevant to the particular accused. The trial judge may not necessarily have had any particularly relevant experience in the field of psychiatric illness.

Remember also that where a fitness question is raised during the actual proceedings as s. 428E (i) allows, then the proceedings, whether they be trial or sentence, would have to be adjourned in any event to allow fresh jury panels to be called to sit on the inquiry.

Why should it not be proper I would ask for a person who is suspected of being unfit to be tried to be assessed solely by the Tribunal? In the majority of cases there is no dispute one way or the other. The decision by the Tribunal that a person is fit to be tried would allow for the immediate institution of the normal criminal process without the duplication or delay which is involved in having a further inquiry before a judge and jury and then a further trial before

a judge and jury. As I have indicated earlier such a determination by the Tribunal would be the subject of right to appeal before the Supreme Court in any event.

Where the Tribunal determined that the person was unfit to be tried then the Attorney-General could be notified and a direction given that no further proceedings be undertaken or that a special hearing be instituted. This would again allow for streamlining of the process, for a reduction in the delay, and any such determination by the Tribunal would also be the subject of a right of appeal. The interpolation of the Tribunal into the proceedings would also help to cure the deficiency I have identified in my paper where a magistrate is sitting in committal proceedings.

If the Tribunal is to have such a case referred to it for determination then a finding of fitness would allow the magistrate to continue the committal. If the finding was of unfitness to be tried, as we are now talking about indictable offences, why should not the Attorney-General again be allowed to direct no further proceedings or to direct that a special hearing be held? The present consequences of a magistrate continuing with the committal, as I have said, is that the accused would be committed for trial and eventually after a waste of a great deal of time a special hearing is still likely to be the end result in any event.

Why should we not have such determinations which reflect in no way on the accused's guilt or innocence, determined by a Tribunal specifically set up with the expertise to assess such matter? The proceedings set out in the two Acts are extremely complex as any of you who have tried to read them will understand. The President in producing his pamphlet has indicated that he has tried to make it as simple as possible and the end result of the paper flow looks like a wiring diagram for a space defence system.

What I am suggesting to you is that the Act needs to be looked at. A number of the papers have indicated that there are problems with the Act as it presently stands. As I have said the main aim of the legislation is the protection of the rights of the mentally ill or those who are unfit. Any suggestions which enable the streamlining of the process should be seriously considered. On that basis I look forward to hearing discussed ways that purpose may be achieved.

MENTAL HEALTH ADVOCACY IN NEW SOUTH WALES

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The ever impending approach of the commencement of the *Mental Health Act 1983* appears to be developing into a legal, psychiatric and administrative "long march". Indeed, one could be forgiven for comparing this process with the 11 year process which was involved in drafting the final passage through Parliament of the *Mental Health Act 1983* itself which had its conception in the establishment of the Edwards Committee in 1972. One unintended side-effect of this delay has been a misconception, widespread in some quarters, that the *Mental Health Act 1983* is in effect in some way. There are variations of this theory, but they all have in common the idea that the new Act is responsible for an alleged deterioration in the standard of mental health care, especially in hospitals.

One variation has it that magistrates are in fact applying at hearings the new definition of a "a mentally ill person". This has no foundation in fact whatsoever, indeed, some magistrates have continued to apply the definition in the *Mental Health Act 1958* in a very broad fashion, continuing the practice of making orders in respect of patients suffering from dementia, contrary to the decision of the Supreme Court in *RAP v AEP* (1982) 2 NSWLR 508. Another variation has it that the new *Mental Health Act* prevents doctors from making admissions as they feel necessary, especially in relation to persons with a suicide risk. Not only is this variation untrue, but it always has been the case and will continue to be so under the 1983 Act that any person being a significant suicide risk does clearly come within the definition of "a mentally ill person". A third variation has it that the new Act compels the early and, apparently improper discharge from hospitals of people who are a significant suicide risk. As in the previous example, it has always been the case under the 1958 Act and will continue to be so under the 1983 Act that patients being a significant suicide risk can be detained as an involuntary patient and may, if necessary be again presented to a magistrate for committal.

Each of the three examples cited above are important in themselves because they reveal difficulties in the practice of psychiatry experienced by doctors and deficiencies in their knowledge of the special legal requirements and regime which apply to their field of practice. Unfortunately, it is the case that there continues to be widespread ignorance amongst doctors in psychiatric practice of the *Mental Health Act 1983*, in general, and the definition of "a mentally ill person", the functions and powers of magistrate's hearings under the Act and the functions of a patient's advocate in particular. On occasion, the media have reported public statements by doctors who have said that "patient's interests . . . are really being exploited by the legal system" and that lawyers "see their responsibility as ending with, as they say, 'getting them off'." The same article blamed this state of affairs on a "new system". (*Sydney Morning Herald* 22–5–86). No such "new system" exists at Rozelle Hospital (the hospital referred to in the article) as legal representation has existed there since a pilot scheme in 1977 and, as noted above, the *Mental Health Act 1958* is still in force, although it is these two things which are often pointed out as being the cause of shortcomings in the system.

By way of comparison, I wish to quote a number of examples involving people who have been presented to magistrate's hearings at various hospitals in Sydney for committal as involuntary patients during the last 12 months. I make certain observations and comments in relation to each case in order to highlight what went wrong in each case. I do so because I believe that the misconceptions, if not disinformation, referred to above indicates that deficiencies in the system of mental health care which brought about the *Mental Health Act 1983* are still present and that their lessons have not yet been learnt. Indeed, it is important that these cases be brought to light because of the disinformation surrounding proposals to increase public scrutiny of the mental health care system, to deinstitutionalise mental health care and to extend legal representation to all proceedings under the *Mental Health Act 1983.*

Case 1

A young man in his late 20's was presented to the magistrate with a request relayed by the hospital administrative assistant that an order to detain the man for three months was being sought by the medical superintendent. The man had been admitted to the hospital under a doctor's medical certificate approximately one week prior to the hearing and had received some treatment and had been observed during that time. The man spoke noticeably slowly and was also visibly slow in his actions. At the request of the man's solicitor and the subsequent insistence of the magistrate, the treating doctor subsequently attended the hearing. The doctor stated that he was seeking the order on the basis of the abovementioned observations and also that the man had been seen in the ward rolling faeces in his fingers and later masturbating in view of other patients without apparent inhibition. During cross-examination, the doctor noted that, after the week's admission and observation, no diagnosis for his condition had yet been made. He further stated that in his opinion the patient was suffering from either some form of psychotic illness or from an organic condition such as a tumor. The doctor further stated that he was not concerned with the two dissimilar diagnoses and pressed his request to the magistrate that a three month order should be made. The man's solicitor pressed his client's instructions that he be discharged, but accepted that, in view of the man's condition, a diagnosis should be made rather than the magistrate concluding the hearing by ordering the man's discharge from hospital. Over the strong objections of the doctor, the magistrate then adjourned the hearing for two weeks in order to have the hospital carry out investigations to enable a diagnosis to be made.

This case gives rise to concern for several reasons, the least of which are that no diagnosis had been made nor had any planned treatment been formulated. The major ground for concern arising out of this hearing is the fact that the doctor was quite prepared to request an order detaining the patient for a period of three months in a psychiatric hospital when he was unable to say whether or not his patient was suffering from a psychiatric condition or an organically caused condition. Had it transpired, as tests later indicated, that the patient's condition was due to organic causes, it would not have been possible to treat him at the psychiatric hospital and his condition would have necessitated his transfer to a general hospital for treatment. In such

circumstances, I would suggest that an order under the *Mental Health Act* to detain the man for treatment and observation would not have served its purpose as no psychiatric treatment whatsoever would have been provided. I would further suggest that the man's attitude in relation to accepting treatment may well have differred if he had been told the true situation rather than being compelled to accept labelling as a psychiatric patient. Indeed, there was some doubt as to exactly how much his treating doctor had told him about his condition.

Case 2

A women in her early 30's was presented to a magistrate for committal and a six-week order to detain her in the hospital was sought. This presentation was the third time she had been admitted to a hospital in a period of 1 month. On the first occasion, she was admitted as a voluntary patient but discharged the next day after assessment by her treating doctor. The second admission occurred some two weeks later when her treating doctor did not seek an order but requested that an order for her discharge be suspended by fourteen days. Effectively, that admission was for a period of fourteen days but specifically aimed at returning her to the community and meeting her needs in so doing. No effective community follow-up care was provided. On each admission to the hospital, although being treated in the same ward, a different treating doctor was assigned to her. On this occasion she was diagnosed as suffering symptoms of schizophrenia. This diagnosis was based on incidents at her home in which she had lit a small fire in a teapot in her room and was seen by her mother lying on a path outside the house. It was not disputed that she had suffered from schizophrenia in the past, her only prior admission to hospital occurring some two years before.

At the hearing, her treating doctor presented her case as one involving the manifestations of schizophrenic symptoms for which the proper treatment was by chemotherapy. No reference was made by the treating doctor to this woman's background or present circumstances. During the hearing, the doctor did not attach any significance to her social environment or history. In fact, the woman although in her early 30's, was still living at home being cared for by her mother and had not managed to live independently outside her parents' home for periods longer than one month. In giving instructions to her solicitor, she stated that her attempts at the independent living, getting job training and employment had proved to be unsuccessful and that she was worried that future such attempts would end in failure. Her instructions on this occasion were to consent to a seven-day adjournment of the hearing whilst she was assessed for community care under the supervision of the local Crisis and Respite Team. Such teams include psychiatrists, social workers and psychiatric and community nurses. Their programs range from psychiatric care to developing social skills.

At the hearing, this course was strenuously opposed by the treating doctor who based his diagnosis and proposed treatment plan purely on strict psychiatric criteria without reference to social factors. Evidence was given during the hearing that in addition to the other social factors referred to above, during the past month the patient's father had been dying, finally passing away in the days immediately prior to this admission. The evidence drew a picture of the patient's mother under extreme stress in caring for her dying husband and for her difficult and dependent adult daughter. The magistrate adopted the course proposed by the patient's solicitor and adjourned the matter for seven days to allow the assessment by the Crisis and Respite Team to take place.

In opposing the adjournment, the treating doctor obliquely suggested that granting an adjournment for such a purpose was a challenge to his professional status and expertise. At the hearing following the adjournment a more senior and experienced doctor appeared who stated that the patient had been seen and assessed by the Crisis and Respite Team as suitable for community care and that he agreed with this course. The magistrate ordered that she be discharged from the hospital, suspending the order for seven days. Subsequently, the woman returned home and commenced attending a living skills centre as a preparatory step before living independently from her mother.

The course that this particular case took and the result which was achieved largely speaks for itself. It is an example of the deficiencies in adopting a purely "medical model" approach in psychiatry. Whilst it was not disputed that the woman did have some psychiatric symptoms the severity of the symptoms was strongly in question. In addition, the result indicates that social factors were not seriously considered, if at all, by her treating doctor to the extent that the doctor did not appear to have either investigated or informed himself of the severe social strain in the woman's background. It would also stand as strong evidence for the proposition that, in appropriate cases, social therapy is as effective and important in its own right as well as in conjunction with psychiatric treatment.

These two examples are cited as reminders that reform and change in psychiatry practice and care in this State are still both necessary and desirable. They are also reminders that legal factors can act as catalysts in speeding up the arrival of specialised and differentiated forms of mental health care. It cannot be denied that hospitalisation may provide only limited assistance at a considerable social cost to the patient. It is worth bearing in mind, that these positive steps forward are the result of scrutiny and intervention by members of non-medical professions and the intervention of outside social processes, including the law and legal representation.

The need for change also extends to the system of care for and review of the cases of forensic patients. Forensic patients may be broadly defined as persons under detention in either Psychiatric Hospitals or prison as a result of criminal charges or proceedings in a court. At present, the care of forensic patients is carried out by the Department of Health pursuant to Part VII of the *Mental Health Act, 1958*. The relevant officers designated with responsibility under the Act are the medical superintendent and official visitors of each hospital and the authorised officer appointed pursuant to the Act.

As will be seen in the examples to be cited below, the manner in which the cases of forensic cases have been administered, must raise, at the very least, severe reservations concerning the existing administrative provisions. This is so despite the fact that s. 29C of the existing Act clearly provides for a system of 6 monthly review by a medical superintendent of the case of each forensic patient. Although it will rapidly become clear in the light of the examples to be given, that this provision is inadequate to ensure the task of review is properly carried out, I must state that it is not my intention to lay the blame necessarily at the feet of the medical superintendents involved.

Case 3

This patient is now 75 years of age. In 1947 she was found not guilty on the grounds of Mental Illness of murdering her two years and eight months old child in 1944. She had been an inmate of the hospital concerned since 1944 and is subject to an order under the *Lunacy Act* of 1898. Without doubt, she is the State's longest serving prisoner, having been held in custody for 42 years. As early as 1949, reports on her file note prognoses that "she is unlikely to recover. Undoubtedly she will gradually deteriorate." Her file indicates that she was suffering from severe delusions and was assessed as a potential danger to the community in the 1960's. Despite the original prognosis noted above, by the early 1970's her condition had sufficiently stabilised so that in 1974, an order was made pursuant to s. 29 of the present Act which allowed her the freedom of the hospital grounds and permitted her to leave the hospital grounds subject to the direction of the medical superintendent, but ordered to continue to reside in the hospital.

In view of the severely limited freedoms allowed to the woman, the recitals in the order contain the statement that she "is unlikely to be of any danger to the community and no longer requires detention under strict security conditions". In turn, this order was based on an examination in 1974. In a further examination in 1982, it was noted that "this lady could be managed in a nursing home outside the hospital and there is no reason to further detain her". Yet a further examination and review was carried out in 1985, which stated that "she is now no apparent danger to others but will need care and shelter for the rest of her days." The later two recommendations were forwarded to the Authorised Officer under the Act, but the files do not reveal any action which may have been taken to effect her discharge and placement in the community.

This woman's history, whilst held in custody at the hospital, raises many worrying questions which cry out for answers. Her file reveals that since 1974, examinations of her have resulted in findings that she has not been a potential or actual danger to the community for some twelve years. Significantly, these very words used by her examining psychiatrist bear a strong resemblance to the words of s. 119 of the *Mental Health Act 1983* in laying down the duty of the Mental Health Review Tribunal to make recommendations to the Minister for Health regarding the six monthly review of forensic patients, effectively, to determine if "the safety of the patient or any member of the public will not be seriously dangered by the patient's release".

Section 29 of the existing *Mental Health Act* already provides that, in relation to Governor's Pleasure prisoners, the Governor "may permit any such person . . . to be liberated from custody or such mental hospital upon such terms and conditions as the Governor may think fit:" indeed it was pursuant to this section and power that this woman was allowed leave in 1974. The immediate question which comes to mind, is to ask why no steps were taken at that time to either effect her discharge from hospital, or, at the very least, to formulate a discharge plan.

Even more startling, is the fact that she has remained in custody despite two specific recommendations not to do so made by the hospital authorities to the authorised officer. On the basis of the evidence noted above which is gathered from the hospital's own files, I would go so far as to say that it is

virtually an inevitable conclusion that this women clearly fulfills the criteria for her discharge into the community laid down under s. 119 of the *Mental Health Act 1983* and has done so for some twelve years. More tragically, in the twelve years since 1974, it appears that she has become physically incapable of caring for herself as the result of age and tardive dyskinesia, a disabling permanent side effect caused by her medication.

Case 4

In 1977, a man in his late 20's was found not guilty on the grounds of mental illness on a charge of arson which involved throwing a petrol bomb from his flat. The majority of the next 7 years was spent by him in two hospitals but included some time in the community living with his wife. After stabilisation of his condition, he was released on a licence as a Governor's Pleasure prisoner into the care of his wife. Some 4 months later, at the request of his wife he was admitted to a psychiatric hospital for presentation as a temporary patient pursuant to a doctor's medical certificate. After an overnight stay, he was transferred to another hospital and held there for a period of 4 months. At no stage, was he presented to a magistrate for an order to be made to detain him as is required under s. 12 of the *Mental Health Act 1958* or was his licence allowing him to reside in the community revoked under s. 29 of that Act.

The man was subsequently interviewed by a solicitor of the Mental Health Advocacy Service. After 4 months being held under illegal detention, the man was released from the hospital by the Department of Health under threat of legal action.

Without any doubt, it can be said that this man was held illegally for some 4 months. Further, after the man's solicitor had made the initial demand for his release, although the Department could have taken steps to detain him legally either as a temporary patient under the *Mental Health Act*, or by variation or revocation of his licence, no such action was taken. Following consultation between a Mental Health Advocacy Service social worker and the hospital's placement officer, the man returned to live with his wife and arrangements were made for follow-up treatment from a local doctor and the local community health centre. Certain conclusions can be drawn from the facts of his case. First, the Department's administrative procedures would appear to be of such a standard that it cannot avoid committing illegal actions in the course of carrying out its duties pursuant to Part VII of the *Mental Health Act 1958*. If this appears to be a harsh judgement, it should be mentioned that the discharge of one further forensic patient being held pursuant to Part VII has also been obtained by order of the Supreme Court as a result of Mental Health Advocacy Service legal representation. This later case is based upon the Department's use of defective medical certificate in its use of s. 24.

The second conclusion is drawn from the fact that the Department chose to permit the man to return to the community rather than to regularise its detention of him. Under such circumstances there must be an implicit agreement on the part of the Department's relevant officers under the Act that this man did not seriously endanger his own safety or that of any member of the public. This is further evidenced by the fact that a discharge plan was both prepared and apparently agreed to by the medical superintendent of the hospital and put into effect. On the basis of this premise, it may be further asked why a similar discharge plan was not considered and put into effect some time earlier.

As stated at the outset of this paper, the purpose of bringing forward and examining these four examples has not been for malicious purposes, but rather as a reminder that the existing system of care for all types of psychiatric patients is inadequate and does not meet the standards which can be expected in this field. The provisions of Parts IV, V, VI and VII of the *Mental Health Act 1958* are couched in imprecise terms and give broad powers to Medical Practitioners and hospital administrators to "get on with the job" of providing care and treatment for those persons in society who are in need of them. On examination of s. 12, whch deals with the admission procedure of temporary patients, legal procedures and safeguards are framed so as to meet the perceived needs and convenience of the hypothetical doctor and hypothetical hospital in their hypothetical day to day routine. The scheme of these particular parts of the Act is to allow institutions and staff carrying out the duties under the Act a large degree of administrative autonomy whilst keeping such external checks to a minimum. In the light of the above examples, in my opinion, it cannot be said that the expectations expressed in the drafting of these Parts of the *Mental Health Act 1958* have been met. If further evidence is sought for this proposition, it is only necessary to refer to a study entitled *Evaluation of the Magistrates' Inquiries at Rozelle and Gladesville Hospitals, September 1982 to January 1983* by Leanne Craze.

The *Mental Health Act 1983* has made a number of innovations which recognize a number of important advances made in approximately the last five years at hospitals where legal aid organizations have provided legal representation. The most noteworthy of these include limits on medication, the introduction of a concept of informed consent as defined under the Act, controls on psychosurgery and electro-convulsive therapy (E.C.T.) and ensuring that persons appearing before certain tribunals are dressed in street clothes. Unfortunately, a reading of the Act reveals that these provisions do not apply uniformly to all proceedings and all tribunals established under the Act. For example, whilst all persons appearing before a magistrate to determine whether or not that person should be made a temporary patient must be dressed in street clothes, there is no such provision which applies to forensic patients appearing before the Mental Health Review Tribunal nor to those people appearing before a magistrate to validate consent to E.C.T. Similarly, on each of the two occasions where a person must be presented to the Mental Health Review Tribunal to consider further detention in hospital, the Tribunal is required to inquire into the effect of medication on the patient's ability to communicate. By contrast, there is no such provision in relation to forensic patients appearing before the Mental Health Review Tribunal, nor even to temporary patients appealing to the Mental Health Review Tribunal against a medical superintendent's refusal to discharge that patient.

Another inconsistency in the Act relates to the provisions controlling sterilization of temporary, continued treatment and forensic patients (ss. 177–179). These sections provide that consent to sterilization in certain circumstances must be given by the Mental Health Review Tribunal, where a patient is either incapable of giving or capable but refuses to give consent. Whilst s. 178 (1) provides that the Medical Superintendent may apply to the Mental Health Review Tribunal for consent to the performance of sterilization, division 3 of Part VIII which deals with sterilization *inter alia*, does not contain any substantive duties which the Mental Health Review Tribunal must carry out either prior to or in the process of giving its consent. It is only the medical

superintendent applying for the consent who must form an opinion that "it is desirable, having regard to the interests of the patient or other person, to perform a surgical operation on the patient or other person" (s. 177 (1)). Whilst it is implicit that the Mental Health Review Tribunal should insure that the provisions of the Division have been complied with before it gives consent, there is no express duty for it to do so nor, surprisingly, does the Division define consent for this purpose nor does it lay down a scheme of duties to be considered during the hearing of the application. This should be contrasted with the detailed duties in those divisions of the Act, dealing with the validating of consent to E.C.T. and the consent to psychosurgery.

This inconsistency is a grave one in view of the serious consequences involved in sterilization. Patients who are surgically sterilized are almost always women. They often suffer from chronic or potentially chronic conditions with a history of recurrent hospitalization. In addition, sterilization is also commonly used for women who are developmentally disabled. In the main, the purpose of sterilization is as a technique to make the management of such women easier, although this purpose is not usually stated so bluntly. To those employing sterilization, its appeal is largely two fold. First, it provides permanent and effective contraception. Second, in terms of cost/benefit, it is a relatively cheap method.

The most serious consequence of this operation is that for the groups of persons upon whom it is most frequently carried out, the result is effectively permanent. The success rate of reversal depends upon the original surgical technique used in sterilization and is, in any case a costly micro-surgical procedure. By and large, alternative methods of contraception depend on sex and sexuality education for the women concerned. Such courses are complex and must be given by specially trained educators. As an alternative to sterilization, it is without doubt more expensive and more time consuming.

It must be conceded that other methods of contraception based on sex and sexuality education are not always appropriate and will not always succeed. However, its use as a mandatory step prior to sterilization is, I would suggest, a recognition of that person's right to the same standards of care which apply generally at law. The direct analogy is with the psychosurgery provisions which are, in turn, based upon the fact that in the past insufficient attention has been paid to fully explaining its consequences to persons who are at the very least severely socially disadvantaged. Given the similar serious and permanent consequences of sterilization, there are compelling reasons to extend to it safeguards similar to those obtained in the psychosurgery provision. In particular, this includes a specialized type of informed consent as well as making legal representation mandatory, unless refused, at the Mental Health Review Tribunal Proceedings.

The *Mental Health Act 1983* is unique in that it makes special provision for legal representation of persons appearing before the bodies established under it. With one exception, it is mandatory in all situations that a patient having a matter before any of these bodies be present at the proceedings, except with

the leave of the tribunal. In addition to the matters referred to earlier proceedings before the Mental Health Review Tribunal for consent to the performance of sterilization or other surgery are not subject to such a provision (ss. 178 and 179).

Section 185 of the *Mental Health Act 1983*, states:

> For the purposes of this Act, the fact that a person is a mentally ill person shall be presumed not to be an impediment to the representation of the person by a barrister or solicitor before the Tribunal, at an inquiry under Section 88, before the Court or before the Psychosurgery Review Board.

Such a provision is essential to enable the legal mechanisms instituted under the Act to operate. The apparent intention of the section is to allow a mentally ill person to play a full role in proceedings under the Act, as well as institute proceedings in the Supreme Court. In particular, it would appear to attempt to ensure that a mentally ill person is able to instruct his or her legal representative directly without the intervention of a third party. The provision is probably quite adequate before the tribunals created by the Act. The Supreme Court Rules, however, provide that an incompetent person (a mentally ill person who is unable to manage his or her affairs) must institute proceedings by means of a Tutor. It is a moot point as to whether s. 185 dispenses with the need for a mentally ill person who is also an incompetent under the Supreme Court Rules to have a Tutor in Supreme Court proceedings.

The section appears in the form of an irrebuttable presumption. Unfortunately, it omits reference to inquiries under s. 169, being inquiries by magistrates to determine the validity of an involuntary patient's consent to E.C.T., although that section does refer to patients who are capable of giving such consent.

The significance of the section should not be underestimated in that it would serve to prevent a challenge to the validity of an advocate's instructions on the basis of the client's alleged incapacity. Such challenges have occurred, in particular, by way of a suggestion that an advocate either cannot or ought not put to a tribunal the instruction of a psychotic or demented client. Implicit in this challenge is the suggestion that the instructions are not the true wishes of the person and that they cannot be the basis for an advocate to contest the proceedings. Ironically, such challenges rarely occur where a psychotic or demented person gives instructions to consent to the application before the tribunal. In fact, it is my observation of people appearing before proceedings under the 1958 Act that, if psychotic, they suffer from varying degrees of disability. Indeed, the large majority of those who are psychotic are often able to give instructions in relation to their circumstances prior to admission to hospital, their treatment in the hospital and the effects of the medication which they are given. In my opinion, this particular attitude is condescending and cannot have a beneficial effect in the doctor-patient relationship. For these reasons, it is my opinion that s. 185 is a progressive step.

The Act contains provisions for legal representation of persons before the tribunal created under the act as follows:

1. The patient shall, unless he/she decides not to be represented, be represented before:
   (a) Mental Health Review Tribunal
   All forensic patients (s. 50 (3)).
   (b) Magistrate's Committal Enquiries
   All persons (s. 88 (5)).
2. The patient may be represented before:
   (a) Mental Health Review Tribunal
   Informal or continued treatment patients at Review (s. 50 (4)).
   (b) Mental Health Review Tribunal
   Temporary patient appealing under s. 109 (s. 50 (4)).
   (c) Mental Health Review Tribunal
   Any patient where consent is sought for sterilization or other surgery (s. 50 (3)).
   (d) Psychosurgery Review Board
   All patients (s. 152 (c)).
3. The Act does not contain provision for representation of patients before:
   (a) Magistrate's E.C.T. Enquiries.
   (b) Supreme Court.

In the first two categories the further option is also available of representation, with approval, by another person of the patient's choice. This provision would allow a patient to be represented by a lay advocate where appropriate, such a situation may well arise where a person of non-legal training possesses special knowledge in relation to the patient as well as concerning alternatives to hospitalisation.

In regard to these provisions on representation, I would refer to my earlier comments on inconsistencies in the Act. There can be little logic making representation virtually obligatory in some proceedings and not for other proceedings such as consent to psychosurgery or sterilization. In my opinion, the drafting of the Act in this regard is unsatisfactory and should be rectified.

Section 50 (3) of the Act provides:

> A forensic patient having any matters before the Tribunal shall, unless the forensic patient decides that he or she does not want to be represented, be represented by a barrister or solicitor or, with the approval of the Tribunal, by another person of his or her choice.

A similar provision appears in s. 88 (5) (a) in relation to persons being presented before a magistrate for committal as a temporary patient.

The formulation is unusual, and suggests something more than a right to representation. The formulation appears to contain the following provisions:

1. *Prima facie* a person must be legally represented.

2. Before a person appears unrepresented he or she must have had the opportunity to decide whether or not to refuse representation.
3. A decision to refuse representation must in fact have been made.
4. That decision must have been made in a voluntary manner.

In making such a decision, it is suggested that in order to make a valid decision, a person must first be in a position practicably to choose to instruct a representative. The decision must be the result of a choice made voluntarily and without duress. Further, the person must have had the opportunity of being made aware of the nature of the proceedings before the Tribunal, their possible outcome and the provisions of s. 50 (3) itself.

If this interpretation seems a little lengthy, it should be recalled that the High Court has held that the *Mental Health Act 1958* should be strictly construed. See *Watson v Marshall* (1971) 124 C.L.R. 621, at 629.

Section 50 (4) provides:

> A patient, other than a forensic patient, or a person detained in a hospital having any matter before the Tribunal may be represented by a barrister or solicitor or, with the approval of the Tribunal, by another person of his or her choice.

While this provision uses the word "may", it is clearly not a discretionary power given to the Tribunal, rather the discretion or choice appears to be given to the patient as the person appearing before the Tribunal. Where the patient desires to be represented by a solicitor or barrister, no leave to do so would be necessary, as these two specified classes of persons are involved. The Act is silent as to representation by any other person and, presumably, leave to appear and to be so represented is necessary. Thus, it is suggested that the provision amounts to the right to be represented if the patient so chooses. In addition, it follows that the patient also would have the right to an adjournment in order to obtain legal representation.

What would be the result if the new provision regarding a right to representation were to be breached? At Common Law, even though a procedure laid down in a statute is not properly complied with, the failure to follow the correct procedure is void only if it is termed "mandatory". If the correct procedure is not mandatory then it is termed "directory" and its breach does not make the proceedings void. There are also a number of other strict provisions regarding procedure throughout the Act, for example, the giving of notice and the enquiry as to the effect of medication. The following comments would apply similarly to any breach of those matters.

In *Clayton v Heffron* (1960) C.L.R. 214, the High Court was required to consider the failure to comply with a strict and detailed procedure prior to and during the convening of a joint sitting of New South Wales Parliament prior to the holding of a referendum. The matter turned on whether or not the failure to comply with the precise procedure rendered the referendum itself void. The court held that the breach would "mainly work inconvenience or worse on a section of the public". The breach was termed "directory" only and thus not void. The court at page 247, contrasted this breach with "the acquisition or exercise of private rights or privileges", implying that procedural requirements

in those terms would be termed mandatory and any breach of the proper procedure therefore void.

In *Willesee v Willesee* (1974) 2 NSWLR 275, the Supreme Court considered s. 3 (1) of the *First Offenders (Women's) Act 1918*. The section provides that "the hearing of such a charge and all proceedings, in connection therewith, shall, unless the defendant elects to be tried in open court, be in private". The section is remarkably similar to the provisions of the *Mental Health Act* 1983 now under discussion.

His Honour Mr Justice Holland considered whether the failure of a magistrate in a Court of Petty Sessions to follow the provisions of s. 3 (1) of that Act made the proceedings amenable to control by the prerogative writs and thus void. At page 282, His Honour said:

> To achieve this intention, the legislature has expressed itself in s. 3 of the Act, not in terms of conferring a right on the class of persons for whom the protection was intended but in terms of imposing duties on the Tribunal, before which the proceedings are brought. I would be reluctant to accept the view that in such a case, the court would not have intervened by use of the prerogative writs—prohibition to prevent a continuance of an existing violation of the statute and mandamus to compel performance of the statutory duty.

In *McInnis v R* (1979–8) 143 C.L.R. 575, the High Court considered whether a failure by a trial judge to grant an adjournment to an accused whose barrister declined to represent him the day before the trial because of a refusal of legal aid amounted to a miscarriage of justice. It should be noted that this matter involved a charge of rape and the majority of judges laid special emphasis on the distress caused to the prosecutrix by the delay in granting an adjournment to the accused. Whilst the court remarkably held that the facts of the case did not amount to a miscarriage of justice, it also spoke *obiter* of an accused's legal representation at trials of serious offences. It is suggested that in matters where there is no factor equivalent to that of the prosecutrix's distress, these latter matters ought to be given effect to.

Barwick C.J., Wilson and Aickin J.J., held that in the absence of legislative provisions the accused's right to representation was only one important factor amongst several in granting such an adjournment. As the majority, they held that any right of the accused to representation had to be balanced against the distress of the prosecutrix as a result of an adjournment. When balanced against this particular element, they held that the judge was correct in refusing the accused's request for an adjournment.

Mason and Murphy, J.J., held that the adjournment was wrongly refused. Murphy J., held that an accused had such a right in order to have a fair trial and that it was an essential element in the administration of justice in such cases.

In considering the construction of the *Mental Health Act 1958*, the High Court has held in *Watson v Marshall* (1971) 124 C.L.R. 621 at 629, "that in the interpretation of an Act which affects personal liberty, supposition as to the intention of the legislature has no place and the function of the Court is limited to interpreting and giving effect to its will, as expressed in the Statute." In effect,

the court stated that the 1958 Act should be construed strictly and by necessary implication in a similar manner to which criminal statutes are interpreted. There is no reason to suppose that the High Court would not apply *Watson v Marshall* to the *Mental Health Act 1983*, in general, and to the representation provisions in particular.

All judges in *McInnis'* case held that the accused's right to representation in serious criminal matters was of importance. The majority held that there was no miscarriage of justice because of the competing factor peculiar to sexual offence trials. There is no such similar competing factor in mental health proceedings and therefore, it is suggested, that the right of a patient in such proceedings is paramount. Further, the minority in *McInnis'* case considered legal representation to be a right.

The Supreme Court in *Willesee's* case held that the breach of a procedure couched in similar terms would make the proceedings void. The language used in the *Mental Health Act 1983* is sufficiently similar to support an interpretation that the representation provisions therein place a duty upon the Tribunal to ensure that the steps outlined earlier in order to comply with the requirements are in fact met. *Clayton v Heffron* also supports this conclusion by suggesting that "private rights" would be upheld in a similar manner, as opposed to matters which would cause "inconvenience".

If any conclusion is to be drawn from the legal representation provisions in the *Mental Health Act 1983*, it is that they are the result of the years of experience since 1977 which, as I have argued, have provided benefits to the individual patient as well as to the community in general. In my opinion, the most desirable result of paying greater attention to the civil rights of the individual is an increase in the standard of services provided to that person. The *Mental Health Act 1983* is itself one step in the recognition of this need. One would hope that it is a first and early step in this direction. The inconsistencies which have been noted in this paper must be eliminated by extending the safeguards to the individual in a consistent manner. If these further steps can achieve the focusing of public attention on the need to provide further services for the mentally ill, especially in the community, then it can be said that all these steps can become a path towards progress.

PRESENTATION OF PAPER

Irving Wallach

The Mental Health Advocacy Service has been referred to as an organization which was unique in this State and probably in Australia. I know that the Legal Aid Commission's activities in this State providing representation for people before the courts and also before other Tribunals does have a system which is well developed and which does attempt to ensure that most people who are unable through social or economic reasons to have representation can have that representation.

The establishment of this unit itself is an important step forward because it operates not only on the assumption that someone can be deprived of the opportunity to put his or her case to advocacy through economic reasons, but also by virtue of social reasons on the basis simply that a person may not have the opportunity to have access to representation before his or her case is dealt with by that Tribunal. That is something of which all of the solicitors, social workers and the education officer of the Mental Health Advocacy Service are proud. I would say they are justly proud to ensure that a person who is going to have his or her future affected in a fundamental way does have the opportunity to put the case on his or her own behalf. It is not just a case that a person would have the opportunity—as some people would have it—of having a lawyer try and get that person off or get that person out, but also that a person would thereby have the opportunity to obtain treatment if necessary as a consenting person. Possibly the best type of treatment would become available to that person. In the extreme case, where someone is to be deprived of not only their liberty but also their right to consent to medical attention, where that deprival of liberty is in no way warranted by the facts of the situation.

The *Mental Health Act 1983* takes a lot of those things into consideration. As you know it is not yet fully in operation. The provisions in relation to the forensic patients have been proclaimed only in recent weeks and the Mental Health Review Tribunal is now in its third week of sittings.

The provisions in relation to involuntary patients at hospitals are generally not in application. It is the fact that the representation provisions under section 50 of the Act which provide that a person shall be represented unless that person refuses are now in operation, and I would think that the policy and intention of the Act itself reflects the concern of the government in establishing through the Legal Aid Commission its Advocacy Service for patients.

The service itself consists not only of lawyers but also social workers and an education officer. The Commission has taken the view that in this particular area it is not enough to have someone's legal needs only met. Quite clearly the vast majority of people do have other social needs which require attention and need to be addressed at a time when they are facing a Tribunal of this State. In addition, there is also the position of an education officer which does recognize the importance that the community at large, including our client group, are aware of their legal rights and that those professionals involved in providing care for the mentally ill also become aware of the state of the law and of the role of advocates in representing persons before the Tribunals under the *Mental Health Act.*

The intention of the Act has been to increase accountability, and not only deal with the question of addressing individual rights. That is certainly a theme which runs throughout the *Mental Health Act 1983*. I know that the question of the term "accountability" is at this very moment a hot one, especially given our other brothers in the legal profession, but it is certainly something which affects patients and people who come within this area. The aim is to ensure that things are now done publicly, that the person has the right to put before the Tribunal, which is going to affect him or her, the available options from his or her point of view or the facts of the situation. I would suggest the intention of the policy is to have all this done openly and without any other factors which may constrain those persons' rights.

Having said that, I must say that there are some things of late which have occurred which to my mind do raise issues of concern, and which do certainly appear to fly in the face of what I believe to be the policies and the intentions of the new legislation.

The first relates to the actual operations of the Mental Health Review Tribunal itself, and I really cannot go into this matter in particular detail because I have only just been appraised of a late development myself. It relates to whether or not a person appearing before the Tribunal has the right to know what recommendation is made to the Minister by the Tribunal and the reasons for it. I feel I must tread very carefully here because it involves a matter in which our chairman, Mr Davidson, has acted in his capacity as President of the Tribunal.

I have just had Mr President's decision handed to me and I have not read his quite lengthy decision in the matter. I have read the "bottom line" and I have read the back page (which is a habit of all lawyers as they go into court) and the President in his wisdom has decided that there is no basis in law for the Tribunal to give the reasons for its decisions to the patient or advocate or to give the recommendation which it will pass on to the Minister. I really do not want to say more about the actual decision because I have not read it and I cannot really say anything in relation to it until I have done so. I would only say I would have to disagree very strongly (as I put to the President during the Tribunal's sittings). Without going into the quite complex legal arguments involved I would have to say that it is certainly contrary to the spirit and, I would go further and say the policy, of the Act by effectively leaving a person before the Tribunal in the dark as to what may or may not have been the result of the representations made on his or her behalf and, further, not even knowing the reasons for it. Given the fact that the system incorporates a six month system of reviews it can well be the case that a Minister of Health could on the same grounds or on similar grounds raised by the Tribunal likewise refuse to inform the person what were the recommendations of the Tribunal or the reasons for those recommendations. Apart from, to my mind, the quite clear breach of any natural justice involved, it leaves the person (who is in a situation where that person has to have his or her case reviewed every six months) in the dark as to what he or she may well put on the next occasion to the Tribunal in order to have conditions ameliorated, in order to have release on conditions considered, or an outright case for discharge from the hospital considered. I regard that certainly as a very serious situation.

The comment by Dr Sainsbury on my paper has been distributed. On page 64* there is what I find a startling disclosure in relation to comments he made on **Case 3** which I have spoken about in my paper. He says as follows:

> The fact is that a second set of files on forensic patients is kept at central administration of the Health Department under lock and key. These files have been made available to other legal officers on request where this is relevant and proper.
>
> * * * *
>
> Had the Mental Health Advocacy Service lawyer asked any of the current authorised officers, including the one working in Head Office in another capacity as well, I am sure that the further information relevant to **Case No. 3** could have been made available—information which shows clearly what further action was taken by the authorised officer in question.

Now I personally am intrigued to discover the existence of this second set of files. Since May this year it has been common knowledge to all relevant officers of the Health Department, and also amongst people involved in the legal profession, that solicitors from the Mental Health Advocacy Service have been taking instructions in order to advance their client's case and to put their client's case before the Mental Health Review Tribunal. During that entire time no one in the Mental Health Advocacy Service has been advised by any person in the Health Department of the existence of a second set of files, a set of files which I can only assume by implication are at the disposal of any of the authorised officers and presumably, Dr Sainsbury can correct me if I am wrong, at the disposal of the Minister and his advisors at the time the Minister may make his final decision, as to the future of a person who appears before the Mental Health Review Tribunal. It would be an understatement for me to say that I am disturbed to find at this stage, in the middle of the third week of sittings of the Mental Health Review Tribunal after the cases of some 30 human beings have been considered by that Tribunal, that a Minister in making his final decision will have access to information of which at the time that that person's representatives put that person's case had no knowledge at all. One may well say, as Dr Sainsbury does say: "had the Mental Health Advocacy Service lawyer asked any of the current authorised officers for files" that no one had any inkling existed. He may well say that, but, of course, he does say so without anyone having been informed of their existence. I think that statement can be seen for what it is. One may well ask now what is the lawyer in each of those cases to do. Ask that the Tribunal re-list each and every one of those cases after access has been had or simply wait and go on and hope for the best.

Well, having been taken on the hop myself, certainly as regards that, I do not think I can express an opinion about what ought to be done. Certainly those two things just come to light recently, almost quite dramatically, one may well ask whether or not the intentions of the Act are being carried out? How meaningful exactly are the hearings at the Tribunal in the light of all of those matters? I suppose having left those questions hanging I will conclude my comments.

**Note:* Page 64, paragraph beginning "I can assure you ..." was added at the seminar in reply to these comments of Mr Wallach. [*Editor*]

THE DEFINITION OF A MENTALLY ILL PERSON

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In an article published in the *Australian and New Zealand Journal of Psychiatry* in 1984,[1] I tried, as objectively as I could, to trace the historical development of the definition of the term "mentally ill person" from the 1958 *Mental Health Act,* through the Edwards Committee and subsequent committees, to its final version in the 1983 Act. One of the assessors of the article suggested that it would be interesting to have my own views on the subject rather than just an objective recital of the facts. In reply, I said that I would present my views in a different forum at a more appropriate time. This appears to be a suitable forum and, with the imminent proclamation of the *Mental Health Act*, it is certainly a suitable time, so let me tell you what I think of the definition of the term "mentally ill person" in the 1983 *Mental Health Act.*

I don't intend to spend any time going through the definition as it stands because I assume that all the people at this seminar have a vested interest, in one way or another, in the new *Mental Health Act* and are therefore already familiar with the term "mentally ill person" and the way it is defined in the Act. I intend, instead, to concentrate on several specific aspects of the definition that I consider need a public airing.

Let me just say first of all, however, that any definition of "mentally ill person" is purposive and the purpose needs to be clearly understood and stated. Similarly, any definition of "mentally ill person" has an underlying philosophy or ideology and that also needs to be understood and stated. In general, the purpose of a definition of "mentally ill person" is to enable people who (a) have a mental illness, and (b) in addition to their mental illness have certain behavioural abnormalities that are presumably associated with and/or caused by the mental illnesss, to be (a) temporarily removed from society, and (b) assessed and treated against their will and/or without their consent.

All these issues (the definition of mental illness, the nature of the behavioural disturbances, the removal from society and forceable (and/or nonconsensual) treatment) are contentious issues and raise a plethora of medical, legal and social problems, none of which will ever be resolved to the satisfaction of everybody in society. There always have been and always will be two or more sides to every one of these issues and there are persuasive arguments on all sides, ranging between the extremes of the "humanitarian" argument ("people who are mentally incapable of looking after themselves need to be looked after by somebody else"), an argument which is sometimes stated as a "rights" argument ("people who are mentally incapable of looking after themselves have the right to be cared for by the State"), and the civil libertarian argument ("nobody has the right to take control of the mind of somebody else

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[1] Shea, P. B. (1984), "The Statutory Definition of a Mentally Ill Person in N.S.W., 1958–1983", *Australian and New Zealand Journal of Psychiatry,* 18:218.

without that person's approval"). For the purposes of this paper I have, of course, caricatured the three arguments.

Whether or not a person with a mental illness and associated behavioural disturbances should be removed from society and treated forceably are matters for society in general to determine (through their elected representatives). The bottom line is the type of society one wants to live in. I do not intend to deal with these issues here although I consider them to be vitally important issues. What I do intend to deal with are the other two issues—(1) the definition of mental illness, and (2) the nature of the associated behavioural disturbances that need to be tacked on to the definition of "mental illness" to complete the definition of a "mentally ill person" for legal purposes.

The definition of mental illness is not a simple matter. There is no satisfactory, all-embracing, all-purpose definition of mental illness. It simply does not exist. There are a number of separate mental disturbances which, traditionally, have been clumped together and called mental illnesses but they are a very disparate group of conditions indeed and it is very difficult to find a common unifying factor or thread to explain why they are clumped together in this way. There is certainly no common aetiological factor. One could be simplistic and say that they are all disorders of the mind but this doesn't really get us very far. We are just substituting one term for another similar term and the term we are substituting, the "mind", is a rather slippery concept in itself.

Now, while there may not be any satisfactory, all-embracing, all-purpose definition of mental illness, there are, as pointed out above, certain individual illnesses that are clumped together and called "mental illnesses". These are the illnesses listed in any standard textbook of psychiatry and in various international classifications of mental illness or mental disorder such as the International Classification of Diseases (I.C.D. 9) and the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (D.S.M. III). The problem here, however, is that the lists do not always coincide and even where they do and there is general agreement that a particular mental illness exists, there is often disagreement as to what signs and symptoms constitute that particular mental illness. The classical example of this is, of course, schizophrenia.

For many years, these difficulties have been seen to constitute an insuperable barrier to a precise definition of the "mental illness" part of the term "mentally ill person". I would like to suggest a possible way out of this dilemma because I happen to believe that the interests of all parties concerned (patients, relatives, professionals involved in treatment and management, and legal personnel alike) would be served far better by having specific definitions of mental illnesses that could be used over and over again than having vague, completely open terminology that has to be re-argued in every magistrate's inquiry and every Tribunal hearing. I believe that, in the past, too much emphasis has been placed on the problems arising from the differences between the various definitions that are available. I do not believe that these differences constitute an insuperable barrier to precise definition for legal purposes because if you look at the differences closely, they are usually differences of emphasis not insuperable differences of opinion. I therefore propose a pragmatic approach.

I suggest that an appropriately constituted and balanced committee consisting of, say, psychiatrists, lawyers, magistrates, judges and consumer representatives, should be given the task of devising a list of those illnesses that most people would agree are clearly mental illnesses. The list would probably be fairly small in the first instance and would include at least the functional psychoses (schizophrenia, mania, major depression, manic-depressive psychosis and the paranoid psychoses). Whether other conditions, such as the organic psychoses, especially dementia, should be included is a matter that would have to be debated but eventually it should be possible to arrive at a list that was a reasonable consensus. The next step would be for the same committee to provide operational definitions for each mental illness on the list. The operational definitions would also be a matter for debate and consensus but the definitions in the standard classifications referred to above (the I.C.D. 9 and the D.S.M. III) would provide a useful starting point for discussion.

The next problem is what to do with the list. It needs to be given some authoritative weight and there are various ways this could be done.

(1) *It could be enshrined in the Mental Health Act itself.* It is interesting to note that there has already been a hesitant step in this direction in the 1983 Act with (a) the naming of the manic phase of a manic-depressive illness as an illness for the purposes of the definition of a "mentally ill person", and (b) the reference to the "serious and permanent physiological, biochemical and psychological effects of drug-taking" (which seems to me to mean dementia) as "mental illnesses" for the same purpose. I will return to this later. The problem with enshrining such lists and definitions in a statute is that it tends to set them in legal concrete. If it was considered appropriate, perhaps just the list of conditions could be included in the Act. The definitions could be promulgated by way of regulation under the Act.

(2) *Alternatively, both the list of conditions and their definitions could be promulgated by way of regulation.* This certainly allows for greater flexibility but it may allow for too much flexibility so there would need to be some way of ensuring that changes in the regulations were not made on the basis of administrative whim but only after an extensive consultative process involving the people who originally devised the list (or a similar group).

(3) *A third possibility is to circulate the list and the definitions as a statement of policy with the imprimatur of both the Department of Health and the Attorney-General's Department.*

Whichever of these options was considered most appropriate (and there are probably a number of other options that I haven't considered) there would also need to be a provision for changing the list and the definitions from time to time. And just to forestall criticism, I might point out that I have no strong personal commitment to any of these proposals. I am merely putting them forward to stimulate discussion.

Nature of associated behavioural disturbances

With the "mental illness" part of the definition in place, the next problem to solve would be the behavioural elements that need to be tacked on to complete the definition of a "mentally ill person". The 1959 Act was rather vague on this matter and used woolly terms such as "for his own good or in

the public interest" and people preparing the 1983 Act rightfully decided to be more specific. They decided, however, that the appropriate categories of behaviour would be restricted to actual or threatened physical harm, through act or neglect, to oneself, and actual or threatened physical harm to others and nuisance and harassment to others "which would be reasonably likely to lead to violence and which is of a degree so far beyond the limits of normal social behaviour that a reasonable person would consider it intolerable". I might just note in passing that, in the field of mental illness, the "reasonable person" concept itself could raise a quite a few problems. I don't want to dwell on this point but we may be able to raise it again in question time if anyone wants to pursue it. I want, instead, to go on to s. 5 (1) (a) (v) of the *Mental Health Act* (1983) because this is one of the most fascinating parts of the Act and it illustrates the many pitfalls that people devising a definition of a "mentally ill person" can fall into.

S. 5 (1) (a) (v) came into the Act between the 1982 Bill and the 1983 Bill and it states that, in the case of a person in the manic phase of a manic-depressive illness, harm other than physical harm (to wit, "serious financial harm or harm to his or her reputation or standing in the community", i.e. serious financial or social harm) can be considered as behavioural disturbances for the puposes of the definition of a "mentally ill person".

Now this brings us to philosophies and ideologies and politics and the starting off point might be to ask: why physical, financial or social harm in the case of a person in the manic phase of a manic-depressive psychosis but physical harm only in the case of all other mental illnesses? The psychiatrists advising the Health Department put forward a very strong case for the inclusion of serious social and financial harm as behavioural elements for all forms of mental illness at the time the 1982 Bill was being prepared. Their arguments were forcefully and totally rejected, not by the Health Department but by the Attorney-General's Department, and it so happened that the Attorney-General's Department's wishes prevailed. Serious social and financial harm were *not* included as behavioural elements for any mental illness in the 1982 Bill. In the 1983 Bill, however, they *were* included but only for people in the manic phase of a manic-depressive illness. If it was considered ideologically unsound to include serious financial and social harm at all in the 1982 Bill, why was it included in the 1983 Bill and why specifically for people in the manic phase of a manic-depressive illness? The answer is, quite simply, political. When the 1982 Bill was tabled, submissions were invited from interested parties. Among the submissions received was a very persuasive submission from the manic-depressive group who lobbied heavily on their own behalf for a provision whereby they could be treated involuntarily in times of crisis. In response to that lobby, the clause about serious financial or social harm in the case of a person in the manic phase of a manic-depressive illness was inserted. There are, of course, no logical reasons whatever for distinguishing between people in the manic phase of a manic-depressive illness and people with other major mental illnesses in this way. People with other severe mental illness, such as schizophrenia or major depression, are likely to suffer as much financial or social harm from their illness as people in the manic phase of a manic-depressive illness. And schizophrenia and major depression are, of course, much more common than manic-depressive illness and likely to affect a much larger number of people.

One might also ask, why the manic phase only of a manic-depressive illness? Why wasn't mania *per se* included? This is very difficult to understand. I have the suspicion that it was a drafting error because it just doesn't make sense otherwise, but I would be interested to hear from anyone who was more directly associated with the final drafting of the Act as to whether there is some alternative logical explanation.

My opinion, for what it is worth, is that harm other than physical harm should be included as a general provision in the definition of a "mentally ill person" for all mental illnesses, provided there is agreement, as proposed earlier, about the list of mental illnesses recognised for the purpose of the Act and provided adequate safeguards are present (as they are in the 1983 Act) to prevent unnecessary detection.

Next, I want to deal with the vexed question of **dementia.** And let me approach it by way of mental retardation (or developmental disability of the mind). I think that most authorities would agree than mental retardation is not mental illness but an entirely separate disorder (or group of disorders). Mental retardation is caused by physical damage to, or arrested development of, the brain. But dementia is also caused by physical damage to the brain. There are no psychological reasons why people become demented. Physical damage occurs and while this, in turn, may lead to psychological signs and symptoms developing, the latter are clearly the result of the dementing process, not the cause. So one could argue, by analogy, that if mental retardation is not a mental illness because it is caused by physical factors not psychological factors, then dementia, which is simply brain damage at the other end of the age spectrum, is not mental illness either because it is clearly caused by physical factors not psychological factors. This is a very persuasive argument. It is, however, an argument with very far-reaching consequences. Some people might argue, for example, quite reasonably, that illnesses such as schizophrenia and major depression can have physical causes and that there is a large body of evidence (from the fields of genetics and biochemistry) to support this hypothesis. It is even possible to extend the argument further and to argue that all mental activity is the result of physico-chemical activities in the brain (unless one postulates a mind independent of the brain, an argument that I do not wish to get into as it involves abandoning the realm of psychiatry for the realms of metaphysics and theology) and that all mental illnesses, therefore, have an underlying physical substrate.

Let me get back to the specific topic of dementia, for an interesting situation will arise with the proclamation of the 1983 Act. Mr Justice Powell, as you are all probably aware, has determined that neither dementia nor mental retardation are mental illnesses for the purposes of the definition of a "mentally ill person" in the 1958 Act. According to Mr Justice Powell, dementia falls into the category of "mental infirmity due to age" and this is not the same as mental illness. In the 1983 Act, however, dementia from at least one cause—drug-taking (which includes alcohol)—is clearly considered to be a mental illness for the purposes of the definition of a "mentally ill person" in the Act. The latter is a fascinating inclusion in the Act and, again, I think it came about because of a drafting error. In the 1982 Bill, certain conditions were excluded, under s. 5 (2) from the definition of a "mentally ill person" and, as just pointed out, they included drug-taking. This was intended to exclude lifestyle situations, i.e. it was intended to ensure that a person whose lifestyle involved heavy drug and

alcohol use could not, by virtue of that lifestyle alone, be treated as a "mentally ill person" under the Act. In line with this ideology, it was proposed that the *Inebriates Act* be repealed when the new *Mental Health Act* was proclaimed. It was obvious, however, that there was a need for a provision to ensure that people suffering from the side-effects and complications of their drug and alcohol-taking were not excluded from treatment under the *Mental Health Act.* In all the discussions in which I took part at the time, however, and these included discussions at ministerial level, the focus of discussion were the toxic psychoses, i.e. the acute complications of drug and alcohol taking (such as the L.S.D. or amphetamine psychoses and delirium tremens). It was because of the need to be able to treat the toxic psychoses such as these that s. 5 (3) was included in the 1982 Bill. S. 5 (3) stated that nothing in s. 5 (2) (which was the subsection that excluded drug-taking *per se* as mental illness) prevented "in relation to a person who takes or has taken drugs, the physiological, biochemical or psychological effects of drug-taking from being regarded as an indication that the person is mentally ill". This subsection clearly picked up people with toxic psychoses from drug taking or alcohol abuse and allowed them to be treated under the *Mental Health Act.* Somewhere between the 1982 Bill and the 1983 Bill, the words "serious and permanent" were inserted into s. 5 (3) and this, unfortunately, excludes the toxic psychoses, which were the very conditions that s. 5 (3) in the 1982 Bill was designed to catch. What it does catch, instead, are the drug and alcohol induced dementias.

Once the 1983 Act is proclaimed, it will be possible to argue, quite forcibly, on the basis of s. 5 (3), that if dementia from drug and alcohol taking is considered to be a mental illness, then dementia from all causes should be considered to be mental illness. This is a matter that will need to be brought to the attention of the Supreme Court, through a test case, at the earliest opportunity following proclamation of the Act.

A final minor point which needs to be corrected in the definition of a "mentally ill person" in the 1983 Act is s. 5 (2), which states, in its stem, "A person is not a mentally ill person by reason only of any one or more of the following", and then goes on to list the conditions that are excluded, such as drug-taking. This is a trifle confusing because the exclusion clauses clearly relate to the "mental illness" part of the definition of a "mentally ill person" not the definition as a whole. I would suggest that the stem be altered to make this clear.

Now I know that what I have said is going to annoy some people, particularly as I am suggesting that changes are needed before the new Act is proclaimed. I am also a realist and am aware that such changes are most unlikely to occur. I believe, however, that the problems that the definition of a "mentally ill person" in the new Act are likely to cause, should be brought to people's attention well in advance of the proclamation of the Act, so that people can prepare themselves. I am also hopeful that this paper will act as a catalyst to change sometime in the future. If I could briefly summarise the main message of this paper, it would be that the definition of a "mentally ill person" in the 1983 Act is a bit like the house that Topsy built. It doesn't just need reconstruction work. It needs to be reworked from the ground upwards.

PRESENTATION OF PAPER

Dr Peter Shea

I am talking about the definition of the mentally ill person in the new Act. It is the most important part of the Act. Everything else revolves around it. There are some problems with that definition as it now stands. I would like to run through them fairly briefly.

I have mentioned four in my paper:

The first is a fairly simple matter—the fact that a person in the manic phase of a manic depressive illness is mentioned as being mentally ill for the purposes of the Act. As I point out in my paper this is ridiculous. People who have mania *per se* have exactly the same illness as a person in the manic phase of a manic depressive illness. Yet the way it is phrased it would appear as though that people with mania *per se* would be excluded from the definition of mental illness. The definition should be changed to mania *per se*. This is only a small point but the significance of the sections dealing with mania is that it also includes under the definition of harm, protection from not just physical harm but also protection from financial and, to summarise, social harm as well. Now, this is interesting because it was not in the original Bill which went into Parliament in December 1982. It came into the 1983 Bill after representations were made by people from manic depressive self-help groups themselves who felt that they should be able to be treated at times involuntarily if they were suffering from the manifestations of the illness.

The question you have to ask is why would you put in protection from social harm and financial harm in the case of a manic patient and leave out protection from financial and social harm in the case of a person with schizophrenia, or a person indeed in the depressed phase of a manic depressive illness or a person who is just plain depressed? All these people can suffer from financial harm and they can suffer from social harm, and they can suffer every bit as much financial harm and social harm as people in the manic phase of a manic depressive illness, so it is logically absurd to just include the people in the manic phase of a manic depressive illness. So you might ask indeed why is it in there in that case? I might say I agree with it being in there. I think it is very important to have it there but I think it should be extended. It is there because it is a fact that people who have a manic depressive illness tend to come from a slightly higher social class than people say with schizophrenia. They also tend to be more often very articulate, and they were a very powerful lobby group when the submissions were asked for on the 1982 Bill. The people who speak on behalf of the schizophrenic population of this world are very few indeed. They are nowhere near as articulate as those who speak on behalf of the manic depressive group and their views were not heard. It was as simple as that.

I am speaking on behalf of the rest of the mentally ill people in this world and I am suggesting that the provision to include protection from serious financial or social harm should be extended to people suffering from other forms of mental illness and not just people in the manic phase of a manic depressive illness. That is the first point.

The second point I want to discuss is the question of dementia. It is not mentioned as such in the Act but the Act in s. 53 raises a very interesting point. If you have seen the wording of s. 53 you will see that it says that nothing in sub-section 2 which deals with the exclusion clauses prevents, in relation to a person who takes or has taken drugs (which includes alcohol) (these are the key words), "the serious and permanent physiological, bio-chemical or psychological effects of drug taking being regarded as an indication that a person is mentally ill". The only thing that I can think of that is a serious and permanent effect of drug taking (which includes alcohol) is dementia. I have racked my brains for others. I thought of a few long term hallucinoses and so on but the major group is obviously dementia. So on the one hand we have this section of the new Act saying that dementia from drug and alcohol taking is in fact mental illness. On the other hand we have a series of Supreme Court decisions by Mr Justice Powell saying that dementia is not a mental illness for the purpose of the Act, which is an interesting paradox.

I might say by the way that this particular section was not intended to read the way it does. When it was first written the words "serious and permanent" did not occur in that particular clause. The clause was intended to catch the person who was suffering from a toxic psychosis, a person in the acute phases of a psychosis from taking L.S.D. or alcohol, or other drugs, or the withdrawal phase of certain drugs.

Somewhere between the 1982 Bill and the 1983 Bill somebody put in the words "serious and permanent" which totally changed what the clause was intended to mean. It was not intended to mean dementia at all, it was intended to mean toxic psychosis. I presume it is a drafting error but it has totally changed the meaning of this part of the Act. I am hopeful that that part can be altered to include the original meaning of the legislation.

Finally the last point is the point I make in the opening part of my paper where I say that I would like to see mental illness defined in some way at law, and I have suggested that there should be a committee to look at this. I would not have said this five years ago to be perfectly honest and anybody who has listened to my lectures over the years knows I hate using psychiatric labels. I do not think labels help us to understand people terribly well. So why am I suggesting that we use psychiatric labels in an Act of Parliament or in regulations under the Act to define mental illness? There are two reasons. There is a precedent for it in the 1983 Act. The phrase, the manic phrase of a manic depressive illness is included and that is a diagnosis, a label.

But secondly we have seen a lot of decisons coming down from the Supreme Court in which the judge on the bench makes his own mind up about what he thinks should be mental illness for the purposes of the Act. At least at the moment it is the 1958 Act. I think that is not the way to go about defining what is or what is not mental illness. I think it should be decided by a group of the people who are involved in caring for patients, the relatives and friends of patients, and the patients themselves and I think it should be enshrined in some way in the legislation. To forestall all the comments I am going to get about this I would like to bring to your attention some of the comments I have already received.

One of the comments is that if you do this there is a danger of making the list too broad or too narrow. That is a danger, I agree, but I think that we can introduce a system to ensure that new conditions can be introduced to the list and other conditions taken out by appeal mechanisms. I have also had people tell me that the labels may be too restrictive in that you need a fairly broad definition, so that where you have a person you cannot diagnose immediately you can use a broad term like mental illness itself and then settle for a definition later. I think that can be overcome by having a broader stem at the start of the definition and then saying: "and this includes conditions such as schizophrenia, depression, mania, toxic psychosis, dementia, and so on". People have told me it is too hard because you get all sorts of degrees of schizophrenia, for example. Some people have a lot of symptoms, some people have a few. My answer is you get various degrees of heart disease as well. That does not preclude you from treating a person who has heart disease. I know it is difficult to use definitions but I do not think it is impossible.

I think there are many other problems in the present Act and one of the major things missing from the Act is a consistent ideology, some sort of underlying philosophy which guides and directs the Act. It has arisen through a whole series of committees and each of those committees has added things to the Act or has taken things away from the Act. All the committtees have had different people on them and they have all thought in different ways. The result is that we have, as I say in the paper, something like the house that Topsy built. In my opinion it needs a total revision, rather than further tinkering.

I would like to see the thrust of the Act being towards community treatment orders rather than having particular places gazetted to which people are taken. I would rather see community treatment orders which can be put on a person wherever they live or happen to be.

DANGEROUSNESS

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The *Mental Health Act 1983*, and the *Crimes (Mental Disorder) Amendment Act 1983*, have forced all concerned with the care, treatment and control of persons who are mentally ill, to focus particular attention on to the concept of dangerousness.

There is a need to define, diagnose, and even to predict this condition. Who best can do this?

A Task Force of the American Psychiatric Association back in 1974 made the following statement:

> The ability of psychiatrists or any other professionals to reliably predict future violence is unproven.

It is now twelve years on and I don't really know whether the American Psychiatric Association has cause to change its mind today. However, it *has* fallen largely to the lot of psychiatrists to act as prophets and guides in three situations: the criminal courts, in civil commitment procedures, and in decisions on the release of offenders[1] where potential violence or dangerousness is a factor to be considered.

I expect this is the reason for the topic of dangerousness to be given to a psychiatrist at this seminar. In defence of the choice of discipline to speak on this topic it is the psychiatrist who almost certainly spends more time than most professionals in getting to know people, not simply at a superficial level but at the level of raw emotion, delusional belief and motive. So one could assume that a clinical psychiatrist should be reasonably placed to predict violent behaviour.

This assumption, however, is probably incorrect and has been challenged from both inside and outside the ranks of psychiatrists. Indeed the diagnosis of dangerousness is based on inquiry and examinations that extensively pursue areas of concern not fully dealt with in routine psychiatric assesment[2], and unless a psychiatrist develops a particular interest and has experience in assessing dangerous potential, his intuitive guess may be little or no better than the next person's guess.

My own particular involvement in assessing the potential for violence in people must be regarded as limited, being comprised of the past three and one half years spent as an authorized officer under the *Mental Health Act*. Part of the role of an authorized officer is to accept responsibility for security conditions pertaining to forensic patients detained in our psychiatric hospitals; and an

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[1] Mullen, P. E. 'Mental Disorder and Dangerousness, Review Article', *Australian and New Zealand Journal of Psychiatry* (1984) **18**: p. 9.

[2] Kozol, H. L., Boucher, R. J., Garofalo, R. F. 'The Diagnosis and Treatment of Dangerousness', *Crime and Delinquency*, **18** (October, 1972) p. 383.

appraisal of dangerousness is essential before authorizing the transfer of a patient to a less secure environment or authorizing the giving of more degrees of freedom which would entail contact with civil patients in hospital, and in many instances, ultimate contact with the general community. With such limited personal experience I shall draw heavily on a review article by Mullen entitled "Mental Disorder and Dangerousness"[3] and on other relevant literature.

Unless touched by mental illness in a friend or relative, it appears to me that people in general are less concerned about a person's dangerousness towards himself/herself than they are about dangerousness towards others, themselves included, and it is on this latter aspect of dangerousness that we shall concentrate.

Defining dangerousness

In order to focus on the concept of dangerousness it seems not unreasonable to start with the topic of violence.

Violence may be a perfectly ordinary non-pathological phenomenon. It may or may not lead to dangerous behaviour. It may be seen in a broad spectrum of events, for example, boys fighting in the school playground, boxing matches, pub brawls, armed robbery, and warfare. Violence is universal among social animals and has complicated functions. Like all complex behaviour it has complex origins and is (perhaps) best understood as being caused by an interaction of factors, some social, some related to habit and learning, others psychological and some medical, either physical or psychiatric.[4]

At primary school I was leader of a gang—naturally the goodies. It was my role as leader to match the skills of the other gang's leader. It was a competitive situation involving playing marbles, playing soccer with a tennis ball, the ubiquitous police and robbers, and naturally enough the occasional fight or test of physical strength. This latter I tried to avoid if possible because the leader of the other gang was captain of the under 6 stone Queensland State Schoolboys Rugby League side and I was considerable lighter than 6 stone.

This competitiveness/rivalrous situation which occasionally erupted into violence was sometimes carried on after school hours. One afternoon my gang and I were in our fort made of sticks and whatever foliage we could find on a vacant allotment. Our rivals were similarly housed. World War II was being fought but we had our own private local war with our home made wooden swords and useless bows and arrows which I don't recall ever being shot in anger. Most of our warfare was in the mind or imaginations. It could hardly be regarded as dangerous until some clown in the opposing gang started shooting at us with a Daisy air rifle.

A harmless if potentially violent situation had become a dangerous one. Sticks and stones, apart from the David and Goliath incident, are no match

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[3] See Mullen, *op. cit.*

[4] Gunn, John, Chapter entitled 'Forensic Psychiatry' in *Recent Advances in Clinical Psychiatry, Number Three*, edited by Kenneth Granville-Grossman (Churchill Livingstone, Edinburgh, London and New York 1979) p. 275.

against real weapons so we beat a hasty retreat back to the protection of one of my gang's mother who lived nearby. We concluded that the chap with the air rifle was dangerous.

I have learned since that dangerousness is not a quality of an individual but of that individual's actions. Dangerous actions are not non-specific actions occurring in a vacuum. They occur within contexts which have particular meanings for the individual who performs the actions. Dangerous actions are in the main intentional and are carried out by people who are, or who believe themselves to be, in a situation which justifies and precipitates them toward aggressive action[5].

The boy with the air rifle could well have been under extreme albeit imagined threat believing that we in our fort matched the combined genius of our better wartime leaders, and were about to deliver some fatal thrust to his side. This may have been his justification for firing at us.

In passing, it should be mentioned that raw emotion and delusional belief associated with mental illness appear to take a back seat to motives not psychiatrically determined in this day and age; and it would be remiss not to highlight political and religious ideologies as being important ingredients in the concept of dangerousness. Throughout history these have provided the motivation for wholesale violence. Such motivation can also underlie the actions of some of the individuals who come within our purview.

To define dangerousness would reify it and in view of the fact that a dangerous act requires an actor and a background and another player or other players, it is best perhaps to vaguely delineate it as "a propensity to cause serious physical injury or lasting psychological harm to others" (Butler Committee, 1975)[6] or as "a potential for inflicting serious bodily harm on another"[7]. We shall confine ourselves to the latter definition.

Who are the dangerous?

We can start by dispelling the myth that mental illness in a global sense correlates with dangerousness. There may, however, be certain sub-groups within the mentally disordered population who are more prone to violence than others. This will become apparent as we proceed. Three main types of study have been carried out to determine a possible relationship between mental illness and dangerousness.

The **first** of these have looked at conviction rates for ex-psychiatric hospital patients. The earlier studies suggested levels of subsequent conviction lower or similar to that of the general population.

More recent studies have suggested that discharged mental patients may be more dangerous than the average citizen. Many of these later studies have been criticised for methodological flaws, including a failure to control, for

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[5] Muller, *op. cit.* p. 9.
[6] *ibid.* p. 7.
[7] Kozol *et al.*, *op. cit.* p. 372.

example, the relevant demographic variables, sample sizes and previous arrest records. Indeed one critic of these recent studies has concluded that "the higher rate of violent crime committed by released mental patients can be accounted for entirely by those patients with a record, particularly an extensive record, of criminal activity that predated their hospitalisation" (Monahan, 1981)[8]. On the other side of the coin, Sobowsky (1980)[9] refutes this by pointing out that in his series, ex-patients with no previous arrests had three times the subsequent rate of offending when compared with the average citizen.

Mullen concludes that the studies available are simply not able to give a definitive answer and do not justify abandoning the null hypothesis that there is no correlation between the status of an ex-psychiatric patient and a conviction for a crime of violence.

He, however, goes on to quote the studies of Hafner and Boker (1982)[10] from the Federal Republic of Germany, who surveyed over ten years all crimes of violence committed by mentally disordered individuals. They used a narrow and strict definition of mental disorder which equates it with mental illness.

Their findings showed that the relative probability of mentally disordered individuals committing a violent crime did not exceed the dangerousness of the legally responsible adult population as a whole.

However, the study also looked at mentally normal offenders as well as the main target population of mentally disordered offenders, and it looked also at non-offending mentally disordered individuals. A number of factors emerged, suggesting there may be higher risk groups within the totality of mentally disordered individuals. For example, in comparison with the non-violent mentally abnormal population, the mentally abnormal offenders had a stronger family history of offending and they were themselves significantly more likely to have a previous history of anti-social traits. Hafner and Boker concluded that a tendency to aggressive behaviour is rooted in the personality and usually manifests itself long before the onset of the mental disorder.

The study also pointed to particular clinical features which may be associated with an increased propensity to violence, e.g., systematic delusions of persecution in schizophrenic subjects when accompanied by the experience of danger or threat to life, and delusions of jealousy.

The violent offenders with psychotic depression seemed to form a special case in their series. In the main, attempted homicide, successful or otherwise, was accompanied by attempted suicide. The authors were of the opinion that the violence was closely associated with the psychotic depressive illness and was not a reflection of pre-existing anti-social personality traits or aggressive patterns of behaviour.

The **second** type of study on the probability of dangerous behaviour in the mentally abnormal is to look at the frequency of assaults immediately prior to and during admission to hospital. There are very few studies on levels of

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[8] Mullen *op. cit.* p. 7.
[9] *ibid* p. 11.
[10] *ibid* pp. 11, 12, 16.

violence prior to admission. Those that have been done are in the main retrospective studies and it is extremely difficult to form conclusions on retrospective studies of case records. One such study[11] of 400 patients from New Jersey reported that 12 per cent committed actual assaults prior to admission. A study specifically of domestic violence prior to admission, reported fourteen (23 per cent) of a group of sixty consecutive admissions had battered their spouses. In another cohort of 1 033 patients, 11 per cent had acts of violence noted on their admission records. A highly selected group of fifty-one disturbed adolescents gave a figure of 66 per cent with histories of personal violence prior to admission. A study of violence in 138 morbidly jealous subjects revealed that over 50 per cent of the males and 40 per cent of the females had assaulted their partners in the six months prior to admission. Two of the studies mentioned, namely those on disturbed adolescents and on morbidly jealous patients, are on highly specific populations. The other studies mentioned do not compare rates of assaultive behaviour in their mentally ill group with rates of such behaviour in matched control groups in the community who are not mentally ill. Assaultive behaviour in the non-mentally ill community could have been just as high. No valid conclusions can be drawn from such studies.

Studies on inpatients give greatly varied figures of violence ranging from 7 per cent of a chronic inpatient group in a three-month period to the findings that serious violence is rare.

A number of authors have pointed to the risks of nursing staff being assaulted—and psychiatrists are not exempt. Whether or not the violent behaviour results from mental illness or an unsatisfactory hospital milieu or atmosphere is a moot point. Certainly in one large English hospital violence was lessened somewhat after the introduction of chlorpromazine, a major tranquillizer, but it still continued. It did abate considerably, however, when an open door policy was introduced and along with it, the application of the therapeutic community philosophy.

Mullen[12] in his paper draws no particular conclusions from his review of papers on pre and post admission violence, and from the data presented I am also at a loss to do so.

He does point out, however, that there appears to be an increased risk of assaultive behaviour amongst acutely disturbed and deluded schizophrenics, among sufferers from acute brain syndromes in some studies; and he also points to a positive correlation between youth and a history of previous violent acts and assaultive behaviour.[13]

A **third** line of study is to look at mental abnormality among prison inmates. The level of mental disorder among convicted prisoners depends on how wide a definition of mental disorder is applied. When the definition includes anti-social personality disorders or psychopathic disorders, a significant proportion of offenders fall within the category of mentally disordered. If mental illness is more narrowly defined and confined to schizophrenia, paranoid states and affective (pertaining to mood) disorders, the figures range from 2 per cent

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[11] *ibid.* p. 12.
[12] *ibid.* p. 11.
[13] *ibid.* p. 13.

to 8 per cent in various studies. Substance abusers (alcohol and drugs) and personality disorders appear to form the bulk of offenders in many instances. The studies of prisoners suggest that although a significant proportion has psychological and emotional problems of a type not infrequently managed by psychiatrists in the community, there are relatively few with major mental illness. The prison population is drawn in the main from economically, socially and culturally deprived strata in society. The level of mental disorder in its broadest sense would be expected to be higher in this disordered group, but they infrequently suffer from definable or diagnosable mental illness.

Mullen,[14] while indicating that studies on convicted felons do not support the contention that mental illness makes a major contribution to crime in general, points to differences when it comes to specific types of offences. He points out that in the United Kingdom over the last decade, 30 per cent of those charged with homicide have been deemed by the courts to be mentally abnormal; and in the period of 1900 to 1949, 61 per cent of murder suspects in the United Kingdom committed suicide or were found unfit to plead or not guilty on the grounds of insanity, or were certified insane after trial. The comparable figure for New Zealand between 1920 and 1955 was 59 per cent. Thus in this most dangerous of all offences, murder, between 30 per cent and 60 per cent of the perpetrators could be classed as mentally disordered. Even given that some of the suicides were not mentally ill and that the defence of insanity may have been stretched somewhat to accommodate some unlikely people it seems more than a possibility that seriously violent bahaviour may be contributed to more frequently by the mentally ill.

Interim summary and comment

I would like to summarise some of the comments made up to this point, then introduce some thoughts on the concept of mental disorder before looking at the question of assessment or prediction of dangerousness.

The concept of dangerousness has been delineated as "a potential for inflicting serious bodily harm on another".[15] Political and religious ideologies may be strong motivating factors in the genesis of dangerous behaviour. It is best not to view dangerousness as a quality possessed by an individual. Dangerous actions have complex origins which are caused by an interaction of factors, some social, some related to habit and learning, others psychological, and some medical, either physical or psychiatric.

In trying to answer the question "who are the dangerous?" it has been noted that studies have been carried out on conviction rates for ex psychiatric hospital patients, on assaultive behaviour of psychiatric patients both before and during admission to hospital, and on mental disorder among convicted prisoners.

Taken globally there appears to be no significant evidence pointing to a strong correlation between dangerousness and mental disorder but there does

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[14] *ibid.* pp. 13, 14.

[15] Kozol *et al., op. cit.*, p. 372.

appear to be an increased risk of assaultive behaviour amongst acutely disturbed and deluded schizophrenics and among sufferers of acute brain syndromes and there is a positive correlation between assaultive behavior, youth and a history of previous violent acts. These latter two correlations hold also for the population in general. It also seems possible that seriously violent behaviour, namely, that leading to homicide, may be contributed to more frequently by the mentally ill.

The problem with many studies undertaken is that they metaphorically lump together hot chillies, peaches, pineapples and lemons which while all are derived from plant life assail the taste buds in different ways.

In botanical or zoological terms the class mental disorder encompasses mental illness in its variety of forms, substance abuse, mental retardation or developmental disability of mind, and personality disorders including anti-social personality disorder (the aggressive psychopath) to name just a few of its orders, families, genera or species.

Our interest is in the mentally ill, not in the psychopath or the mentally retarded, although we do have some concerns with the mentally retarded who also develops mental illness, and in the psychopath in as much as it is relevant to exclude mental illness in such a person who may have performed grossly anti-social acts including rape and murder. It is unfortunate that many studies have obscured matters by not confining themselves to the issue that concerns us, namely dangerousness potential in the mentally ill *per se.*

The Assessment of Dangerousness

While all professionals dealing with the mentally ill are concerned with the question of dangerousness there are three major groups of people who under the *Mental Health Act 1983,* should have more than a nodding acquaintance with this propensity—the magistrates, the Mental Health Review Tribunal and the Patient Advocacy Service.

The Act spells out in s. 5 (1) (b) the dangerousness criteria for involuntary detention of a mentally ill person and these should not be too difficult to apply as the sub-paragraphs all refer to recent acts; though one could ask, "how recent is recent?"

Assuming that the acts or conduct referred to are recent both at the time of the Magistrate's Inquiry under s. 88 and at the time of Determinations by the Tribunal under s. 95 and s. 97, they probably cannot be regarded as recent at the time of review by the Tribunal of many of the continued treatment and informal patients under ss. 102 and 103 of the Act. Other factors have intervened notably time, the effects of a management programme for the patient, and the effects of the institutional setting. The Tribunal is faced with the problem that a psychotic person with a history of violent assaultiveness may harbour an extremely dangerous potential even if he is consistently docile in an institutional setting[16].

[16] *ibid.* p. 391.

This particular aspect of assaultiveness is probably more relevant to the Tribunal's functions in the forensic part of the Act (Part VII ss. 117 (1) (b) (ii), 117 (3), 118 (1) (b) (ii) and 119 (3)) where it has to satisfy itself that the safety of the public (or the patient) will not be seriously endangered by the patient's release.

Whatever the case, in review procedures one is moving further away in time from a dangerous act committed by a patient whose compliance in an institutional setting may tend to lead one to believe he will function in the same non aggressive fashion in the outside community. The problem is one of correctly predicting future dangerous behaviour if the interests of the public as well as the patient are to be served.

The difficulties associated with this exercise have been pointed out already. Scott, in an article titled "Assessing Dangerousness in Criminals"[17], quotes Steadman and Cocozza (1974) saying:

> If we attempt to distinguish the potentially dangerous patient, we double our error by identifying as dangerous all of a group of patients when only one third of them will live up to those expectations.

To reach this conclusion Steadman and Cocozza followed-up almost 1,000 ex-patients. However, these supposedly dangerous patients were a group of middle-aged people who had been hospitalised on average for 14 years many having committed comparatively minor offences. Therefore, it may be unwise to generalise their conclusions to all patients in all secure psychiatric facilities[18].

I will not attempt to give a detailed account of examination procedures undertaken to assess dangerousness but will refer to areas looked at by one author. Scott[19] considers a series of factors and points out that there are no direct indications of dangerousness and that each factor may become important in the presence of other factors or may be neutralised by yet others. Facts are collected under the following headings:

(1) The offence, covering detail of the behaviour, the degree of and more importantly the quality of violence, disinhibiting factors such as substance abuse, and the offender's behaviour after the offence.

(2) Criminal record and past behaviour, past behaviour being the best indicator of future behaviour.

(3) Personal data including sex, age, marital status, personality traits, deceptiveness and transparency, jealousy, and other dangerous traits such as pathological (paranoid) suspicion and sadomasochism.

(4) Historical data including childhood, "deprivation", parent/child relationships etc., history of mental or physical illness.

(5) Progress in custody or hospital which can be prognostically useful, but also misleading.

(6) After-care dealing with the subjects, plans or lack of them for life outside the institutions, remembering that it is often unwise to return offenders to the setting in which their problem arose.

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[17] Scott, P. D., 'Assessing Dangerousness in Criminals', *Brit. J. Psychiat.* (1977), **181,** 127–142.

[18] Mullen, *op. cit.*, p. 15.

[19] Scott, *op. cit.*, pp. 129–138.

The data thus collected is analysed from as many theoretical standpoints as possible, and motive has to be considered alongside other factors deduced from the data, especially the current level of personality integration and the ease with which regression under stress recurs.

To Scott[20] there are two basic questions to be answered which are more concerned with the future than with the current offence. First, is the person capable of compassionate feelings; is he able to feel sympathy with the sort of persons who may become his victims, or is he so egocentric or so indoctrinated or influenced or damaged that such feelings are absent or lastingly obscured? Unless there is some recognizable sympathy for others, and revulsion at causing suffering, there is always a vulnerability to situational aggressive impulses which are bound to recur.

The second question to be answered is, "Is this person's capacity to learn by experience still intact?"

Scott points out that a single interview near the time of release by a stranger is not a good basis, on its own, for assessing dangerousness. Most help is to be got from plodding through records, nurse's notes and trial manuscripts and talking to the staff who are in daily contact with the patient. It is generally accepted that involvement with patients on a long-term basis is a *sine qua non* for the assessment of dangerousness.

Such a luxury, if one may call it that, is not afforded the Tribunal, nor the magistrates, nor the Patient Advocacy Service. The corollary to this is that much homework needs to be done on individual cases, and modes of reliable communication need to be set up to make available to these groups all relevant information that will assist in decision making on the question of dangerousness.

Conclusion

Straws show which way the current flows. A few of these straws have been mentioned in the body of this paper indicating that there may be subgroups within the family called mental illness who may have a greater potential than "average" citizens for inflicting serious bodily harm on another. I shall not summarise these here but simply express the hope that researchers in this area can tease out and identify such possible subgroups in order that we can come a little closer to accuracy in our predictions of dangerousness. In the meantime we would be the greatest of fools to assume that all mentally ill are dangerous or that mental illness in some instances does not precipitate dangerous behaviour.

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[20] *Ibid.* p. 140.

COMMENT ON PAPER BY I. WALLACH ENTITLED "MENTAL HEALTH ADVOCACY IN NEW SOUTH WALES"

Dr M. J. Sainsbury

I have thought long and hard about commenting on Mr Wallach's paper and would have preferred to have discussed certain matters privately in the interest of better understanding between lawyer and doctor. The paper, however, is now a public document and I would be most remiss not to comment on it publicly in order to clarify at least some points that are made.

Mr Wallach has demonstrated the role of the Mental Health Advocacy Service in protecting the legal rights of citizens who have psychiatric problems. He quotes one case supporting his argument that "legal factors can act as catalysts in speeding up the arrival of specialized and differentiated forms of mental health care". When this occurs it is to be applauded. There is another side to this coin, however, and a number of my colleagues can quote cases where they consider the intervention of legal factors have led to unfortunate outcomes. No system is perfect and some doctors and psychiatrists no doubt have a lot to learn about legal process and about how to present their evidence and conclusions, necessarily based on probability, to the black and white legal minds of certain lawyers. The Department of Health is taking steps to rectify this situation in public sector psychiatry.

The paper attacks the Department's administrative procedures quoting as a prime example a case (page 34) discharged by the Supreme Court as a result of Mental Health Advocacy Service legal representation. There appeared to be some urgency in having this case heard in the Supreme Court in spite of the fact that it was known that the proclamation of Part VII of the *Mental Health Act 1983*, was imminent and the Mental Health Review Tribunal would shortly be operating. Mr Wallach states that this "case is based upon the Department's use of defective medical certificates in its use of s. 24.".

The facts are that two Schedule III Certificates were completed by visiting psychiatrists to the Prison Medical Service approximately two weeks before the person was committed for trial. This rendered the certificates which were otherwise competently executed invalid or defective. Had the certificates been written two weeks later I doubt whether the Supreme Court would or could have made the finding it was obliged to make in the given circumstances—that the plaintiff had been unlawfully held and detained.

While appreciating the importance of conforming to the letter of the law, from a practical point of view, the date of writing the certificates made not a scrap of difference to the management in hospital of this young patient.

There are a number of points in the speaker's paper with which issue can be taken, but I shall refer only to some comments made on **Case 3** (page 33). My comments do not reflect on the speaker any more than they would reflect on the Director of the Legal Aid Commission who one presumes is ultimately responsible for what emanates from lawyers in his service.

There are two references to the Authorized Officer. The first refers to two recommendations being "forwarded to the Authorized Officer under the Act". The second states, "Even more startling, is the fact that she has remained in custody despite two specific recommendations not to do so (*sic*) made by the hospital authorities to the authorized officer" (my underlining).

The facts are that the first recommendation was made to an authorized officer in 1982 and the second recommendation was made to a second authorized officer in 1984, the first-mentioned authorized officer having left the Service in 1983. There are currently three psychiatrists appointed as authorised officers under the *Mental Health Act 1958* and, since 1982 there have been five different psychiatrists holding the office of an authorized officer at one time or another as well as at least one non-psychiatrist appointed as an authorized officer with limited functions. Given these facts, one wonders why the paper refers to "the authorized officer".

Of more importance than this failure to determine the true nature of departmental appointments to the position of authorized officer is the fact that certain conclusions have been drawn that are not based on all the available facts.

The paper states the following in relation to recommendations made for the removal of **Case 3** from under the provisions of the forensic part of the *Mental Health Act 1958*:

"the files do not reveal any action which may have been taken to effect her discharge and placement in the community." On the basis of this, criticism is levelled at the authorized officer.

The fact is that a second set of files on forensic patients is kept at Central Administration of the Health Department under lock and key. These files have been made available to other legal officers on request where this is relevant and proper.

I can assure you these are not kept secret. Ever since I have worked in the Department of Health we have had a Director of State Psychiatric Services, we have had Directors of Mental Health Services, we have had a string of people who worked as Senior Specialists in Mental Health Services or Principal Advisers, and now we have a Senior Specialist, Mental Health Services. Throughout a whole string of years these files have been there. They are necessary because these officers have had to arrange for transfer of patients from prison hospital and so forth, and they regularly reviewed them as part of their administrative job with the Department. At the moment it is part of the job of the Senior Specialist, Mental Health Services. Now, why they did not know surprises me. The Ombudsman's Office is very much aware they are there. They have looked at least one of them very closely. Other people doing reseach know they are there. In fact one of the Official Visitors appointed under the *Mental Health Act* has been using them to do a Ph.D. thesis. Now probably 98 per cent of all the administrative material is in the patients' files at Head Office. In some instances there may be a little bit more on the files in hospital. Maybe in these particular instances that have been referred to there may not be sufficient evidence in the hospital files of the patients. There certainly is in the files in Head Office because copies of all authorizations in respect of patients and in respect of their security within the hospital are kept on file in Head Office. That

is part of the job. So the clinical notes are available to the Mental Health Advocacy Service both in the patients' files and, if they want to, in the files in Head Office. There is no cover up there.

Had the Mental Health Advocacy Service lawyer asked any of the current authorized officers, including the one working in Head Office in another capacity as well, I am sure that further information relevant to **Case No. 3** could have been made available—information which shows clearly what further action was taken by the authorized officer in question. One cannot assume that the legal officer concerned would have altered his conclusions in the light of this further evidence, but the fact remains that either he, or the speaker (or both) has publicly impugned the sound reputation of an officer of the Department of Health without taking cognizance of all the available facts which were readily available.

In passing, one would assume that Mr Wallach thought carefully about the implications of s. 186 of the *Mental Health Act 1983*, dealing with disclosure of information before describing **Case No. 3.**

PRESENTATION OF PAPER

Dr M. J. Sainsbury

On re-reading my paper it appeared to me that in trying to define dangerousness I had taken a leap from violence to dangerousness without indicating what I saw as a connecting link. In case the relationship between the concepts of violence, an action, and dangerousness, a property or potential, have been obscured I should like simply to say that in the context of the subject I am addressing violence is the point at which the potential for inflicting serious bodily harm on another is released or triggered and action results. Put simply one might say violence is dangerousness in action.

The paper points out that it is best not to view dangerousness as a quality possessed by an individual. A person who carries out dangerous actions in one situation may not do so in another. Indeed dangerous actions have complex origins which are caused by an interaction of factors, some social, some related to habitant learning, others psychological, and some medical which can have a bias either in physical or psychiatric disturbance.

In trying to answer the question "Who are the dangerous?", the paper describes three types of studies. It also points out the difficulty in drawing conclusions from these studies. Taken globally there appears to be no significant evidence pointing to a strong correlation between dangerousness and mental disorder, but there does appear to be an increased risk of assaultive behaviour amongst acutely disturbed and deluded schizophrenics and amongst sufferers from acute brain syndromes of whatever cause. There is also a positive correlation between assaultive behaviour, youth, and a history of previous violent acts. It also seems possible that seriously violent behaviour, namely that leading to homicide, may be contributed to more frequently by the mentally ill. This is becoming more evident.

While I am aware that most lawyers, my daughter included, just love to get their teeth into case studies I have quite deliberately avoided describing individual cases which frequently provide anecdotal material only, and have chosen to draw from literature provided by world experts in the field of forensic psychiatry. One might add that this State has very little research material on forensic psychiatry from which to draw and in my view there is a need to seriously consider setting up a Chair of Forensic Psychiatry in New South Wales so that the many questions still unanswered can be addressed and psychiatrists can be attracted into this important field.

Lastly, the paper comments on the assessment of dangerousness both in terms of the factors studied by the psychiatrists in coming to a conclusion and in terms of the responsibility that the *Mental Health Act 1983* places on the Mental Health Review Tribunal, magistrates, and patients advocates.

It will have been noted that I have referred to the Patient Advocacy Service when, in fact, I meant the Mental Health Advocacy Service. There are a number of possible reasons for this and I will mention just a couple.

Two or three years ago there appeared to me to be two distinct groups of lawyers keen to take their place in the sun in what was then to be called the Patient Advocacy Service, a service that was to look after the interests of people who through disability required the type of assistance proposed. One particular group of lawyers appears to have come out on top and at some stage the originally talked about name disappeared to be replaced by the current title. In view of my continuing use of the old terminology discerning clinicians in the audience will undoubtedly be considered the possibility of "perseveration" which is the abnormally persistent, repetition of the word, phrase, or sentence possibly indicative of a dementing process. On the other hand, it could be a Freudian slip based on the fact that I see the role of an advocacy service representing people, in this instance patients or sufferers. I can understand a Tribunal reviewing the mental health status of a person but for the life of me find it difficult to comprehend how one can be an advocate for such a difficult concept to define as mental health.

It will be noted also that little reference has been made to female offenders. This is not entirely due to male chauvinism or whatever term is applied to sexism these days, but to the fact that most of the research that I was able to dig out deals with males and my limited work in the forensic sphere has been predominately with males, my apologies. One little sop to the ladies is a statement that depressive homicide among women is twelve times that among men according to West German figures.

Mr Wallach's paper coupled with my comments on it would suggest, and this grieves me, that all is not well between psychiatrists and at least some lawyers in the Mental Health Advocacy Service although they all appear to be pretty well orchestrated. Unlike Mr Wallach I did not think it appropriate to use my paper as a platform to beat another professional over the head—in his case psychiatry, a profession that requires a minimum of twelve years training at a post secondary level, most of these years involving contact with people or patients with their problems. I would however welcome the opportunity to discuss the *modus operandi* of the current Mental Health Advocacy Service in another place before an unbridgeable gap develops between the patients advocacy service, the legitimate aims of which I fully support, and my psychiatric colleagues working in the most difficult area in medicine.

DISCUSSION PAPER I

MENTAL HEALTH ACT 1983: SECTION 178 (2) (b) (iii)

Janet V. Coombs, B.A., LL.B.
Barrister at Law

I wish to raise the following issues as questions for the seiminar:

In New South Wales the *Mental Health Act 1983*, section 178 (2) (b) (iii) has enacted that a tribunal be appointed with power, *inter alia,* to approve a sterilization to which the patient is unable or unwilling to consent even where this operation is not for the life or health of the patient.

Without such legislation the acts necessary for sterilization are certainly an assault and when performed by a doctor for the purpose of sterilization would constitute assault with the intent of occasioning serious bodily injury which would involve a penalty of penal servitude for life.

The enactment of such a section in the legislation is contrary to the United Nations declarations on the rights of mentally retarded persons and of disabled persons and if inflicted on a child is contrary to the Declaration of the Rights of the child. It is on contravention of Article 23 (2) of the United Nations Convenant on Civil and Political Rights which entitles persons of marriageable age to marry *and found a family*—impossible when the person has been sterilized.

Mental patients may go into remission or be cured at any time. Sterilization of imbeciles was one of the first of the excesses of Nazi Germany. Section 178 (2) (b) (iii) should be repealed and doctors warned against performing such operations.

I noticed that one of the papers (Wallach: see pages 35–36) dealt with sterilization and said that sterilization was usually sought for female patients and that it was done basically for the convenience of those who had management of the patients to make them easier to look after. That is one of the reasons that my submission was put in, to say how important it was for people to be aware of the proper medical ethic in this matter. Patients should not be treated for the benefit of other persons, they should be treated only for their own benefit and that, as far as sterilization was concerned, is a treatment which involves an assault, an assault occasioning grievous bodily harm if it has not been done for the health of the patient. The doctors, and probably the Tribunal considering such an application for such a treatment, should be very aware that this is a criminal act that is being considered, it is well recognized by International Law that people have a right to their bodily integrity and that they should not be assaulted in this way. These are the matters that I wanted to draw to the attention of this seminar because under the *Mental Health Act* it is possible for applications to be made for these operations to be done even without the consent of the patient, though one would say that such patients very probably would not have the capacity to consent.

It is the seriousness of this matter which caused me to speak at this seminar.

DISCUSSION PAPER II

SECTION 178 (2) (b) (iii) IN HISTORICAL PERSPECTIVE

John Parnell, S.M.

1927

"We have seen more than once that the public Welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute the degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough".[1]

1941

"Five others are stated to be totally useless, for racial and biological reasons; one of these, Agnes Fiala, should be sterilized immediately, as the young fellows in the camp are said to be already beginning to take an interest in her. Also two of the boys should immediately be made incapable of reproduction, one of them, Nikolaus Reizer, because he has tuberculosis, and the other George Kuhn, because with his protruding ears and round shoulders he makes an impression of degeneracy".[2]

1986

Today, in the penumbra of Nuremberg, yet the glare of the pursuit of Mengeles to the grave and Ronald Reagan's side step of the "DAS REICH" burial ground at Bitteberg, we in Australia appear intent upon raising the "Totenkopf" again by proposals in New South Wales and Victoria for the stated "welfare" of the mentally ill.

I refer to:

(1) The New South Wales *Mental Health Act 1983*, s. 178 (2) (b) (iii), which permits involuntary sterilization and,

(2) The Victorian Guardianship Bill (still in the Parliament) which provides, in addition, not only for involuntary abortion, but also filching of non-regenerative tissue from the living. (Clauses 42 a, b. c.) Leaving aside Criminal Law issues these measures appear

(a) repugnant to

(i) The Universal Declaration of Human Rights Article 16 (1).

(ii) The United Nations Covenant on Civil and Political Rights Article 23 (2).

(iii) The Nascent Australian Bill of Rights Article 13—all of which provide a right to marry and procreate without discrimination.

(iv) The Nuremburg Code of 1949[3].

(b) to provide a genocidal tool for any authority so inclined.

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[1] *Buck* v *Bell* 274 US 200 (1927).

[2] Report to Lebesborn H.Q. Berlin 25.8.41 *"Children of the SS"* Corgi 1977.

[3] Sir Ronald Wilson 'Experimenting with Life and Law: The Impact of Human Rights on Experimenting with Life'. *Aust. Journal of Forensic Sciences*, June 1985. Vol. 17, p. 61

Transcending temporal endeavours moreover, *the worth of man is not to be gauged by handsomeness of countenance, length of the throw or knowledge of the Brownian theory.*

On the practical side—

(a) The surgical acts necessary to compulsorily sterilize, leaving aside any question of statutory defence, involve an assault[4]. What occurs is probably a serious bodily injury and intent to act is not in issue. Unless, therefore, the Tribunals' approval to act can be stretched to a statutory defence, the offence in s. 33—maliciously inflicting grievous bodily harm with intent, punishable by penal servitude for life, may be complete.

(b) As to abortion—without some specific statutory defence it is difficult to see how even the "Menhettit" ruling could save an accused.

(c) As to compulsory acquisition of organs a clear precise statutory defence would again be necessary.

The paternalism which produced this "Jekyll and Hyde"[5] outcome ought to go back to the respective Parliaments for more considered debate.

I am concerned that the matter of elective type surgery in s. 177 may be forced upon patients on such vague grounds as "the interests of the patient or other person". One wonders what the interests of other persons is doing in a Mental Health Act, but it is there.

A direction is to be made on these grounds by a Tribunal or authorized person, not subject to the laws of evidence or procedure, able to inform itself from any source, and apparently on what has been said earlier, not liable by statute in any event to give reasons. I feel that this is just another case of abdication of responsibility by the legislature. I spoke about this at a previous seminar[6], and it is a case where proper legislative guidelines are necessary and if the Act has got to be amended then it will have to be amended in that regard.

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[4] Michael D. Bayles "Sterilisation of the Mentally Incompetent" World Congress on Philosophy, Family Law and Social Philosophy, Sydney–Canberra, 14–21 August 1977.

[5] *Advocate* (Melbourne) 3-4-86, p. 1.

[6] *Syd. Inst. Crim. Proc.* No. 69 "Policing Public Order" p. 72.

DISCUSSION PAPER III

DEFINITION OF A MENTALLY ILL PERSON

Dr James Durham
Director of Psychiatry,
St Vincent's Hospital, Darlinghurst.

I wish to address the topic "Definition of a Mentally Ill Person", and to make certain points regarding the Mental Health Act 1958 and the Mental Health Act 1983.

1. **Mental Health Act 1958**

(a) I recently applied for a magistrate's order under s. 12 (9). The patient presented was clearly mentally ill in a medical sense (this was not disputed). In addition, evidence was tendered of his having made threats of violence against a particular person and of his having spoken of obtaining a firearm and shooting "all the people" in a certain building. The patient lived in the open, had no income, but obtained and prepared food from unknown sources; he was well-nourished and healthy in appearance and sufficiently clothed; and he claimed to be quite happy with this eccentric mode of existence. These latter circumstances were held to show that he was not "incapable of managing himself or his affairs"; and it was decided in consequence that he could not satisfy the Act's criteria of a "mentally ill person". The magistrate cited the ruling of Mr Justice Powell (*PY* vs *RJS and Others* May 5–7 1982) according to which it appears that the words ". . . and is for the time being incapable of managing himself or his affairs . . ." constitute a separate and necessary condition or criterion which must be satisfied in addition to the other criteria. Moreover, in this interpretation, it seems that it must be additional in the sense of "independently of anything implicit in the evidence of which he/she may satisfy the other criteria". In other words, this criterion may be addressed first; and if it can be shown that the patient is able, left to himself, to satisfy his basic needs, and to safeguard his property, if he has any, then there is no reason to consider whether he/she satisfies any other criteria; thus evidence that he/she is *both* mentally ill in the medical sense *and* dangerous to others becomes irrelevant. So, at any rate, it was held in this case; and a reading of Mr Justice Powell's judgment might be held to support this interpretation. But this seems to mean that a person could be severely mentally ill in the medical sense, and highly and immediately dangerous to others, yet be not a "mentally ill person". For example, a man might have gross delusion of persecution and have made preparations to kill the person he imagines to be his persecutor, or have credibly threatened to do so; but if it can be shown that he is well-provided for, cares for his bodily well-being, and is shrewd in matters of business, the other matters escape consideration altogether.

It is true that the Act, after specifying that the person must be in need of "care, treatment or control for his own good", goes on ". . . *and* is for the time being incapable of managing himself or his affairs . . .", thus logically imposing the latter as a further necessary condition. But it obviously was not intended to lead to the absurd conclusion I have just mentioned, and there is not need for it to do so. In the foregoing

example, it would be consistent with the Act to hold that if the person had no insight—did not realize that he was mentally ill and dangerous, sufficiently to submit to care, treatment or control—then from these facts alone, he was "for the time being incapable . . ." etc. For his affairs will soon take an unfortunate turn if he carries out his plans or threats.

In other words, there is no need to hold that the question of capability in the ordinary affairs of life must be settled *independently* of the question, arising from other considerations, of the patients need for treatment, etc. When these other questions do not arise, then of course the ordinary criteria of capability—ability to obtain necessary food, shelter, clothing, etc., to avoid common hazards, and to safeguard one's property within reason—are sufficient. But if one is also mad and dangerous, these ordinary criteria are no longer sufficient.

(b) *Dementia and mental illness*

I believe this subject will be fully dealt with by others.

2. **Mental Health Act 1983**

(a) The most obvious of its many defects is surely the repeated occurrence of "probable" and "probably" in Section 5. Unless otherwise specified, this seems to mean "more probable (or probably) than not", i.e., with a probability greater than 0.5. But this seems to require acceptance of a degree of danger which would not be tolerable in most instances, and/or an unattainable degree of prognostic accuracy or confidence. It is also inflexible: a certain level of risk, or probability, of suicide might have to be accepted in the case of an elderly, sick patient, whereas the same risk would be much less tolerable in the case of a young healthy person.

? Substitute for "probable" and "probably" the phrase "with a degree of apparent probability which is deemed unacceptable in the circumstances".

(b) A very serious deficiency is the denial of ECT, under s. 172, to patients who are deemed incapable of giving *informed* consent, but who are unlikely to die immediately if it is not given. This would mean months of intolerable misery and distress for many melancholic patients. The criteria for informed consent set out in s. 163 (4) are not exhaustive and would not be held to be sufficient alone. The patient must, in order to be capable of giving informed consent, be cognizant of the fact of his illness and of the benefits to be derived, as well as of the possible risks, from treatment. Many melancholic patients are incapable of this, by reason of their illness, and yet are quite willing to have the treatment.

The requirement of *informed* consent in such cases is too strict. *Simple* consent—unconstrained, of course, and backed by the necessary medical evidence of its desirability—should be sufficient. (We are not here talking about ECT given *against* the will of the patient, for which the stipulation that it must be life-saving is very proper).

PRESENTATION OF PAPER

Dr James Durham

First, I would like to comment on Dr Shea's paper. I do not often find myself in disagreement with Dr Shea but I am violently in disagreement with his proposal to define mental illness in terms of a list of diagnoses. I know Dr Shea is well aware of some of the practical difficulties, such as that it may be very obvious that somebody is mentally ill long before a diagnosis is available and it may be urgent to do something about it. I think that making or providing shall we say "catch all" terms, broad terms as Dr Shea says, really does away with any merits that the original proposal has.

But I think there is a more important objection to it than that. In the ordinary person's mind there is a very clear idea of what he means by someone who is mad or insane or as we now say "mentally ill". It is a very robust idea which has not changed much across cultures or generations and I think it is a safeguard, a civil liberties safeguard against abuse of mental health legislation. You can stick a diagnosis on almost anybody, but a layman, a good lawyer or somebody like that will soon see where this is different from saying that the man is "mentally ill" or mad in the legal sense. In other words I disagree with Dr Shea. I think mental illness, where it is a question of depriving somebody of his liberty, that is, in some sort of legal context is really a lay or legal notion rather than the medical one. Obviously doctors may be better at eliciting the facts on which such a judgment is finally made but I think that in the last analysis it has to be a layman or a lawyer who decides whether an individual is mentally ill, and really the lawyers or laymen ought to have the last word as to the definition. I realise that has not worked out very well so far but I think that it should be corrected through the ordinary processes of appeal rather than trying to wrest the notion of mental illness back into a purely medical framework.

We have at the moment a very odd situation, if it is at all general and Dr Shea tells me it is, that under the present *Mental Health Act* a person can apparently be indisputably very mad and indisputably very dangerous but not a "mentally ill person" if he is nevertheless apparently able to look after himself in the ordinary matters of existence like obtaining sufficient nourishment, shelter, clothing, and is able to protect himself from common dangers. I think this is a misreading of that section of the Act, which I think everyone will know about, where it says: ". . . and is for the time being incapable of managing himself and his affairs . . .". Mr Justice Powell has read that as if it imposed a completely independent criterion which the patient has to satisfy, i.e. that he is incapable *quite apart* from the other criteria (which are very roughly of being mentally ill in the medical sense and being either dangerous to himself or others). I do not think that that is a necessary reading of that section because, of course, in the case of an ordinary person the criterion of whether he is able to look after himself might well be that he is able to provide himself with food and clothing and protect himself from common dangers; but if he happens to be also mentally ill and dangerous I think then that you can only say that he is capable of managing himself and his affairs if he is also capable of saying: "Yes I need to be looked after, I need some treatment". Of course, in that case you do not need an order; but if he has not got so much insight I think that he does then satisfy that third criterion.

It has been held quite to the contrary in the case that we had recently at St Vincent's Hospital which I wrote up. There it was held that the criteria could be tackled in any order you liked and if you could show that the man was fit and healthy and had a means of looking after himself in the ordinary way, then the question whether he was mentally ill in the medical sense or dangerous did not arise. I feel sure that this is wrong. I think that is does seem to follow from Mr Justice Powell's judgment in the case that I quoted and I would be interested to hear what other people think about it.

Dr Peter Shea

Just a brief comment. I wanted to tell you that Jim Durham and I had a very amicable conversation about this very issue and we have agreed to disagree on this matter of defining mental illness in the legislation.

The point that I made at the time of our conversation was in fact that in every magistrate's inquiry, in every Tribunal hearing, someone says "What is this person's diagnosis?" and so someone has to make a diagnosis. It happens thousands and thousands of times every year and having made the diagnosis someone says "What symptoms or signs etc. support this diagnosis, doctor?" and the doctor has to give a list of symptoms and signs to support the diagnosis. Now, if you can do this at a magistrate's inquiry several times a year it strikes me that we could do it in a sort of consensus fashion and put it into some legislation or regulatory form.

I. Wallach

In relation to what Dr Durham said about the question of the definition of mental illness I would agree with him that such a person as he mentioned ought to be considered to come within the definition of a mentally ill person in the Act. I would disagree with Dr Durham in relation to the way he says Justice Powell has interpreted the definition. What Justice Powell did say, in the case *PY* v *RJS and Others* is that in relation to establishing the need of treatment for the public benefit that the question of a breach of the peace could be used to establish that leg. I would also think that that same evidence would also be sufficient to establish the third leg, that of incapacity, as he pointed out. I do not think that the case that he mentioned, if the case was reported accurately as he said, would necessarily be outside that realm of the definition. However, having got Dr Durham's question in advance I very carefully checked up with the solicitor who does our hearings at Caritas Centre, where Dr Durham is based. In that particular case, as I understand it, there was very much an issue of dangerousness being questioned before the magistrate and by the magistrate. As I understand it the facts of the case differed substantially as viewed by our solicitor and presumably by the magistrate as to the person's dangerousness. I would say that in the case that was raised by him there was a serious conflict as to the facts, and a serious difference as to how the facts were viewed rather than turning on a nice legal definition.

Chairman

I think it might be useful to note that we are considering in those remarks of Dr Durham, Dr Shea and Mr Wallach the definition under the 1958 Act, and not that under the 1983 Act which is not yet in operation.

DISCUSSION PAPER IV

Edgar Freed, M.B., B.Ch., D.P.M., F.F.Psych.(S.A.), M.R.C.Psych., F.R.A.N.Z.C.P.
Staff Psychiatrist, St Vincent's Hospital, Darlinghurst.

I wish to raise the following issues as questions for the seminar:

1. A person may have been found not detainable as an involuntary patient under the *Mental Health Act.* If such a person commits an act of violence without any additional evidence of mental deterioration, what avenues are there for the victim to:
   (a) Lay a charge and, assuming that the evidence is forthcoming, obtain a conviction, without the defendant being able to use as a defence that he was mentally disturbed. This would be a ludicrous no win situation for the victim as the defendant has been excluded from involuntary detention in a mental hospital.
   (b) Obtain a court order whereby the defendamt is ordered not to harass the plaintiff in any way. To what extent would such an order be enforceable. Again there is the risk that the mentally ill person may have it both ways; he or his legal advocate will have persuaded the magistrate at the committal hearing under the *Mental Health Act* that he was not a mentally ill person within the meaning of the Act, and at the same time may persuade a civil or criminal court that he is not responaible for his actions as he did not know what he was doing by virtue of mental illness.
   (c) What avenues are open for a victim to obtain compensation if the victim was the subject of an attack by a mentally distrubed person who has been found to be not detainable as an involuntary patient under the *Mental Health Act,* but who claims insanity or diminished responsibility as a defense.
2. The above issues address the question of legal redress that the victim of the actions of a mentally disturbed person might wish to pursue. I would ask the learned speakers at the seminar what form of political action they would recommend as being either opportune and/or effective if the situation arose where a victim felt that the present legal system was not effective in protecting him or her from assault, threats of assault, or other harassment.

N. Harrison

With reference to Dr Freed's paper, it is very hard to comment on what you might call hypothetical situations. In reading the contribution as it is written I thought to myself: Well, it may be the victim has to lay charges, it may be more likely the police would lay a charge on behalf of the victim if there was an assault depending on what degree of mental disturbance the accused may have, there may be an issue of his fitness to plead, or he may have a defence of mental illness or diminished responsibility depending on the nature of the charge. As far as the harassment is concerned the victim would have rights to seek a restraining order in the way of apprehended violence or domestic violence and so far as the question of compensation is concerned if there was in fact no conviction of the accused person the victim would never the less have rights under the *ex gratia* scheme in *Criminal Injuries Compensation Act.* I am not sure that answers the questions or raises more problems.

I. Wallach

Under the *Crimes Mental Disorder (Amendment) Act* which will add provisions to the *Crimes Act*, sections 423W to Y, magistrates in summary proceedings, and it specifically excludes committal proceedings, will have a discretion to deal with people who come before them on criminal charges by sending the person for assessment to a psychiatric hospital. If six months elapses from the time of the charge then it is deemed that the charge will be dismissed. On the other hand where the proceedings do come back to court, prior to the end of that six months period, the magistrate is directed to take into account any time spent receiving treatment in a psychiatric hospital. Those sections I think will give an important discretion to magistrates, it will also I think seek to emphasise the nature of some of the offences or some of the proceedings which come before them. I certainly applaud those sections.

Dr Yolande Lucire, Psychiatrist

I have two questions, maybe three. The first one is this. Is it true that a large sum of money has been allocated to the Mental Health Advocacy Service? Would that service be prepared to disclose at this forum how much that money is? Will the service be writing in Annual Report of the Legal Aid Commission on the expenditure of such money? And does the service actually follow up the clients for whom it has been successful? That is my first question.

Chairman

Forgive me for saying so but I thought that was all three. Perhaps Mr Wallach might respond.

I. Wallach

I take it that the series of questions referred to the Mental Health Advocacy Service. When I was writing a few comments on what Dr Sainsbury was saying in relation to alleged personal attacks, the next comment I had written, rather sarcastically I might add, in large letters was "MOSCOW GOLD?" It now seems that the question of "Moscow gold" has in fact reared its ugly head. I suppose

I should reply in the same terms as our former Prime Minister Malcolm Fraser did, that possibly we should all begin by putting it under the bed. However I will not say that. As far as the money allocated to the Mental Health Advocacy Service is concerned I cannot tell the doctor the complete budget. It is allocated to us as part of the Legal Aid Commission's funding and I think the proper course would be to have the Director or the Director's nominee answer that question. I do not consider myself qualified to do so and I do not think I have the knowledge to do so.

The question in relation to an Annual Report on expenditure I can only say again on the question of actual expenditure I do not know, but the Legal Aid Commission does publish an Annual Report as does almost every other government agency, and the Mental Health Advocacy Service does have a section in that Report in which we report on our activities during the past year.

In relation to follow up, we do carry out some follow up. I think that we carry out as much follow up as is possible under the circumstances. I think it is unfortunate to raise this presumably within the context of suggesting that we appear for our clients and then dump them. If that is the case I think it is doing everyone concerned a disservice. I would like to at least think that everyone involved in this business, both medical and legal people, do have the interests of their patients and of their clients at heart. I do not believe that anybody in this game deliberately dumps a client or a patient.

T. Kelly, Director, Legal Aid Commission

The figures are in the Annual Report. I cannot give you a figure for this year because the matter is not up and running, we are still waiting on much of the Act to be proclaimed. If it finally gets going it will be around the $1,000,000 mark.

Dr Lucire

Thank you very much. I have another question: When will ethicists and philosophers be involved and be available as consultants to both psychiatrists and lawyers who work in this field to provide an ethical and philosophical structure against which the present situation can be evaluated from the point of view of what is in the *best* interests of the patient? I think that we have to start off with a situation as we have with the custody of children in the *Family Law Act.* We have to start off from the position of what is in the best interests of this patient and the adversary system does not appear to do that.

I am aware that in the United States ethicists and philosophers are used in this way. I think they should be available to lawyers and doctors to consult as part of the staff of perhaps the hospital or the Legal Services Commission.

Dr P. Shea

Just a passing comment to Tom Kelly. My Arts Major happened to be in philosophy, so I fully support Dr Lucire. Perhaps the million dollars or so could be spent on providing people who could give a sound philosophical basis to what goes on, rather that all of us depending upon the whims of particular parties.

I. Wallach

The major point which is raised by Dr Lucire in that last question did relate to that vexed phrase, "the best interests of the patient". Now the real crux of the entire issue is who decides what are the best interests of the patients. That is the reason why it is not the person, or the organization wishing to detain the patient which is left with the decision as to whether or not a person is to be detained. Rather a magistrate, an outsider, is brought in to make the decision. Similarly the patient himself or herself obviously has to be able to have the rights to state what in his or her opinion are in his or her own best interests. Now, if we could simply switch on a computer or a machine which would tell everybody what is the best interests in every possible situation, it may well be that there would be no need for the system. However, the real issue is rather that all people involved in this business have their own view of what the best interests of the patient are and that is the real difficulty.

Dr Lucire

I would like to answer Mr Wallach. I am not saying that anyone of us can determine what is in the best interests of the patients but what we can have is a theoretical structure as to what questions ought to be asked to determine the best interests of the patient. The information that we allow into the discussion is what determines its outcome and in fact what we need is somebody there who is able to ask each of us, doctors and lawyers, a lot of questions that a lot of us are not thinking about. So I am suggesting a change of criteria, not at the legal level, but at the informal level.

My third question is a bit tricky I suppose. Many symptoms of mental illness are negative ones. These are lack of certain capacities, lack of the capacity to work, lack of the capacity to judge, lack of the capacity to maintain a stream of thought, and lack of the capacity to behave appropriately. How does the lawyer know that the person from whom they are taking instructions has the capacity to instruct?

I. Wallach

The lawyer when acting for people in either magistrates' hearings or before the Tribunal obviously does have a difficult task. Dr Lucire has raised a most legitimate point and one which is actually in the foreground of any lawyer's mind when taking instructions. It is certainly one that we are aware of. What we have to do, I think, is to hear what it is that our client is telling us, bring to that person's attention any problems that we can see, advise them accordingly and then assist that person in taking up some of that advice. In a lot of other cases what will occur, for example, is that we will in fact call our own expert witnesses on behalf of the the person facing the Tribunal or the magistrate. The point that is often missed by many critics of the system is that we, as the patient's advocate, often bring in independent experts to assist us in coming to any conclusions regarding advice we might give our client and also the course which we might adopt before the relevant Tribunal. Now, there is very much a mistaken attitude that lawyers seen to make some value judgement or snap judgement in some other way and simply go off and take that course. What is often missed is the fact that advocates, solicitors of the Mental Health Advocacy Service, do in fact employ their own expert evidence. For example, whenever any of our solicitors on behalf of a client does take up a matter on appeal to the Supreme Court we will always have the evidence and assistance of an expert

witness. Very often this is an independent psychiatrist, or a social worker and other expert witness. It is not the fact that we go off and make a lot of these judgements on our own—we get assistance.

N. A. Harrison

I think in writing my paper I threw up a lot of questions which are still all in mid air and have not been answered. On pages 20 and 21 I raised that particular point as to how the advocate is able to receive instructions. I did not come up with an answer unfortunately.

Dr D. Russell, General Philosophy Department, Sydney University.

I did not really come to speak about Dr Lucire's comment. I do not think philosophers do have a role in these hearings, and as things are presently being conducted I am really pleased about the Mental Health Advocacy Service—how it has been set up and how it is running. That is not to say it will always be wonderful, but at the moment I think it is very good. I think that these are legal matters that should be faced legally and not informally, as Dr Lucire said. I think that what Mr Wallach said about hearing what it is that the client is telling is a very good thing to go by because I think it is primarily the client, the patient, who should be expressing what they wish to do and should be heard.

The point I really wanted to comment on was the definition of mental illness in the new Act and what Dr Shea said about extending the clause relating to social and financial harm to other types of mental illness apart from anything to do with manic depression. I think this would be a terrible step backwards. I think it would open up a whole lot of woolly indeterminate issues that are still prevalent in the old Act. It would be getting back to something like the "patient needs care, treatment and control for their own good". The great advantage of the 1983 Act is that it has tried to narrow the definition for committal by keeping it basically in terms of actual or potential physical harm to self or others. I think to try once again to broaden that would be a terrible step backwards.

Finally I would just like to ask if any members of the panel could tell us when the section relating to mental illness of the new Act will be proclaimed?

Dr P. Shea

I have heard the same comment many times before.

The phrase is "serious financial harm or harm to his or her reputation and standing in the community". It spells out fairly specifically in the Act exactly what that phrase means. I think the term "serious" is important. It does not just imply *anybody* who is suffering from financial or social harm could be included.

The important point I was making, and I made it in my paper as well, is that when you have a person who is mentally ill and who requires treatment the aim is to get them into treatment. Once they are in treatment you can introduce a whole series of appropriate safeguards to ensure that that treatment is not prolonged beyond the time the person should be in hospital.

I think in the new *Mental Health Act* we have all those safeguards. The point I was making, and I am sure Dr Russell would appreciate this, is that it is logically inconsistent to have that phrase for one particular type of mental illness when, in fact, the degree of financial and social harm that can occur with schizophrenia and depression can be every bit as great or even more so than in the case of a person in the manic phase of manic depressive illness.

Dr Sainsbury

Just in answer to the question as to when Part V of the Act is being Proclaimed, that is the Minister's perogative.

Doug Humphreys, Solicitor, Mental Health Advocacy Service

I would like to take issue with a couple of comments made by Dr Sainsbury in his second paper, the comment on the paper by Mr Wallach.

On page 63 he refers to a matter which was taken up in the Supreme Court. He makes a comment:

> While appreciating the importance of conforming to the letter of the law, from a practical point of view, the date of the writing of the certificate made not a scrap of difference to the management in hospital of this young patient.

Firstly I would like to quote from a paper that was given by Sue Schreiner to a Magistrates' Conference some years ago and she was then dealing with the defective documents which are placed before magistrates in mental health inquiries in hospitals and she said there:

> The consequences of the deprivation of liberty cannot be too seriously stressed. The questions that arise are not merely matters for lawyers to argue about. They are questions involving the most fundamental human right of all, mainly the right to one's liberty. The only other occasion when citizens under our system of justice are deprived of their liberty is after conviction by a court for a criminal offence after trial, open to public scrutiny which embodies in it the safeguards to ensure that the accused is properly tried and convicted, and sentenced.

She then goes on to talk about the documents that she has seen in magistrate's inquiries and she says later on:

> It is with regret that I find it necessary to say that in many cases those documents are seriously and inexcusably defective. It often appears at inquiries that certain medical practitioners have taken the view that their decisions are not to be questioned, that they should not be subject to any scrutiny, and that the deprivation of the person's liberty is something that lawyers take too seriously and argue about unnecessarily.

In view of the fact that Dr Sainsbury said it did not make a scrap of difference as to how this young man was treated I think I should point out first of all that he had been in custody for some number of years and this included the number of years after the charges for which he was made a forensic patient had in fact been No Billed or dropped by the Attorney-General, and he was still being held as a forensic patient. Secondly as the result of the action in the

Supreme Court which declared he had been unlawfully detained since 1983 he was discharged from the intermediate security ward, the forensic ward at Morisset, he was transferred to another hospital in an open ward, he also had his pension restored to him. Now if that is not a scrap of difference I am sorry I do not know what it is.

Dr Sainsbury

Thank you Mr Humphreys. I am very much aware of Sue Schreiner's paper, and I know that numbers of certificates that have been written in the past could stand a fair bit of improvement. With this patient there were difficulties with section 24, which you well understand and I think it is a thing that we cannot enter into here. It was one of the reasons why changes were made to the 1983 Act, and even though the patient is 'No Billed' it is still a matter for debate. I am not a lawyer, and I will not enter into that but, it is a big problem. That particular patient went through a process of rehabilitation as far as one can in a limited number of wards in the particular hospital to which he had been admitted. He used to work in the industrial rehabilitation unit and when his condition warranted it he was given quite great freedom within that situation. If his condition deteriorated, and it did fluctuate, one had to exercise a reasonable amount of control in the matter. The question of his pension is an unfortunate Social Security matter that is going to be reviewed by the Social Security Department of the Commonwealth. We feel a lot of our forensic patients were very hardly done by through that Act of the Commonwealth. I do not think I need to say any more but still I am learning, you see.

Dr P. Shea

I will only add to what Mr Humphreys said in this sense, that clearly the action taken on behalf of this man did improve his condition and his immediate environment significantly. When you say, as Dr Sainsbury says, as the result of a long process of rehabilitation, it is remarkable and coincidental the actual move occurred within a matter of days after his appearance in the Supreme Court and the action taken on his behalf.

Dr Sainsbury

I have not seen him since to know what the situation is at the moment. You may have knowledge that I do not have.

Dr P. Stanfield

Regarding that patient, (I think we have the same patient in mind), he is being re-assessed at that hospital and thought to be unwell enough not to be in an open ward. In fact, he has not been in an open ward and remains in a closed ward and we think that his future treatment certainly in the immediate and medium term will require him being in a closed ward.

Dr Graham Edwards, Psychiatrist

I would just like to make some brief comment on my friend Peter Shea's paper and give some background of the original committee looking at that area.

One of the things that we actually first did in those early days was to draw up huge lists of mental illness, much along the lines Peter Shea suggested, and realized that that would really make it very broad and impractical. The thrust of that legislation which appears to be eventually coming assists with the matter that mental illness is very much a matter for psychiatrists to determine, but the accessory criteria of dangerousness itself and others may need amplification which appears to be the current sort of emphasis.

I would like to emphasise one thing that Peter Shea did raise in his paper that could only have been a drafting oversight—omitting toxic psychosis from the Act. One can hardly have parliamentarians and others under the influence of LSD jumping off ledges and I hope they will amend that.

One final comment on Mr Wallach's paper. I think the original members of that committee would be quite delighted to see at this stage what looks like a professional Mental Health Advocacy Service to be developing. Even though controversial in some ways as long as it is properly funded and staffed it should have an important role to play.

Dr P. Shea

Five years ago I would not have said what I am saying today. Probably two years ago I would not have said what I am saying today. I am saying we need the definitions now because of the altered circumstances and the way that things are being dealt with. I do not like using labels as I mentioned. I think they are hopeless, but I think they are being forced upon us by other people and other circumstances. The best we can do is come to some agreement which particular labels mean mental illness for the purpose of the legislation.

Anne Newham, Association of the Relatives and Friends of the Mentally Ill.

I would like to talk about the relatives' points of view because in this process with the Tribunals the relatives do not have a legal representative. I am afraid they are very much subject to stress and harassment by the person who is mentally ill, and I would like to ask what process of law is really going to help these people because under existing legislation (and I would say that people have been acting as though the 1983 Act is in place for three years now even though it is in fact not) it is very difficult to get a Restraining Order that is effective? It will actually work on a person who is in a very demented state so that the people are still at grave risk. I know of a case where a policeman had to be stationed at a woman's house for two nights running when she was under extreme stress from some act of provocation from the husband who was not living with her. But also I feel that the Apprehended Violence Orders fall down, in fact they do not work, where a person has got access to guns and other instruments. Assault charges do not work because the person who is mentally ill does not turn up to court. I would like to know what redress people do have because people are not being committed under this Act, or under the new Act, at the moment for those acts of violence and dangerousness. Through the 24-hour support line we hear of these cases where people are very very stressed and under real danger in many instances.

N. A. Harrison

I will go first and decline. I do not know that answer unfortunately as my paper indicates. My expertise is really in the area of fitness to be tried and the consequences therefrom and not the earlier stage as to what happens before the patient reaches that point in the criminal process.

I. Wallach

I would agree with the general point of view expressed. There are a hell of a lot of difficulties encountered by the families of those people whom I see and have represented who are presented before a magistrate in hospitals. Very often it is the family of the person involved who will be ultimately the last support for that person and I agree certainly that those people do need a lot of support. The situation cannot just be answered by legal measures. I would think there are two things involved. First, there needs to be a real effort both in terms of man power and money into the extension of community treatment services as opposed to what Dr Shea has called community treatment orders. I would make that distinction very strongly. I would think community treatment services are essential and they must be built where they are needed. I can only refer you to the beginning of my paper where I expressed the opinion that where police are necessary to protect people or where there is a real risk of violence including the use of firearms, quite clearly, in my opinion, that person would come within the definition of "a mentally ill" person both under the existing Act and certainly when the definition under the 1983 Act comes in.

The question of exactly how that person is to be brought into a hospital under those extreme circumstances is a very difficult one, and I would think involves as much again the question of community treatment and community health personnel and not just lawyers. One solution is to extend and increase the education of doctors involved in the field so that they are better aware of the legal provisions of both the existing Act and the new Act which is yet to come in.

Dr Sainsbury

I have the greatest of sympathy for people who are in the position of Mrs Newham and those people who are tied up with the Association of the Relatives and Friends of the Mentally Ill. I have quite a deal to do with them in terms of crisis services and services in the community. Indeed we have nine crisis teams in the State covering 20 per cent of the population at this moment which is not enough, but I just wonder with all this how do you provide support? I would ask Mr Wallach how do you support the mother *in the house* where the child says "I am going to do you in Mum". These are some of the problems, and, in fact, many of the relatives have very strong feelings that if they go to a magistrate's hearing they feel that their voices are not really heard. They are the people who first know that something is going to go wrong. They can pick it up probably days or even weeks before that their child is going to become assaultive but it seems to me that until the child becomes assaultive, then nothing can be done. The families of these patients, particularly the sufferers from schizophrenia, are in a very invidious situation, and I have a great deal of sympathy for Mrs Newham.

Anne Newham

It is really the relatives who need the sympathy. I would just like to add a comment on the matter of community services. I think they are marvellous and where they are provided they are very effective in dealing with these situations, but where that particular person really lacks insight into their condition, denies the need for any treatment, and in fact refuses to have any, what recourse do the community treatment people have then, in that instance?

You are asking me to draft a legislative provision which will be an effective magic wand to wave over a problem which is really difficult, which is vexed, and which is obviously as sensitive as you have made out. As I said earlier I do not think that there is a magic legislative provision which you can use to cure all those problems but I would think that that attitude is part of the problem. Very often, as Dr Shea pointed out in his paper, he would support the idea of a community treatment order. In my mind that is similar to what you are asking for, but the real problem is that there is no point bringing in a system of community treatment orders unless you have in place first a comprehensive system of community treatment which can back up those orders. That is really what you are talking about. I think to talk about bringing in legislative provisions rather than the actual services that are needed in really putting the cart before the horse. I personally would think that trying to lobby and campaign for those sorts of resources would by far take priority over asking for legal provisions to coerce people into getting treatment which may not be available. After all, I think Dr Sainsbury has said that those services as yet cover only 20 per cent of the population. I think that it would be in the interests of A.R.F.M.I. and everyone here to try and get the extension of those community services to 60 or 80 per cent, if not 100 per cent, of the population.

Anne Newham

Yes, I agree with you and that is something we are doing.

John Stratton, Mental Health Advocacy Service

I have got a question for Dr Shea about the vexed question of senile dementia. Would you agree that admitting someone with senile dementia to a large scale psychiatric hospital is likely to be the worst setting for their treatment, and that studies show that their conditions is likely to deteriorate after they are admitted to such an institution? It was a finding of the Richmond Report that it was far better to deal with people suffering from senile dementia in any setting other than a large-scale psychiatric institution. It is really not good enough for people from the Health Department to say: "Well, there is really nowhere else for these people to go," when the Health Department is not implementing the recommendations of the Richmond Report in providing some other place where people suffering from senile dementia can be housed.

Dr Peter Shea

It is a loaded question. I would not like to comment on the actions of the Health Department. I did write a paper some years ago in which I pointed out very clearly that in my opinion the best place for anybody to have treatment is where they live and work rather than in a hospital setting, and I still hold by that belief. I think that if we had the resources the ideal place to begin both assessment and treatment is as far away from hospital as you can possibly get. All I am suggesting is that we do not have anything like those services for people who are old and who have a multiplicity of social, psychological and physical problems. So in one sense I am agreeing with you. I agree if we had those services the best place to start would be the person's own home in an environment with which they are familiar. Unfortunately we do not have those services and we do have to assess people. So in the meantime, in the absence of any alternatives, I have suggested dementia should be considered a mental

illness for the purpose of ensuring assessment can be carried out at least somewhere.

John Stratton

But that means the assessment will take place in the hospital after they have already been taken out of their homes.

Dr Peter Shea

Yes, that is correct.

John Stratton

And it is a self-fulfilling prophesy.

Dr Peter Shea

Yes, it is to some extent. The same thing applies to any patient who is taken away from their home setting whether they are schizophrenic, depressed, or manic, or anything. I will not extend this argument but by the same token any person going into a professional setting is disadvantaged, whether it is a lawyer's office or a doctor's office.

Dr B. Draper, Psychiatrist

I specialise in health care of the elderly and I totally agree that the best setting for health care of any person is in the home or in the immediate environment. However, with dementia now seeming to be an exclusion under the new Act as a mental illness, we have a problem because, unfortunately, some patients with dementia become extremely violent, and I mean violence at the level of causing quite a degree of bodily harm. We have the problem where there is no safe place these people can be acutely looked after besides psychiatric hospitals. It is all very well to say that it is due to an organic condition and therefore not mental illness, but the reality is that these people are very disordered and they cause their carers a great number of problems.

I believe it is a rather silly situation where we base the definition of mental illness on exclusions such as organic disorder because it does not reach the crux of the matter. The crux of the matter is "Is this person regarded in some way by society as being mad or insane?" It does not matter whether it is organic or not, that is irrelevant. The relevance is, as we have been saying earlier, whether the lay person believes this person is in some way insane. That is the basis that we should look at. If we are going to say that demented people cannot be treated involuntarily simply because they have an organic disorder, then I tell you what we have rather a big problem on our hands because the number of demented people that we are going to have in this society in the next 10 to 20 years is escalating. The big problem is that while it is only a few demented people who are violent or unable to be looked after in institutions for other reasons, all of our community services will be taken up with them—and ineffectively at that—at the expense of the majority.

Dr Peter Shea

Just a brief correction. Under the new Act dementia from drugs and alcohol is included as a mental illness under s. 53. It is under the present Act that it is excluded following Mr Powell's decisions to that effect. I assume if dementia from drugs and alcohol is included as a mental illness then you must include other forms of dementia as well unless the Act is changed. I cannot see how it can apply to one and not apply to the other.

I. Wallach

Dr Shea is talking about s. 5 of the 1983 Act which, of course, as we keep on saying is yet to come into operation. He is talking about in particular sub-section (2) and sub-section (3). Sub-section (2) lists a number of conditions to which the preamable states "a person is not a mentally ill person by reason only of any one of more of the following" and, of course, included in that list are references to developmental disability of the mind and taking of drugs including alcohol. Sub-section (3) is what Dr Shea uses to bring this definition of dementia and other similar organically caused conditions within the definition. It states that nothing in sub-section (2) (which is that long list) "prevents in relation to a person who takes or has taken drugs the serious and permanent physiological bio-chemical or psychological effects of drug taking from being regarded as an indication that the person is mentally ill". Now try and break that down. It is a reference basically to that prior sub-section which is itself effectively an exclusionary clause on the original section which is sub-section (1) and that section effectively still retains the basic scheme of the 1958 Act, which still requires this presence of mental illness. I do not think that sub-sections (2) and (3) which are basically exclusionary clauses enable the conditions to clear that hurdle. In the first place it still has to be a mental illness that we are talking about and of course the Supreme Court has said that the condition of senile arterioselerotic dementia itself is not a mental illness. Now, given the fact that the condition of senile dementia would not come within the meaning of mental illness in sub-section (1) in the first place I do not see how that defect can be cured by exclusionary clauses referring to the same concept. If a person is not mentally ill in the first place then merely because of what is said in sub-sections (2) and (3) I do not think that the problem can be cured.

Dr Peter Shea

This is a matter that Mr Wallach and I will be arguing before the Court of Appeal shortly I hope. My point was that historically if you go back to the way the Act was developed, and if you look at the 1982 Bill, and if you look at the Cabinet Minutes and so on, you will find that what I said is correct.

I. Wallach

Well, on that note I would not dare contradict Dr Shea. I withdraw everything I said!

Chairman

One thing I find intriguing about this whole question about arteriosclerotic dementia not being a mental illness is that I seem to recall in my days as a Crown Prosecutor being firmly convinced that there was solid authority for it being regarded as a disease of the mind for the purposes of the *M'Naghten* Rules. It seems to me extraordinary that we should have a different notion of mental illness to disease of the mind. Indeed I seem to recall also Mr Justice Powell defined mental illness in terms of a disease of the mind and I also seem to recall that none of these decisions which recognize arteriosclerotic dementia, i.e., an organically caused condition, as a disease of the mind were cited or if they were cited they certainly weren't referred to by him in any of his decisions relating to this question.

Peter Brain, Psychologist

I am a community-based clinical psychologist, as well as a part-time third year law student at Sydney University. But it is in a third capacity I wish to make a comment. The debate has moved on considerably from the point where I would have liked to have commented, particularly the representative from A.R.F.M.I. talking about community services and the services they provide.

It is in the capacity as Union delegate that I wish to make a brief industrial political statement. In the Southern Metropolitan Region where I work, from 1981 to 1986 there was a 23 per cent reduction in community-based mental health workers. In the light of the Richmond Report and staff that have been appointed since then under the Richmond Programme, the total reduction after those people had been added in is now 8 per cent which demonstrates to me the commitment of the government generally to providing these sort of services in the community for these patients.

I think that the government has to consider what many of the ramifications are going to be with the *Mental Health Act* coming into effect and despite, some of the comments in the papers at this seminar, people should realize that many of the community facilities are acting in the spirit of the Act in the way they assess people, in the way they Schedule people and put them in hospital, and direct them towards hospital. At the moment it is these facilities that are bearing the brunt of managing difficult patients.

Matthew White, Law Student, Sydney University

As we are all aware under the Richmond Scheme the government's policy is to move people out of institutions and into the community, usually into community houses. The people that cannot be moved out presumably are kept in the institutions and I can give an example of this from my local area. Morisset Hospital which is a Fifth Schedule system hospital in the Hunter Valley is slowly being closed down. The patients which cannot be put out into the community are being put into Stockton Hospital which is already terribly overcrowded. It has something like 500 beds. When Morisset will be closed down it is estimated there may be up to 850 beds needed in Stockton Hospital. The point I want to make is that when the new definition of mental illness comes into play, which is very heavily based on harm to other people, presumably the people who are going to be involuntarily incarcerated under that system will not be moved out into the community under the Richmond Scheme. Could I ask Dr Sainsbury where will they be put if the Fifth Schedule system is already overcrowded?

Dr Sainsbury

I would like to get some clarification here. Speaking about Stockton, you are actually talking about developmental disabled people, people with developmental disability of the mind. They are going to be moved back. Many months ago administratively and financially there was a separation in those large hospitals that had both mentally ill people and developmentally disabled. Obviously things will be phased out of the isolated Morisset area part of the hospital and some will be taken up into Stockton. It is hoped they have also got a place at Tomaree on Nelson Bay, and there is a whole service for the Hunter Region.

Matthew White

Tomaree used to be a holiday lodge I believe for the patients, and now it has been closed down and turned into a virtual hospital.

Dr Sainsbury

It is part of the developmental disability service for the Hunter now.

Matthew White

The point is, if these institutions are going to be overcrowded because you are closing down Fifth Schedule hospitals where are you going to put people who are involuntarily admitted under the new Act if the present institutions or the ones you have by then are all crowded?

Dr Sainsbury

There is a part of Morisset which is looking after mentally ill people, and that is part of the Hunter Mental Health Service which now involves the Hunter Hospital as well as the Morisset Hospital. Admissions will go to the Hunter Hospital, and there are certain wards in the "mental health" part, if we can call it that, of Morisset which will undertake specialized functions and take some of the longer-term people, some of these people who may be brain damaged. It will have a psychogeriatric type service there too. I am still not clear. There is a category of persons, of course, the developmentally disabled person who is also psychiatrically ill. Naturally that person if he or she were a mentally ill person as defined under the new Act he or she would be dealt with no doubt in the psychiatric type situation.

Matthew White

I was wondering if I could ask a second question to Dr Sainsbury. In your reply to Mr Wallach you refer to the recommendations being sent to authorized officers. You say the first recommendation went to an authorized officer in 1982 but he left in 1983 and nothing was done, and then it was sent to a second person.

Are we to presume from this that there is no sort of central co-ordination in the Health Department when these things happen, and, if not, why was something done by the first authorized officer in 1982 anyway?

Dr Sainsbury

The authorized officer has no particular power to do anything in that situation in any case. A recommendation was made to the Legal Services Unit indicating that the position was such, not in 1985 but in 1984, that these people do not need to be detained under a forensic section of the Act. The question was asked: "What can be done to reverse it?" From December 1983 the new Mental Health Act had been passed through both Houses of Parliament, it was going to be Proclaimed every two months from then on. There were some particular legal difficulties as to how a couple of people could be moved from under the forensic part of the Act but that was put into the hands of the Legal Section of the Department. It involves too much detail to go into individual cases at this particular stage but there was confusion as to how it could be done, and it was felt they were better off in any case in the particular situation in which they were living. The staff knew them, they were quite happy and they needed the geriatric sort of care they could get at that time.

Dr Jean Lennane, Psychiatrist

I am also a unionist. We have had one union speaker already. I would like to raise several matters, one where I have already been involved as a unionist and that is the great problems medical staff are experiencing owing to this one sided advocacy system. When we are running an adversarial system in the courts normally both sides are represented. There is a prosecution side and a defence side, but in the system as set up with the Mental Health Advocacy Service what might be called the "prosecution" side is left really to the doctor who is trying therefore to act both as a medical expert witness and as the Director of Prosecutions, and this, of course, without any legal knowledge except what we can scrape up from just asking around the place. It seems to me unfortunate that if we are having an adversarial system that it is adversarial, but only one side is represented and that is not the way the rest of the system runs. I would like a comment on that.

The other matter that I would like to comment on which has been touched on is really the unfortunate state of the relationship between the medical and legal profession around this area. There should be every effort made on both sides to get together more and find out more about each other's fields. I personally find it very strange that Judge Powell's decision, which had such far reaching effects, appears to have been made without the basis of any expert medical advice, and from reading it seems to be based on a fairly complete lack of knowledge about both dementia and psychiatric illness in general. Of course, most serious psychiatric illness if probably organic and with another few years of knowledge if we are excluding organic diseases we will have to exclude definitely manic depressive illness and probably schizophrenia. I would just like to make a plea for some more efforts on both sides to respect each other's area of expertise, to refrain from the unfortunate tone which I feel Mr Wallach's paper showed, and try to look for ways to work together to get the best possible services for the people who are involved. We should not be trying to compete or build up our own empires at the expense of this particularly vulnerable group in the community.

Angela Karpin, Magistrate

I would like to comment on those observations. I was horrified recently to hear a psychiatrist suggest that psychiatrists should be legally represented at these hearings and I think it is very important that it be clearly understood that these hearings are not the adversarial system in full swing. These are inquiries, and it is not the case that the opinion of the doctor is at risk. It is an inquiry being conducted to determine whether or not the patient should be kept at the hospital against his/her will in these circumstances. It made my blood run cold to think how these inquiries will deteriorate if psychiatrists are going to feel they have something at stake in having their opinion upheld by the magistrate. I think it is very important that every effort be made to reduce the adversarial system. We live in a common law system, unfortunately lawyers think in terms of an adversary but certainly when I conduct such inquiries I do my best to ensure that everybody has it in mind that it is an inquiry for the interests of the patient. I think that should be kept well in mind.

Certainly I think the Mental Health Advocacy Service has as its basic tenet that in accordance with the instructions they receive from the client they are there to assist the client, the patient, to leave the hospital or not to be held there against their will if possible. Can I put this question or this proposition? I have heard of some cases already where people are excluded from the mental health system only to fall into our criminal justice system because, in fact, they commit offences which then bring them before the criminal justice system. In talking about the protection of relatives the idea that recourse would have to be had regularly to the legal process in various ways e.g. apprehended violence, assault charges, etc., seems to me to be contrary to the interests of the patients. I do not know the solution to that and obviously community health based services are the ideal but it seems to be to be very unfortunate that cases may arise where people will be excluded from the mental health system where they may be cared for and put into the criminal justice system which can hardly be to their advantage in the long term.

I. Wallach

I agree that it would be a shame for people to be forced into the criminal justice system rather than the mental health system but as I pointed out at the beginning of my paper I think it is simply not true that someone who has a mental illness and who can be shown to be violent or potentially violent is not a mentally ill person within the meaning of the Act. If that is the case there is something at fault in the actual admission system itself. I think that Dr Lennane's comments unfortunately reveal the need for the increased education of doctors in the elements of mental health law.

In that respect I would certainly agree with her, no one is expecting doctors to become lawyers or apparently engage in that "dehumanisation", but if doctors are better acquainted with the definition of who is a mentally ill person, then I would think that someone who is potentially violent and who is mentally ill would come within the mental health system rather than the criminal justice system.

In relation to doctors actually getting their legal representatives it is a matter for the Health Department to determine whether that occurs, but I think it would be very unfortunate. This is the only comment I would like to make about Dr Lennane's comments in relation to that. It is very unfortunate that she even uses the terms of prosecution, or defence or even adversary in relation to these things. I think it is a great misnomer and I think she is doing a great disservice to her own profession and the mental health system in general by even making any comparison, no matter how passing, between the mental health system and the criminal justice system in that regard.

Dr Durham

I deserted the microphone prematurely when I spoke before. I meant to raise a legal question rather than discuss a case but Mr Wallach cut the legs from under my legal question by suggesting that the account of the case which I had submitted in writing was inaccurate. He said that on his information the case has turned on the question of dangerousness and in particular had been settled on the ground that insufficient evidence of dangerousness had been presented. Now, this is so far from being the case that I had a witness, the man who was most afraid of this patient waiting to give evidence, and I was told that I could not bring him, that it was irrelevant, the matter having been decided on what Mr Justice Powell calls the "third leg" of the case. In other words, the account that Mr Wallach got from other people's memories is not correct and indeed the case was settled on the simple issue of whether he was able to care for himself physically or not. The question of dangerousness was not allowed to be discussed.

Dr Peter Shea

Like any other profession, psychiatric medicine in fact swings backwards and forwards between extremes. It is not so long since we were putting patients into chairs and swinging them around in the air to try and cure them or placing them into cold baths and so on.

At the moment we have a swing in the *Mental Health Act* of 1983 towards one particular position. I have not the faintest doubt that it will swing back again, because the history of psychiatry is that it swings backwards and forwards between institutionalisation and de-institutionalisation. Eventually I hope we will reach some sort of reasonable point in the middle of this swing where we can stay for a while.

The second factor is that practice moves ahead of legislation all the time. If you look at the old *Lunacy Act,* for example, when it was first proclaimed there was no provision for voluntary patients in it. In fact, a lot of people came to be admitted as voluntary patients. They had to revise the Act and put in a provision for voluntary patients. There is never a time when the legislation has ever reached a stable point where it is satisfactory.

So much as I hate to suggest this, because my recent work experience has given me an absolute abhorrence of committees, I would suggest that what we really need is a Standing Committee which constantly reviews both the *Mental Health Act* and the application of it.

N. Harrison

I have been called upon to say very little at this seminar. I do not know whether it is gratifying or not to have found that my paper and the issues raised in it, which were particularly related to issues of persons being fit to be tried or not and defences of mental illness, raised very little comment. On that basis I will pass the bat to my co-lawyer who has had most of the floor this seminar and no doubt has a lot to say in summing up.

I. Wallach

I think the central thrust of what I wanted to say at this seminar is that the advocacy service is to act for patients and people in the mental health system in determining, what has often been raised at this seminar, the best interests of the patient. Those best interests cannot, I believe, be determined by one group alone or even seen as one group alone. It is often the situation that there are conflicting points of view as to what may be the best for that person in regard to treatment, and also conflicting points of view as to what actually were the facts which brought a person into hospital in the first place. I think the exchange between Dr Durham and me as to different views of the facts of that case illustrates that point perfectly.

As I said earlier and in relation to a number of questions, this is just not a legal matter alone. Legal matters are there and are important to safeguard the views and the rights and the wishes of the patient, but it is also a question, I believe, of providing adequate and proper community treatment and increasing those services, as well as retaining quite clearly the hospital system to provide the specialised services in the crisis situations which do undoubtedly arise. I think it is very unfortunate that some people who are professionals in caring for the mentally ill have seen legal representation reduced into such terms as the lawyers versus the doctors. I do not believe that assists anyone or takes anyone any further, let alone the person I believe we all should be acting for and in the interests of, and that of course is the person who represents our client and our patient.

Can I just conclude by saying this? Next week is Mental Health Week. One of the activities which will be held during that week is going to be hosted and will be organised by the Mental Health Advocacy Service. It is a seminar which will be held next Tuesday night, 23rd September, and it will be held at the YWMCA in Wentworth Avenue, Surry Hills. Anyone who is interested in the area and wishes to come along would you please contact us in order to register in advance and you can contact us through the Legal Aid Commission. I thank the Chairman for allowing me to make that commercial announcement.

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