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RIGHTS OF THE MENTALLY ILL: REPRESENTING PATIENTS AT MENTAL HEALTH ACT HEARINGS

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INSTITUTE OF CRIMINOLOGY
SYDNEY UNIVERSITY LAW SCHOOL

Proceedings of a Seminar on

RIGHTS OF THE MENTALLY ILL
Representing Patients at Mental Health Act Hearings

CHAIRMAN:

The Honourable Mr Justice J. A. Lee
Supreme Court of New South Wales

15th March, 1978
State Office Block, Sydney

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A PILOT STUDY OF REPRESENTATION FOR INVOLUNTARY PATIENTS AT THE ROZELLE HOSPITAL

An Introduction, Overview and Evaluation

By

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"Involuntary mental hospitalization is like slavery. Refining the standards for commitment is like prettifying the slave plantations. The problem is not how to improve commitment but how to abolish it." (Szasz, 1973).

"Compulsory psychiatric care is not a threat but a right. Every citizen should have the right to be admitted against his will to the care of a first class psychiatric service." (Birley, 1973).

"Everyone, after all, should have the right to a lawyer before he is stripped of his liberty, labelled mad, and bussed away, perhaps for life, to a mental hospital." (Ennis, 1972).

"In the course of commitment proceedings and, thereafter, patients should have access to competent and compassionate legal counsel. However, this latter safeguard may itself be subject to abuse if the legal counsel acts solely in the adversary tradition and undertakes to carry out the patients' wishes even when they may be destructive." (Chodoff, 1976).

Introduction

Debate over the rights of persons subject to involuntary hospitalization procedures has been and has continued to be a major source of conflict between the medical and legal professions. (Peszke, 1975). Notwithstanding the comments of Dr Thomas Szasz, there are many people who believe that there are measures available which would improve the protection of many civil rights for involuntarily hospitalized persons. In particular, patient representation has been put forward as a means for increasing the protection of patients' rights. (See Appendix A).

In this Report, we provide a description of the background, implementation as well as some preliminary evaluation of a recent pilot study of a patient representation service.

Provisions of the New South Wales Mental Health Act, 1958 (as amended)

The provisions for the involuntary hospitalization of mentally ill persons are set out in Section 12 of the Act. Involuntary hospitalization may be initiated on the certificate (Schedule 2) of a Medical Practitioner. (s.12.1(a)).

It may also be initiated by one of the following:– the person himself, a relative or friend, a Justice, a member of the police force or a welfare officer. If any one of these five procedures is used, a medical officer at the admission hospital must see the person "as soon as practicable" after his admission and certify that he is "a mentally ill person or ought to be detained for observation and treatment". (s.12.1)

In all instances of involuntary admission, the person must also be examined by two medical practitioners separately and apart from each other as soon as practicable after admission. (s.12.4). If two doctors do not recommend that further observation and treatment are necessary, then the person must be discharged. If two doctors formally recommend that further observation and treatment are necessary, then the person must be brought "as soon as conveniently may be" before a stipendiary magistrate.

After the hospital has given notice of the hearing to the person's relatives, the magistrate holds the inquiry to satisfy himself that the person is a "mentally ill person". If the magistrate is not satisfied that the person is a "mentally ill person", then he must order the person to be discharged (Outright Discharge). If, on the other hand, the magistrate is satisfied that the person is a "mentally ill person" then he may order that the person either be detained as a "temporary patient" for a period not exceeding six months, or be discharged to the care of a relative or friend (Discharge Under Care).

The magistrate may suspend any order for a period not exceeding fourteen days.

For the purposes of the Act, a mentally ill person is defined (in s.4) as:

> "A person who owing to mental illness requires care, treatment or control for his own good or in the public interest, and is for the time being incapable of managing himself or his affairs".

A person who is committed (i.e. made a temporary patient) to involuntary hospitalization may be discharged at the discretion of the medical superintendent at any stage of treatment. However, if the person has not been discharged at the expiry of the six month period, then he must be reviewed by a Mental Health Tribunal. The Tribunal may discharge the person, make him a temporary patient for a further three months or order him to be made a continued treatment patient.

Review of the Mental Health Act

In 1972, a Committee was set up to review the N.S.W. Mental Health Act. This Mental Health Act Review Committee became known as the Edwards Committee. A summary of the guiding principles and major recommendations of the Review is presented in Appendix B.

The first Report of the Edwards Committee recommended that a pilot scheme be implemented to investigate the desirability or otherwise of providing a legal representation service for all patients coming under the involuntary provisions of the Act. The Committee put forward several arguments both for and against the implementation of a patient representation scheme.

There were three arguments in favour of instituting such a scheme:

Firstly, there is strong trend to provide legal representation for accused persons in routine criminal cases. Since restrictions of liberty are at issue for involuntary psychiatric patients, then representation should be provided for them at committal hearings.

Secondly, since persons with mental disorder are by definition mentally disturbed, they are incapable of looking after their own interests regarding legal representation.

Thirdly, persons who become involuntary psychiatric patients lose not only their liberty but also other rights (such as right to vote, to control property, etc.). It is thus necessary that legal protection should be made available for all persons who may be involuntarily committed.

The following arguments against the introduction of a patient representation scheme were raised:

(a) Under the present Act, there is provided a system for protection of patients' rights which is superior to that available in other Australian States and in England, since the magisterial inquiry applies to all persons who may be involuntarily committed.

(b) Over the last decade, the aim of the mental health system has been to treat patients for short periods and to return them to the community as quickly as possible. Therefore, a plan for the comprehensive provision of patient representation would be directed to a need which really does not exist.

(c) If lawyers weere to become involved in the day to day operation of the admission system, considerable administrative difficulty would result. Delays would be inevitable. Conflict between lawyers and doctors would result in a lowering of morale among therapeutic staff. Patients' interests would be adversely affected by conflicts of opinion as to the necessity of detention or continued detention.

In reviewing these three counter-arguments, the Edwards Committee considered the current experience of people coming under the involuntary provisions of the Act, and raised the following points:

Firstly, there is overseas evidence to suggest that where patients have legal representation they are less likely to be detained on an involuntary basis. (Wenger & Fletcher, 1969; Kumasaka, 1972; Ennis, 1972).

Secondly, patient representation is rare – less than ten per cent are represented by a barrister or solicitor at Mental Health Act hearings.

Thirdly, magisterial hearings are extremely brief, less than five or ten minutes on average. While a longer hearing is not necessarily a guarantee of better judgment, the present period does seem short.

Fourthly, as a corollary of the third point, there seems to be inadequate exploration of alternative sources of care for the patient.

Finally, it is unusual for the treating doctor to be present at the inquiry. The magistrate decides the case on the results of his interview and on the evidence in the certificates of the medical practitioners.

Establishment of the Legal Representation Project

Following the recommendation of the Edwards Committee, the Minister of Health, the Right Honourable Mr Kevin Stewart and the Health Commission announced that a grant of $19,000 was available to fund a pilot mental health representation scheme. A committee, subsequently

known as the "Legal Representation Committee", independent of the Health Commission, was established to "implement and oversight the project". A list of members of the Legal Representation Committee is given in Appendix C.

The Legal Representation Committee met for the first time in December, 1976, and it was decided that the pilot scheme would be implemented at Rozelle Hospital. The project began operation in March, 1977 and finished in November, 1977.

Project Staff

A full-time social worker was employed by the Committee to function as an assistant to the legal officers used in the scheme. In the latter stages of the project she functioned as an administrator and resource person to the non-legal patient representatives.

A research assistant was employed for a short time (four months) and a research psychologist was seconded from the hospital staff. Their duties involved: the collection and analysis of data concerning all involuntary admissions and appearances before the magistrate at Rozelle Hospital; the collection of comparable data from other psychiatric admission centres; and the performance of many of the administrative tasks associated with the Committee and the project.

The patient representatives both legal and non-legal were employed as the needs of the scheme arose, and their duties will be discussed in detail in the material reviewing the three stages of the project.

Guiding Principles of Patient Representation

The major principles of the representation service are described in detail below. This description needs to be exhaustive because there is little available material on a representation scheme in a similar setting (However, see Cohen, 1966).

There were four guiding principles which determined the broad characteristics of the patient representation service at Rozelle Hospital. They were:

(i) representation was provided completely free of charge;

(ii) the representation service was independent of the hospital;

(iii) patient representatives relied on the stated interests of the patient;

(iv) representation was offered to all potential clients.

Representation was free of charge:

Because this was a pilot study funded by a grant from the Health Commission, patient representation was provided free of charge to all clients. It should not be assumed that this situation would necessarily continue if and when a representation service were set up on a permanent basis.

Independence of the representation service:

In their report, the Edwards Committee expressed the opinion that a patient representation service ought to be independent of the hospital (therapeutic) staff. The Legal Representation Committee approved this suggestion and it was made one of the guiding principles of the pilot study. This meant that the aims of the representation service were different from the aims of the hospital staff. In particular, patient representatives were concerned with the protection of the civil rights of their clients. They were *not* concerned with the adequacy of treatment.

To preserve the independence of the representation service, it was decided by the Committee that no information collected by the patient representatives was to be made available to hospital staff.

Reliance on the stated interests of the patient:

The basic principle of the service was that the representative relied solely for his instructions on the stated interests of the patient. An example which illustrates this is in the case of a person who is suffering from a diagnosable mental illness, who is actively suicidal. This person requests the representative to seek a discharge. Many hospital staff feel that the representative should make a judgment about the *best* interests of the patient, which presumably in this case is for the patient to remain in hospital for treatment.

In support of the view that the representative should act for the patients' stated interests, it may be pointed out that the doctors put a case at the inquiry for continued detention of the patient and the magistrate has the role of an independent judge to decide between the case for the hospital and the case for the patient. Under these circumstances, it was felt that the representative should always be partisan for the patient, and that it was not his duty to act as the judge of a patient's best interests.

Offer to aid to all persons:

The Edwards Committee suggested that the question of who should be represented would need to be examined in the pilot study. The Legal Representation Committee decided that the offer of representation should be made to all involuntary admissions.

Major Functions of The Patient Representation Services

Potential clients of the representation service were identified by the research psychologist who obtained lists of all admissions to the hospital as well as re-classifications (from voluntary to involuntary status).

As soon as practicable, a member of the representation service approached potential clients and attempted to explain four basic points:

(i) that the patient representative was independent of the hospital;

(ii) the implications of being an involuntary patient in a psychiatric hospital;

(iii) the nature and purpose of the magistrate's inquiry;

(iv) the availability of free representation for the patient at the magistrate's inquiry.

In the discussion about involuntary status, three main points were made:

(a) that the person lost the right to freedom of movement;

(b) that the person could not refuse psychiatric treatment if the doctors thought it necessary;

(c) that his affairs would be managed by the Protective Office for the duration of his stay in hospital and possibly after discharge. (s.39.2).

At this point the person was offered free representation for his appearance at the magistrate's inquiry. Three main responses to the offer of representation were identified. They were:

(i) positive acceptance (YES);

(ii) clear disavowal (NO);

(iii) neither a definite acceptance nor rejection of the offer (NIL).

Both the Edwards and the Legal Representation Committee felt that persons who clearly refused representation should not be represented.

Persons who rejected the initial approach and offer of aid were approached a second time, usually by a different member of the representation staff.

Those people who were classified as "Nil" responses to the offer of representation were treated differently in each of the three phases of the project, as will be described later.

If the patient accepted the offer of representation, the patient representative determined what outcome the person desired. Using a standard format, the patient representative also collected further background information concerning social circumstances, financial resources, accommodation, etc. At this stage, the permission of the client to make whatever enquiries necessary was sought. This included permission to read his hospital file.

Enquiries involved reading the client's file, contacting relatives and friends, liaison with the hospital staff and contact with persons connected with the patient's accommodation. Other activities involved contacting local doctors, community health centres, arranging interpreters, etc.

An additional function of the service, at this stage, involved investigation and assessment of alternative arrangements for the client's care. This ranged from community health centre support to in-patient care in alternative institutions. This duty was performed only on the instruction of the patient.

At the inquiry, the client's case was put verbally by the representative, and the client often responded to direct questions from the magistrate. In no case was a written report submitted. For clients who requested discharge there could be two lines of argument: (1) for an outright discharge – the client may instruct the representative to put the view that he is not a mentally ill person under the terms of the Act, so ought to be discharged by the magistrate; (2) for a discharge under care – here the client may request the representative to argue that, although he is a mentally ill person he may be treated (cared for and controlled) by a relative or friend, rather than remaining in hospital.

Clients also instructed the representative to seek outcomes other than discharge. Some wished to sign a voluntary admission form and instructed the representative to put that view to the hospital staff and/or magistrate. Others wished to remain in hospital as temporary patients for a period shorter than the maximum 6 months.

It should be re-emphasized that it was the client's stated interest which determined the arguments advanced by the representative.

In the majority of cases, the involvement of the representation service ended at the magistrate's inquiry. There were however two types of situations where involvement continued. The first instance occurred with clients whose inquiry was adjourned. Here the patient representative continued to research the case collecting other information for the adjourned hearing. The second situation concerned clients discharged to other care. In this case if the representative had arranged the alternative care, it was expected he/she would ensure that the arrangements proceeded smoothly.

Description of the Three Types of Patient Representation

Three different types of patient representation were investigated during the course of the pilot study:

(a) The duty solicitor scheme – 16 weeks.
(b) The full-time legal officer scheme – 10 weeks.
(c) The non-legal representation scheme – 10 weeks.

Initially it had been planned that the pilot study would run for six months and that the duty solicitor scheme would be implemented as the form of patient representation service. After several months of operating this type of scheme, the Committee decided that there was sufficient need and scope for the appointment of a full-time legal officer to represent patients. Additional funds were obtained to enable the project to continue beyond the six month deadline. Towards the end of the project, the Committee decided (in accordance with suggestion in the Edwards Committee's Report) to investigate the feasibility of persons without formal training in law (such as social workers) representing the interests of patients appearing before the magistrate. In total the project extended over a period of approximately nine months.

A brief description of the major features of each phase is outlined below.

Phase I – Duty Solicitor Scheme

(i) Staff:– A full-time social worker was employed, and a duty solicitor attended on the day of the inquiry. There were three duty solicitors and each served a period of one month. In addition, two of the solicitors appeared together for one month. The social worker was designated as an assistant to the solicitor.

She interviewed the patients, and, where they accepted the offer of representation, made the enquiries outlined above and investigated alternative sources of care. The duty solicitor spent the morning of the inquiry receiving the reports of his assistant and, where possible, reading the medical files and interviewing patients who wished to be represented. He then attended their inquiries in the afternoon.

(ii) Patients:– Initially the patients who were approached were a 50% random selection of all those persons who could appear before the magistrate. Selection occurred to limit the number of clients while the staff learned the appropriate specific work skills. This figure was gradually increased to 100 per cent.

During the duty solicitor phase, all persons classified as "Nil" responses were treated by the solicitor's assistant as though they were acceptances; and the duty solicitor decided which of these cases he would represent. The majority (73%) of "Nil" responses

were represented. Overall there were 190 involuntary patients during this period and 110 (58%) were represented.

Undoubtedly this figure would have been higher if all eligible clients had been approached with an offer of representation. Of the 80 unrepresented cases, 39 refused representation and 41 were not approached. The percentage of approached cases which were represented was approximately 74 per cent.

(iii) Magistrates:– Five different magistrates were in attendance at Rozelle Hospital during the course of Phase I. However, one magistrate conducted most (60%) of the hearings.

Phase II – Full-time Legal Officer Scheme

(i) Staff:– A full-time legal officer (barrister) was appointed as the patient representative, and she was assisted by the social worker from Phase I. The interviewing task was divided between them, with the social worker conducting 60 per cent, the legal officer 30 per cent and joint interviews 10 per cent.

In the majority of cases those persons who accepted representation were interviewed at some point by both staff members. Because the Legal Officer was full-time, there was greater contact between her and the treating doctors.

(ii) Patients:– In this phase, there were 119 persons approached with an offer of representation. Of this number 64 (54%) accepted representation. All "Nil" responses were treated as refusals, because the legal officer felt she was unable to act without proper instructions.

(iii) Magistrates:– Seven magistrates attended Rozelle Hospital in Phase II. The main magistrate from Phase I once more conducted the largest share (40%) of the hearings.

Phase III – Full-time Non-legal Representation Scheme

(i) Staff:– In the third and final stage of the project two persons without legal training (one social worker seconded from another hospital and one graduate research assistant) were appointed. They combined the two tasks of patient representative and social worker (i.e. solicitor's assistant) which had been separated in the previous two schemes. The workload was divided between them. Provision existed for calling a duty solicitor to represent the patient, if requested. In three instances patients requested legal representation. In each instance the patient was from a higher socio-economic level than the majority of other clients, and appeared more articulate, and more accustomed to using legal channels of redress.

(ii) Patients:– 123 persons appeared before the magistrate in this phase. Of these, 60 (52%) were represented or assisted (see below) by the non-legal patient representatives.

For the first six weeks of this scheme "Nil" responses were treated as refusals of the offer of aid. However, on the basis of the experience gained in this period and in the light of the previous two phases, the Legal Representation Committee decided that some form of assistance should be given to patients who could not or would not give any indication of their wishes regarding representation. Assistance given to these people was qualitatively different from that given to people who positively accepted representation. It consisted of research into background details, contact with relatives and investigation of alternatives to involuntary hospitalization. The information was then presented to the magistrate for consideration. In these cases, the non legal representative operated in the role of an assistant to the magistrate and not as a patient representative.

(iii) Magistrate:– One magistrate conducted all the inquiries in this phase.

Results of the Project

A large amount of information was collected in the course of the project. This contrasts with the sparse information previously available on magisterial inquiries at Rozelle and other psychiatric hospitals. Only a part of the total information will be discussed in this report. A more comprehensive report is in preparation.

The data presented below were selected because they reflect some of the concerns raised by the Edwards Committee (see page 15). These data consist of:

(i) the proportion of inquiries attended by doctors;
(ii) the proportion of inquiries attended by relatives of the patient;
(iii) the duration of the inquiry;
(iv) the outcome of the inquiry (discharge, deferment, or committal).

The analysis of the impact of representation on committal hearings involved three comparisons:

(i) a comparison of represented and unrepresented cases for each of the three phases of the study and over all phases of the scheme;
(ii) a comparison between hearings held before and during the operation of the scheme at Rozelle Hospital;
(iii) a comparison between hearings at Rozelle Hospital and hearings held at other psychiatric hospitals.

The results that follow summarise the outcomes of statistical tests conducted on information collected during each phase of the scheme. Detailed results are presented in Appendix D and only the major points will be discussed here.

A Comparison of Represented and Unrepresented Cases within each Scheme.

Duty Solicitor Scheme

The main findings for this phase of the scheme were that:

(i) doctors attended more represented than unrepresented cases (42% *vs* 21%);

(ii) relatives attended more represented cases (29% *vs* 10%);

(iii) the median duration of the inquiry was longer for represented cases (7 minutes *vs* 4.6 minutes);

(iv) the outcomes of the inquiries were different for represented and unrepresented cases. More represented cases were deferred by the magistrate at the first hearings (34% *vs* 10%). All 6 persons discharged by the magistrate were represented. A greater percentage of represented patients were given committal orders of 1 month or less (20% *vs* 4%). Orders for committal for the maximum period of six months were less common among represented patients (54% *vs* 86%).

Discussion

The impact of representation was not particularly marked in this first phase. The attendance of doctors and relatives increased but doctors still attended less than a half the inquiries and relatives less than a third. The duration of the inquiry increased but in the majority of represented cases (73%) the duration was below 15 minutes. The number of represented persons not made temporary patients (i.e., not given committal orders for up to 6 months) was comparatively small. Only 5 per cent of represented persons were discharged by the magistrate. The percentage of represented patients not made temporary patients increased to 19 per cent if patients who were either discharged by the ward or made voluntary patients during deferments are included.

There were several factors that affected the impact of representation. Firstly, the magistrate who conducted the majority of the inquiries had strong reservations about the value of patient representation. Secondly the part-time duty solicitors had insufficient time to adequately prepare cases for the large number of individuals (12 on average) presented at each inquiry. Thirdly, the solicitors were less forceful in their representation of persons they believed to be

mentally ill. The propensity of lawyers to make judgments about whether patients are mentally ill has been noted before (Kumasaka, 1972) and may present problems if lawyers are asked to represent unselected cases.

The Legal Representation Committee decided that a full-time legal officer be appointed so that more time could be given to the preparation of each case. A trial of this type of representation was accordingly the subject of the second stage of the scheme.

The Full-Time Legal Officer Scheme

The main findings for this phase of the scheme were that:

(i) doctors attended more represented than unrepresented inquiries (64% *vs* 33%);
(ii) relatives were *not* more likely to attend represented inquiries (27% *vs* 22%);
(iii) the duration of represented inquiries was longer (medians : 9.3 minutes *vs* 4.9 minutes);
(iv) the final outcomes of represented and unrepresented inquiries differed. More represented cases were discharged; by the magistrate (14% *vs* 0%). If persons who signed voluntary forms or were discharged during deferments are added to those discharged by the magistrate then the percentage of represented persons who were not made temporary patients increases to 30 per cent (as against 4 per cent for unrepresented cases). In addition, fewer 6 month committal orders were given to represented persons (36% *vs* 75%).

Discussion

The main differences between the outcomes of the Duty Solicitor Scheme and the Full Time Legal Officer Scheme were that:

(i) the full time legal officer was more successful in securing the attendance of doctors at inquiries;
(ii) the full time legal officer had less effect on the attendance of patients' relatives at the inquiry;
(iii) the full time legal officer was more successful in obtaining discharges by the magistrate and in reducing the number of persons who became temporary patients.

Two factors may be involved in the greater attendance of doctors at inquiries during the second phase of the scheme. First, was the vigorous style of representation made by the full time legal officer. In her representations the legal officer often questioned the adequacy of the evidence of mental illness. This approach was more threatening to hospital staff who attended more inquiries to ensure that the hospital view was defended before the magistrate. An adversary situation arose that engendered antagonism among hospital

staff. The antagonism was evident in the responses of hospital staff to a questionnaire and in the suggestion made by some hospital medical staff that they too be given legal representation. The second factor which influenced attendance at inquiries was a verbal directive from the Medical Superintendent of Rozelle Hospital that doctors attend inquiries when possible.

The smaller number of committal orders issued during this phase can also be accounted for by a number of factors. Firstly, the full time legal officer was much more selective in the cases she represented. Patients whose response to the offer of representation was NIL (see page 18) were not represented. Secondly, more magistrates were involved during this phase of the project and their attitudes towards the value of patient representation were more varied. Thirdly, the more vigorous representation provided by the full time legal officer may have been more effective than the restrained approach of the duty solicitors. Finally, there was more time available for case presentation; a skill in which the solicitor's assistant had acquired greater expertise during Phase 1 of the project.

No obvious reasons present themselves to explain the absence of a difference between represented and unrepresented cases in terms of the proportion of inquiries attended by patients' relatives.

The Legal Representation Committee decided to adopt non-legal representation in the third phase of the project. This was done in an effort to avoid the adversary situation that had arisen between the legal representative and hospital staff.

The Full Time Non-Legal Representation Scheme

The main findings for this, the third phase of the project, were that:

(i) doctors did *not* attend more represented than unrepresented inquiries (43% *vs* 37%);

(ii) relatives of the patient attended more represented than unrepresented inquiries (38% *vs* 20%);

(iii) the inquiries of represented patients lasted longer than those of unrepresented patients (medians : 7.3 minutes *vs* 3.5 minutes);

(iv) the outcomes of represented and unrepresented cases differed. The magistrate deferred more represented than unrepresented cases (25% *vs* 10%). All 6 persons discharged by the magistrate were represented. Fewer represented persons were committed for the maximum period of 6 months (56% *vs* 92%). If persons who signed voluntary forms or were discharged during deferments (10%) are added to those discharged by the magistrate (10%) then the percentage of represented persons who were not made temporary patients increases to 20% (as against 5% for unrepresented cases).

Discussion

The change from legal representation (Phase I and II) to non-legal representation did not produce any radical changes in outcome. The duration and outcomes of inquiries in Phase III are similar to those of the previous stages. The only difference in outcome was the decrease in the proportion of inquiries attended by doctors; a decrease balanced by the increase in the proportion of inquiries attended by relatives.

This last mentioned difference may be attributed to a change in the tactics of representation. The non-legal representatives were unable to contest the adequacy of evidence for mental illness because the magistrate refused to allow them. They argued that the person should be discharged into an alternative type of care which the person preferred to involuntary psychiatric hospitalization. One might expect that doctors would be less likely to attend inquiries when their opinions were not contested while relatives would be more inclined to attend when alternatives to hospital were likely to be considered.

A Comparison of Represented and Unrepresented Cases with the Three Schemes Combined

The previous discussion has revealed that the outcomes of the three schemes were similar. Those differences that do occur in doctor and relative attendance and the outcomes of the inquiry may reasonably be attributed to some combination of the magistrate's attitude to representation, the tactics of representation, and the vigour of representation. Because the differential effects of the three phases of the scheme are small, no violence is done if the results are combined and the effects of representation evaluated over the whole period of the project. (The results of this evaluation are presented in detail in Appendix D, Tables 4a and 4b).

The comparison of represented and unrepresented inquiries over all three phases reveals that:

(i) doctors attended more represented than unrepresented cases (48% *vs* 29%);

(ii) relatives of the patient attended more represented than unrepresented cases (30% *vs* 16%);

(iii) represented inquiries were of longer duration than unrepresented ones (medians: 7.2 minutes *vs* 4.2 minutes);

(iv) the magistrate deferred more represented than unrepresented cases. (32% *vs* 8%);

(v) there were two differences in final outcome between represented and unrepresented cases:

(a) more represented than unrepresented persons were discharged by the magistrate. (8% *vs* 0%);
(b) fewer represented persons were committed for the maximum period of 6 months (50% *vs* 84%).

A Comparison of Hearings Held Prior to and During the Legal Representation Project

Data was collected on inquiries held in the period three months prior to the introduction of the project, (the "baseline period"). This data permits us to make two comparisons of interest. Firstly, since only 3 per cent of persons were legally represented in the baseline period, a comparison of the outcomes of represented hearings during the project with the outcomes of hearings in the baseline period provides a further test of the effect of representation. Secondly, a comparison of unrepresented cases during the project with cases heard during the baseline period provides an indication of the "non-specific" effects of the legal representation project i.e. unintended effects on unrepresented cases. (See Tables 5a and 5b).

A Comparison of Represented Cases and Cases Heard During the Baseline Period

The comparisons between cases heard during the baseline period and represented cases heard during the project were statistically significant on all variables. The main findings* were that:

(i) doctors attended more inquiries among during the project period than during the baseline period (48% *vs* 5%);

(ii) relatives attended more inquiries during the project period than during the baseline period (30% *vs* 15%);

(iii) there were more deferments during the period of the project (32% *vs* 8%);

(iv) the final outcomes of hearings held during the two periods differed. The magistrate discharged more persons during the project period (8% *vs* 2%); more represented cases were committed for 1 month or less (16% *vs* 2%); and fewer represented cases were committed for the maximum period of 6 months (50% *vs* 89%).

The results substantiate the findings of the comparisons between represented and unrepresented cases *within* the study period.

* The duration of inquiry was not recorded during the baseline period.

A Comparison of Unrepresented Cases Heard During the Study Period and Cases Heard During the Baseline Period

Only one comparison between cases heard during the baseline period and unrepresented cases heard during the project period was statistically significant. Doctors attended more unrepresented cases during the study period than during the baseline period (29% *vs* 5% estimate). This finding may be artifactual. In any one session of hearings both represented and unrepresented cases were heard. A doctor who attended a represented case would have a reasonable chance of witnessing an unrepresented case.

Discussion

The two comparisons above suggest:

(i) that representation affected the attendance of doctors and relatives at inquiries and the outcomes of the inquiries; and

(ii) that on the measures used the outcomes of unrepresented cases during the study period were similar to the outcomes of unrepresented cases heard before the project commenced.

One further comparison must be made before the substantive or practical importance of representation can be evaluated. This is a comparison of represented cases heard at Rozelle Hospital with cases heard at other psychiatric hospitals during the same period.

A Comparison of Hearings at Rozelle Hospital and Hearings at Other Psychiatric Hospitals

During the period the project information was collected on magisterial inquiries held at 9 State Psychiatric Hospitals.[1] No information was collected from authorized[2] General Hospital psychiatric units because smaller numbers of involuntary patients are admitted and magisterial inquiries are accordingly less frequent. The information collected is presented in detail in Appendix (D) (Tables 6a and b). No statistical analysis has been performed on this data and the discussion that follows is limited to an impressionistic survey of variation between hospitals on each measure.

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1. The survey period was 6 months approximately with the exceptions of Newcastle P.C. (3 months) and Bloomfield Hospital (data collection in progress). See Appendix E for hospitals included in the monitoring system.

2. Units gazetted to admit involuntary patients.

Number of Cases Heard

The number of persons presented to the magistrate during any one hearing at Rozelle was approximately twice the number presented to the next busiest hospitals (12.0 *vs* 5.8). This situation probably constrained the duration of inquiries at Rozelle Hospital and presumably (though not necessarily), the comprehensiveness of the inquiries.

Attendance of Solicitors at Inquiries

The Edwards Committee estimated that less than one in ten persons appearing before a magistrate were legally represented. It may be confidentially stated that the actual rate is less than one in a hundred.[3]

Attendance of Doctors at Inquiries

One effect of the patient representation scheme at Rozelle Hospital was to increase the number of inquiries at which doctors were present from an estimated 5 per cent in the baseline period to 48 per cent for represented cases during the project. This effect seems less than impressive when compared to attendance figures at Morisset and Newcastle where 98 per cent and 92 per cent of inquiries were attended by doctors.

This comparison, however, is misleading, and any evaluation of the effect of representation based on it would be an underestimation. This is so for two reasons. First, the figures for Morisset and Newcastle are exceptional when compared with Sydney hospitals where doctors attended fewer than 10 per cent of inquiries. Secondly, the capacity in which doctors attended inquiries at Rozelle Hospital differed from the capacity in which doctors attended inquiries at Morisset and Newcastle hospitals. In the majority of cases at Rozelle Hospital the doctor in attendance was the doctor who certified and treated the patient. The doctor attending could accordingly answer the magistrate's questions about the patient's present condition and likely prognosis. At Morisset and Newcastle hospitals the doctor who attended as a representative of the Medical Superintendent was not necessarily the treating or certifying doctor. The role of the attending doctor in such cases was to explain and amplify written evidence on medical schedules and in the patient's file.

Attendance of Relatives at Inquiries

The effect of patient representation at Rozelle Hospital was to increase the number of inquiries attended by relatives from an estimated 15 per cent of cases in the baseline period to 30 per cent

3. Excluding the project data from Rozelle there were 7 solicitors presented at 909 inquiries; a rate of 0.77%.

of represented cases. As shown in Table 6a the Rozelle figure was exceeded by two hospitals, Parramatta (42%) and Rydalmere (43%) and not appreciably different from the figures for Gladesville (19%), Morisset (25%), Newcastle (21%) and North Ryde (23%). These variations in the proportion of inquiries attended by relatives may be a consequence of differences in hospital practice or a consequence of differences in the degree of social and familial isolation of persons appearing before the magistrate at each hospital.

Duration of the Inquiry

The effect of representation at Rozelle Hospital was to increase the median duration of inquiries from 4.2 minutes to 7.2 minutes. When compared to the duration of inquiries at other hospitals, however, the effect of representation seems small. The duration of represented inquiries at Rozelle Hospital was shorter than the duration of unrepresented inquiries at all other hospitals except Newcastle. The simplest explanation of this is that representation had only a small effect on the duration of the inquiry because the inquiry's duration was externally constrained : a larger number of cases had to be heard in a single session at Rozelle than at any other hospital.

Number of Deferments

The proportion of represented inquiries deferred at Rozelle Hospital (32%) was twice as large as the proportion of inquiries deferred at the nearest hospital, Morisset (16%). Patient representation, then, would seem to increase the number of deferments granted by magistrates. The question of whether this outcome is desirable will be taken up later.

Final Outcomes

The proportion of *represented* persons discharged by the magistrate at Rozelle Hospital was 8 per cent. Three other hospitals, Bloomfield (8%), Morisset (7%), and Parramatta (5%), recorded discharge rates for unrepresented cases in the same range as Rozelle Hospital.

Similar findings emerge with respect to another measure of outcome, namely, length of committal. Marginally more represented persons were committed for 1 month or less at Rozelle Hospital than at other hospitals. The proportion of represented persons committed for the maximum period of 6 months at Rozelle (65%) was similar to the proportion so committed at Bloomfield (65%), Parramatta (58%), and Rydalmere (65%).

These findings suggest that patient representation has little effect on the final outcome of magisterial inquiries. But such a conclusion would be premature. Inquiries held at Rozelle Hospital differ in a

large number of ways (other than in being represented) from inquiries held at other psychiatric hospitals. Some of these differences include: the attitudes of the presiding magistrate, the number of patients presented at a single inquiry, the characteristics of the patients presented, the availability of alternate forms of care etc. The variation in the outcome of inquiries produced by these sorts of differences makes it difficult to make unequivocal inferences about the effect of representation. When many of these factors are controlled (as they are to a degree when comparing the outcome of represented and unrepresented cases at Rozelle Hospital) representation does seem to have an effect. The question of whether this effect is of substantive or practical importance is taken up in the following section.

A Substantive Evaluation of the Legal Representation Project

Statistical significance of research findings is an uncertain guide to the practical significance of the research. This is especially so in the case of the present research where statistically significant differences between represented and unrepresented cases seem "small".

Attendance of Doctors at Inquiries

Patient representation increased the proportion of inquiries attended by doctors from an estimated 5 per cent to 48 per cent of inquiries. This effect would seem to be important. The greater attendance of doctors provides the magistrate with the opportunity to examine the doctor's evidence in greater detail. However, there is not much consolation to be drawn from the fact that at over half of the inquiries the sole medical evidence for committal is in written form; a fact that limits the magistrate's ability to evaluate the adequacy of the evidence on which the doctor's opinions are based, or consider the advisability of alternatives to committal.

Attendance of Relatives at Inquiries

Patient representation also increased the proportion of inquiries attended by the patient's relatives (from 15% to 30%). This effect is important but its size is disappointing. At 70 per cent of inquiries the magistrate had no opportunity to discuss with relatives the advantages and disadvantages of various treatment or care options. Many patients, however, have no relatives.

Duration of the Inquiry

The median duration of the inquiry was increased by patient representation from 4.2 minutes to 7.2 minutes. As argued earlier the size of the increase was probably constrained by the number of cases that had to be heard in a single session. Nevertheless it is cause for

possible concern to realize that in 72 per cent of cases the decision about whether to deprive a person of his liberty for up to 6 months is made in 10 minutes or less.

Number of Deferments

One of the most noticeable effects of patient representation was to increase the number of deferred inquiries from 8 per cent (baseline) to 32 per cent. It is arguable, however, that this outcome is desirable. During the period of deferment the patients rights are restricted. The person whose case has been deferred can be detained and treated against his will. The fact that a substantial proportion of deferred cases are discharged during deferment or sign voluntary forms is not sufficient justification for the practice. If the option of deferment is retained in the revised Mental Health Act the legal status of deferred persons will need to be clarified.

Enquiry Outcomes

The proportion of persons discharged by the magistrate was increased by patient representation from 2 per cent in the baseline period to 8 per cent. The evaluation made of this effect will depend upon whether one regards an error in committal to be more serious than an error in discharge.

The other effect that representation had on the outcome of inquiries was on the period of committal. In represented cases magistrates more often exercised their discretion to order committals for periods less than the maximum period of 6 months. This result, however, may well have been achieved in a simpler way than patient representation. One of the authors (G.E.) suggested to a magistrate at Parramatta Hospital that committals need not be for the maximum period. The magistrate thereafter exercised his discretion much more when writing committal orders.

Some doctors may be inclined to argue that a reduction in the period of committal is trivial because the majority of involuntary patients are discharged long before the expiry of the maximum 6 months period. There are a number of points to be made in response to this argument. First, if the majority of patients are discharged before the expiry of the committal period it may be more appropriate to commit patients for a shorter period in the first place. Secondly, a committal order for 6 months may severely distress a disturbed patient who fails to appreciate that the 6 months period is not mandatory.

Conclusions

After reviewing the research findings one might be tempted to draw the following three conclusions:

(i) the patient representation had little effect on the manner in which committal proceedings were conducted on their outcome;

(ii) that not all the effects of patient representation were necessarily desirable (e.g. increased number of deferments and antagonism between the legal representative and medical staff);

(iii) that, in view of the two previous conclusions, the desirability of establishing a State-wide patient representation service is questionable.

We believe that to draw these conclusions would be misleading and we will present those implications which seem more suitable.

With regard to the magnitude of the effect that patient representation had on attendance at, and duration and outcome of, committal inquiries, the data suggest:

(a) that patient representation does, in fact, have a demonstrable effect on committal proceedings;

(b) that effects due to differences in the three representation schemes piloted are minor compared to the effects of introducing a patient representation scheme *per se;* and more importantly;

(c) that there are other factors which have a greater effect on the measures collected regarding the magistrate's inquiry than the effect of a free patient representation service.

The effect of patient representation is demonstrated by the comparison of represented and unrepresented cases at Rozelle. Similar effects of each type of representation are shown in the comparison of represented cases at Rozelle for each of the three representation schemes. The presence of other factors which markedly affect committal proceedings is seen in the comparison of data concerning inquiries at different hospitals.

It would seem to us, on the basis of observations of magistrates' inquiries at Rozelle and other psychiatric hospitals that some of the most powerful factors, in terms of their impact on committal proceedings, are: the magistrate and his general attitude towards the inquiry and patient representation; the administration of the hospital and its organization of the procedures surrounding the inquiry; the patient themselves, both in terms of their type of illness and their degree of social support outside the hospital; and the size of the hospital as reflected in the number of patients presented at a single hearing.

If it is true, that factors such as those listed above play an important role in the conduct of committal proceedings then the necessity of instituting reform in areas independent of patient representation should be considered.

To this point discussion has mainly been concerned with data collected in the course of evaluative research. An important point to remember in this context is that measures such as attendance of doctors, length of hearing and outcome of hearing were chosen because they can be objectively established, not because they themselves are the variables we are most interested in. In fact, measures such as these reflect only indirectly the central concern which in the protection of patients' rights.

One question that needs to be asked is whether the scheme has enhanced the protection of various legal and civil rights that patients are expected to have in relation to involuntary hospital care. It certainly can be said that the right of the patient to have adequate information concerning the nature and purpose of the magistrate's hearing as well as the implications of being an involuntary patient has been a very important and obvious gain. With regard to the degree to which these have been gained in relation to the protection of legal rights, this has received considerable attention with the presence of lawyers in the project and on the committee. The paper from our legal colleague will discuss in some length issues of legal rights.

The fact that a patient representation scheme as put into practice at Rozelle Hospital had some consequences which may be undesirable underlines both the need for a more wideranging reform of committment procedures, as well as the necessity of considering alternative ways of delivering a representation service so as to minimise unintended consequences. An example of the need for reforming the committment system can be seen in the number of patients appearing before the magistrate in a single afternoon at Rozelle. As long as it is possible that as many as 25 patients may be presented in one 3 hour session, it is likely that detailed and strenuous representation will merely result in deferment of an order to the detriment of the patient in spite of the comprehensiveness of the information available.

Where do we go from here?

In our opinion we have not yet found a satisfactory means of protecting the rights of persons subject to involuntary hospitalization. We believe that the pilot project at Rozelle has demonstrated that patient representation is a feasible and worthwhile service, and, if implemented, would represent a significant reform of existing practices. However in itself it is not sufficient to guarantee the protection of patients' rights.

As the Legal Representation Committee is still in the process of discussing and evaluating the experience, evidence and data gathered during the Rozelle project before making its final Report it would be premature for us, at this stage, to formulate detailed recommendations.

However, there are several broad issues that we believe need further investigation:

(i) The need for reform in the aspects of committment proceedings other than patient representation. Such aspects may include administrative arrangements associated with the inquiry (e.g., provision of suitable accommodation in which inquiry can be held, arrangements to facilitate the attendance of doctors at the inquiry), provision of adequate social work staff in each hospital to thoroughly assess each patient's circumstances and possible alternate sources of care, and possible changes to the relevant Acts governing the manner in which the inquiry is held.

(ii) The need to formally provide services other than, and in addition to, representation for patients appearing before the magistrate. The need to provide simple and accurate information about the nature and purpose of committal proceedings to patients, relatives and staff on a routine basis has been driven home to us during this project. The feasibility of offering some form of protection of rights for continued treatment patients also requires investigation.

(iii) The need to determine what proportion of legal and non-legal staff to employ in a representation service. Experience at Rozelle indicates that non-legal patient representatives have a valid role to play in committment hearings. They also have the advantage that they are less expensive and possibly more acceptable to medical staff than lawyers. On the other hand the presence of lawyers is probably necessary to give "teeth" to a representation service. We would envisage that legal or non-legal representatives would be available as patients' needs and hospital circumstances require. The relationship between legal and non-legal staff is another matter that needs consideration.

In order to investigate these issues while keeping up the momentum of change we favour the introduction of a representation and an information service employing both legal and non-legal staff to one specific health region in the state. We would like to see the service implemented in a region which included a number of different admission centres – both large and small, both general hospital units and psychiatric centre units. We believe that experience gained in implementing such a service in a limited region would enable a more efficient and effective system to be developed for the protection of the rights of involuntary psychiatric patients. We are also concerned to avoid the premature implementation of a service which in itself is not sufficient to adequately protect those rights. The long term effect of such an eventuality may prove counter productive.

At this stage, our most pressing concerns are to focus awareness on the need for increasing the protection of patients' rights and to stimulate the momentum for reform.

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APPENDIX A

Draft Submission on a Proposal for a Pilot Scheme on Legal Representation in Mental Illness (Involuntary Admission) Hearings

The Need

In new South Wales there are approximately 3½ thousand persons detained at the present time in prisons. In hospitals, there are over half this number (approximately 2½ thousand) involuntarily detained at the present time on the basis of being mentally ill and in need of care, treatment or control.

Of course hospitals are not prisons, since they are dedicated to care and treatment of patients, but they are like prisons in one important respect – that those sent there involuntarily are deprived of the basic legal right of free movement.

In the proceedings leading to deprivation of liberty in accordance with criminal law, enormous care is taken to ensure that wrongful detention does not occur. Particularly:

(1) a defendant is presumed innocent until proven guilty;
(2) proof of guilt must be "beyond reasonable doubt";
(3) evidence of past criminal or dangerous behaviour is generally considered irrelevant to the current allegation and is not accepted in evidence;
(4) the defendant is almost always asked whether he wishes to have legal representation, and in many cases representation will be provided for him if he cannot afford it privately, In serious cases where there is a risk of imprisonment for a long period representation is usually provided by the Public Solicitor and Public Defender, or through the Law Society's Legal Aid Scheme.

Not only extreme radical critics of the present mental hospital system but also many responsible and concerned persons working within it are worried that the legal protections accorded to the several thousand mentally ill persons presently detained in New South Wales compare very unfavourably with the protections accorded to accused criminals.

There is no rule that the grounds for hospital detention must be approved beyond reasonable doubt. Past acts can be and are taken into account in the decision on current liability for admission. Perhaps these omissions are unavoidable. More importantly, however, there is rarely any legal representation of persons against whom involuntary admission proceedings are brought. As conscientious as the magistrates and Mental Health Tribunal members are, their function is one of determining the issue, not of presenting a case for or against a point of view. They do not have the time to perform as detectives and investigators.

The need for representation in mental illness cases stems particularly from the nature of the illness. In many instances mental confusion leads to inability to remember facts, answer allegations and generally to present a point of view.

The idea that lawyers have no place in mental hospitals and that mental illness should be purely a medical matter is in conflict with the philosophy of the present Act. One may ask, how can involuntary admission be a purely medical matter when the schedule certificate that the doctor signs provides for the assistance of a police officer in the transfer of the patient to the hospital, and for the breaking down of doors if necessary? How can involuntary admission be a purely medical matter when it involves in some cases the administration of sedating or tranquillising drugs, or the locking up of patients against their wills? The fact is that involuntary admission is partly a legal matter and partly a medical matter. This submission proposes a method of evaluating whether the legal aspects of the matter could be significantly improved by the provision of representation.

Dr Brian Thwaites, Principal Adviser on Mental Health,
Health Commission of New South Wales. 1975

APPENDIX B

Proposed Amendment of the Mental Health Act, 1958

(Extract from a business paper submitted to The Health Commission by the Chairperson of The Mental Health Act Review Committee, Dr G. A. Edwards, October 1977).

Principles of the Proposals

> "I believe that the Committee has kept the balance between the need to compulsorily treat and the need to allow citizens freedom of choice and to allow for an adequate protection of their rights. The Committee has some good solutions to this problem which should not make it any harder for people to receive treatment".*

This in essence has been the guiding principle behind the Mental Health Act Review Committees proposals both at the 1975 seminar and subsequently. It is essential that a proper balance is achieved in mental health legislation between the protection of those basic jurisprudential values, the right to liberty, self-determination and prevention of reputation on the one hand and of medical, humanitarian and community concerns on the other. That is, it is essential that mentally ill people have prompt and effective treatments freely available to them and that such care should be available in an atmosphere of humanity and dignity. On occasions this may be necessary against their wishes to prevent serious harm to themselves or the community and legislation needs to provide for these contingencies.

The present Mental Health Act, 1958, already provides many protection and safeguards for patients. However in recent times there has developed a community expectation that legislation needs to be more explicit with respect to the rights and liberties of individuals. It is in this direction that a number of recommendations have been made. Perhaps the most important example of this relates to the definition of mental illness in connection with involuntary admission.

Although the Act should reflect the generally held view among psychiatrists that a mental illness is a matter which should be determined independently of legal and moral norms of the time, involuntary referrals due to mental illness need to occur only when absolutely essential for the purpose of the person's own protection or the protection of others. We have felt the need to articulate in the legislation in reasonable detail the criterion that must be satisfied for a person to be involuntarily referred to hospital because of mental illness.

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* W. A. Barclay (Commissioner for Personal Health Services) *Syd. Inst. Crim. Proc.* No. 22 "Proposed Amendments to N.S.W. Mental Health Act" Government Printer (1975) p.109.

In addition there are proposals to contain this information in notes for guidance for medical practitioners and other who institute involuntary referral. The doctors, police and welfare officers will remain the agents for instituting involuntary hospital referral with some limited extensions of the responsibilities of the welfare officer and some provision only in situations of remoteness and urgency for the ordinary citizen to have some capacities in this area.

The hospital provisions for admission, detention, review, leave, discharge and the functions of the magistrate, tribunals and official visitors have all been retained. However there have been significant modifications in many respects due to administrative difficulties that have become evident in the last 20 years as well as a need to ensure that maximum attention to patient rights is attained. Using the patient as an example will illustrate this need. At present a patient appearing before a magistrate can be made a temporary patient for a period up to 6 months. An order is frequently made for a lesser period which is often very much in the patients interest. However a tribunal has no authority to see the patient if he still is in hospital at the end of this lesser period. This causes confusion and uncertainty for hospital staff and patients as to the proper course of action as well as denying the patient the benefit of a tribunal. An amendment in the proposed revision will correct this anomaly and enable a tribunal to see patients within the 6 month period.

Also to give more focus on patient rights the tribunals will be required to assess all long stay patients and forensic patients at defined intervals.

An important step taken in the present Act and a continuing objective of the proposed legislation is "to bring illness as far as possible in line with physical illness". Further steps in this direction are the replacement of the term "mental hospital" by "hospital" and by the introduction of "informal patients" in lieu of "voluntary patients". This not only accords with successful English legislation in this respect but has become essential in a health care system in which the majority of acute psychiatric care now occurs in general hospital psychiatric units in which the co-existence of informal and voluntary systems leads to considerable confusions and absurdities. The introduction of informal admission systems will have significant benefit for the welfare of patients within general and psychiatric hospitals.

Other major principles and recommendations in the proposals include the following:

(1) In relation to forensic patients there will be transfer of court processes to the *Crimes Act*. However there has been review of the treatment and detention provisions in this group in which there will be elimination of indeterminate hospitalization procedures and some modifications to transfers between goals and hospitals to facilitate treatment processes in selected instances.

(2) There is a need for an alternative to property provisions, to enable persons to apply to the Protective Commissioner to manage their estates when hospital treatment is not required. An amendment to the Act will clarify this important right for a person to obtain assistance with care of property without necessarily being hospitalized.

(3) The Foster Committee recommendations in relation to the control of psychosurgery have been adopted by Cabinet and will form part of the mental health legislation.

(4) Recommendations to supervise hostels for some discharged patients and patients on leave are necessary, but may form part of other legislation.

(5) The constitution of present safeguards in relation to the use of electro convulsive therapy are still necessary. In view of the use of this treatment in life threatening situations, treatment is still necessary in that situation even if there is objection by the patient.

(6) The last, but most important and innovative recommendation, which is currently in progress, is the pilot study of patient representation at the magistrate hearings at the Rozelle Hospital. This study endeavours to assess the feasibility of a legal and non legal advocacy and representation service. It is not considered at this stage that any amendments to legislation will be necessary, although this may be a future eventuality.

In summary the legislation should bring up to date many important aspects of a patients rights – medical, legal, social and humanitarian, in mental health care. The first test of these proposals, if adopted will rest on an evaluation as to how far they serve "the patients interests".

It is hoped that the legislation will measure very favourably in this regard.

APPENDIX C

Membership of the Legal Representation Committee

Mr Gill BOEHRINGER	Lecturer, School of Law, Macquarie University.
Dr Graham EDWARDS	Health Commission of New South Wales, Chairperson of the Mental Health Act Review Committee.
Dr John ELLARD	Northside Clinic, Australian and New Zealand College of Psychiatrists.
Mr Ken KERSHAW	Manager, Legal Aid, Law Society of New South Wales.
Miss Carolyn SIMPSON	Barrister, President of The New South Wales Council for Civil Liberties.
Dr Laurie YOUNG	Division of Health Services Research, Health Commission of New South Wales.

APPENDIX D

Table 1 (a) : Details of Inquiries – Duty Solicitor Scheme

Variable	*Totals*	*Represented*	*Unrepresented*	*Test of Significance*
Number of cases	190 (100%)	110 (58%)	80 (42%)	
Doctor in attendance	63 (33%)	46 (42%)	17 (21%)	$\chi^2 = 8.9$ P $< .05$ d.f. 1
Relatives in attendance	40 (21%)	32 (29%)	8 (10%)	$\chi^2 = 10.2$ P $< .05$ d.f. 1
Duration of inquiry	Median = 7 mins.	Median = 4.6 mins.	Median = 5.6 mins.	$\chi^2 = 11.2$ P $< .05$ d.f. 1
Number of cases adjourned	45 (24%)	37 (34%)	8 (10%)	$\chi^2 = 14.3$ P $< .05$ d.f. 1

Table 1 (b) : Final Outcomes – Duty Solicitor Scheme

Outcome	*Totals*	*Represented*	*Unrepresented*	*Test of Significance*
Discharged Outright	6 (3%)	6 (5%)	0	$*\chi^2 = 22.3$ $P < .05$ d.f. 2 * for purposes of analysis, discharges were combined with "other" to form one category and committed 1 mth or less and committed between 1 mth and 6 mths were combined to form one category.
Discharged under care	0 (0%)	0	0	
Committed 1 mth or less	25 (13%)	22 (20%)	3 (4%)	
Committed between 1 mth and 6 mths	17 (9%)	10 (9%)	7 (9%)	
Committed 6 mths	126 (66%)	62 (54%)	64 (86%)	
Other	16 (9%)	15[a] (13%)	1[b] (1%)	
TOTAL	190	115[c]	75[c]	

Notes to Table 1 (b)

a *This includes seven persons who signed voluntary forms and seven persons who were discharged after an adjourned inquiry. Furthermore, one person proved difficult to categorise : In this case, the Magistrate ordered that the person "was to remain at this hospital until arrival of patient's father whereupon she is to return with him to S.A." (South Australia.)*

b *The person was discharged by the ward after an adjourned inquiry.*

c *Five persons who were initially unrepresented asked at their inquiry for representation. The Magistrate adjourned the inquiry, and subsequently all five persons were represented at the second hearing.*

Table 2 (a) : Details of Inquiry – Full-Time Legal Representative Scheme

Variable	*Total*	*Represented*	*Unrepresented*	*Test of Significance*
Number of cases	119 (100%)	64 (54%)	55 (46%)	
Doctor in attendance	59 (50%)	41 (64%)	18 (33%)	$\chi^2 = 11.6$ $P < .05$ d.f. 1
Relatives in attendances	26 (22%)	14 (22%)	12 (22%)	$\chi^2 = .01$ $P < .05$ d.f. 1 Not significant
Duration of inquiry	Median = 9.2 mins.	Median = 4.9 mins.	Median = 6 mins.	$\chi^2 = 6.6$ $P < .05$
Number of cases adjourned	25 (21%)	23 (36%)	2 (4%)	$\chi^2 = 18.6$ $P < .05$ d.f. 1

Table 2 (b) : Final Outcomes – Full-Time Legal Representation Scheme

Outcome	*Total*	*Represented*	*Unrepresented*	*Test of Significance*
Discharge Outright	8 (7%)	8 (13%)	0	
Discharge under care	1 (1%)	1 (2%)	0	
Committed 1 mth or less	20 (17%)	11 (17%)	9 (16%)	$\chi^2 = 21.2$ $P < .05$
Committed between 1 mth and 6 mths	14 (12%)	11 (17%)	3 (5%)	d.f. 2
Committed 6 mths	64 (54%)	23 (36%)	41 (75%)	See Note Table 1 (b)
Other	12 (10%)	10 [a] (16%)	2 [b] (4%)	
TOTAL	119	64	55	

Notes to Table 2 (b)

a This includes 6 persons who signed voluntary forms, and 3 persons who were discharged after an adjourned inquiry. It also includes one woman who argued that she should be allowed to sign a Voluntary Form and was successful.

b One person was discharged and the other signed a Voluntary Form after an adjourned inquiry.

Table 3 (a) : Details of Inquiry – Full-time Non-legal Representative Scheme

Variable	*Total*	*Represented*	*Unrepresented*	*Test of Significance*
Number of cases	123 (100%)	63 (51%)	60 (49%)	
Doctor in attendance	49 (40%)	27 (43%)	22 (37%)	$\chi^2 = 0.5$ P .05 Not Significant
Relatives in attendance	36 (29%)	24 (38%)	12 (20%)	$\chi^2 = 4.9$ P $<.05$ d.f. 1
Duration of inquiry	Median = 5.3 mins.	Median = 7.3 mins.	Median = 3.5 mins.	$\chi^2 = 26.8$ P $<.05$ d.f. 1
Number of cases adjourned	22 (18%)	16 (25%)	6 (10%)	$\chi^2 = 5.0$ P $<.05$ d.f. 1

Table 3 (b) : Final Outcomes – Full-Time Non-legal Representative Scheme

Outcome	*Total*	*Represented*	*Unrepresented*	*Test of Significance*
Discharge Outright	6 (5%)	6 (10%)	0	
Discharge Under Care	0 (0%)	0	0	
Committed 1 mth or less	7 (6%)	5 (8%)	2 (3%)	$\chi^2 = 20.7$ $P < .05$ d.f. 2
Committed between 1 mth and 6 mths	11 (%)	11 (17%)	0 (0%)	See note Table 1 (b)
Committed 6 mths	90 (73%)	35 (56%)	55 (92%)	
Other	9 (8%)	6[a] (10%)	3[b] (5%)	
TOTAL	123	63	60	

Notes to Table 3 (b)

a *Five persons signed voluntary forms and one person was discharged after an adjourned inquiry.*

b *Two signed voluntary forms and one person was discharged after an adjourned inquiry.*

Table 4 (a) : Details of Inquiries – Three Schemes Combined

Variable	*Totals*	*Represented*	*Unrepresented*	*Test of Significance*
Number of cases	432 (100%)	237 (55%)	195 (45%)	
Doctor in attendance	171 (40%)	114 (48%)	57 (29%)	$\chi^2 = 15.93$ $P < .05$ d.f. 1
Relatives in attendance	102 (24%)	70 (30%)	32 (16%)	$\chi^2 = 10.22$ $P < .05$ d.f. 1
Duration of inquiry	Median = 5.7 mins.	Median = 7.2 mins.	Median = 4.2 mins.	$\chi^2 = 38.7$ $P < .05$ d.f. 1
Number of cases adjourned [a]	92 (21%)	76 (32%)	16 (8%)	$\chi^2 = 41.3$ $P < .05$ d.f. 1

NOTE (a) : Period of adjournments (N=92) were as follows: 48 hours, one case; seven days; 59 cases; 14 days; 31 cases; 21 days; one case.

Table 4 (b) : Final Outcomes -- Three Schemes Combined

Outcome	*Totals*	*Represented*	*Unrepresented*	*Test of Significance*
Discharge Outright	20 (5%)	20 (8%)	0	
Discharge under care	1 (<1%)	1 (<1%)	0	
Committed 1 mth or less	52 (12%)	38 (16%)	14 (7%)	** $\chi^2 = 59.3$ $P < .05$
Committed between 1 mth or 6 mths	42 (10%)	32 (13%)	10 (5%)	d.f. 2
Committed 6 mths	280 (65%)	120 (50%)	160 (84%)	** See Note Table 1 (b)
Other	37 (9%)	31 (13%)	6 (4%)	

Table 5 : Comparison of Baseline with Study Period

(a) Details of Inquiries

Variables	*Baseline Period (3 mth)*	*Study Period (9 mth)*	*Test of Significance*
Number of cases	133	432	
Represented cases	4 (3%)	237 (55%)	
Doctor in attendance	* Estimated (5%)	171 (40%)	$\chi^2 = 53.9$ $P < .05$ d.f. 1.
Relatives in attendance	* Estimated (15%)	102 (24%)	$\chi^2 = 3.9$ $P < .05$ d.f. 1.
Number of cases adjourned	10 (8%)	92 (21%)	$\chi^2 = 12.1$ $P < .05$ d.f. 1.

(b) Final Outcomes

Outcome	*Baseline Period*	*Study Period*	*Test of Significance*
Discharge outright	2 (2%)	20 (5%)	
Discharge Under Care	1 (1%)	1 (<1%)	
Committed 1 mth or less	3 (2%)	52 (12%)	$\chi^2 = 32.3$ *$P < .05$ d.f. 2
Committed between 1 mth or 6 mths	1 (1%)	42 (10%)	*Note Table 1 (b)
Committed 6 mths	119 (89%)	280 (65%)	
Other	7 (5%)	39 (8%)	
TOTAL	133	432	

Note: * Estimated by the Magistrate's secretary who attended all the inquiries.

Table 6 (a) : Comparison of Rozelle Hospital with Other Psychiatric Hospitals : Details of Inquiry

Hospital	*Number of Cases*	*Number of Hearing Days*	*Ratio of Cases/Hearing Days*	*Number and % Solicitors Attending*	*Number and % Doctors Attending*	*Number and % Relatives Attending*	*Median Duration of Inquiry*	*Number and % of Cases Adjourned*
Rozelle	432	36	12.0	174 (40%)	171 (40%)	102 (24%)	5.7 mins	92 (21%)
Bloomfield	26	11	2.4	1 (4%)	5 (19%)	2 (8%)	20 mins	0 (0%)
Gladesville	117	34	3.4	0 (0%)	3 (3%)	22 (19%)	10 mins	12 (10%)
Kenmore	110	19	5.8	0 (0%)	0 (0%)	15 (14%)	N.A.	2 (2%)
Morisset	133	33	4.0	0 (0%)	131 (98%)	33 (25%)	10 mins	21 (16%)
Newcastle	66	16	4.1	1 (2%)	61 (92%)	14 (21%)	3 mins	2 (3%)
North Ryde	173	34	5.1	2 (1%)	11 (6%)	40 (23%)	15 mins	13 (8%)
Parramatta	203	35	5.8	2 (1%)	19 (9%)	85 (42%)	8 mins	6 (3%)
Rydalmere	81	32	2.5	1 (1%)	4 (5%)	35 (43%)	15 mins	2 (2%)

Table 6 (b) : Comparison of Rozelle Hospital with Psychiatric Hospitals : Final Outcomes

Hospital	*Discharge Outright*	*Discharge Under Care*	*Committed 1 mth or Less*	*Committed Between 1 and 6 mths*	*Committed 6 mths*	*Other*
Rozelle (N = 432)	20 (5%)	1 (>1%)	52 (12%)	42 (10%)	280 (65%)	37 (9%)
Bloomfield (N = 26)	2 (8%)	0 (0%)	1 (4%)	6 (23%)	17 (65%)	0 (0%)
Gladesville (N = 117)	0 (0%)	3 (3%)	0 (0%)	2 (2%)	111 (95%)	1 (1%)
Kenmore (N = 110)	1 (1%)	0 (0%)	1 (1%)	0 (0%)	108 (98%)	0 (0%)
Morisset (N = 133)	3 (2%)	7 (5%)	8 (6%)	3 (2%)	107 (80%)	5 (4%)
Newcastle (N = 173)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	65 (98%)	1 (2%)
North Ryde (N = 173)	1 (1%)	0 (0%)	4 (2%)	3 (2%)	158 (91%)	7 (4%)
Parramatta (N = 203)	7 (3%)	4 (2%)	8 (4%)	62 (31%)	117 (58%)	5 (2%)
Rydalmere (N = 81)	3 (4%)	0 (0%)	5 (5%)	18 (22%)	53 (65%)	2 (2%)

APPENDIX E

State Psychiatric Hospitals Included in the Monitoring System

	Total Admissions June 1974 – June 1975	*No. Residents 30 June, 1975*		*No. of Beds (1977)*	
		Involuntary	*Voluntary*	*Acute*	*Other (including Long Stay, Mental Retardation and Special Unit Beds)*
Rozelle	4220	473	334	222	174
Bloomfield	613	295	422	30	230
Gladesville	1357	356	297	92	520
Kenmore	860	407	265	101	429
Morisset	1159	489	252	72	291
Newcastle	2109	11	72	101	30
North Ryde	2032	140	231	133	52
Parramatta	2631	350	323	210	280
Rydalmere	1366	444	156	90	105

PRESENTATION OF PAPER

Dr G. A. Edwards

The preparation of this paper has been an interesting and stimulating exercise and on a topic that has major significance in relation to the care and rights of mentally ill persons in New South Wales. It has been a joint paper and in it we expressed the viewpoints of a number of the project staff who participated in this research project.

In particular I would like to express my appreciation of the work of the late Madeline Matthews who died tragically in an accident in January. She was a young social worker who worked extremely hard on the project and had great empathy with the hospital patients with whom she came in contact. She was a first class health professional and a great credit to her profession.

I would also like to thank Dr Peter Shea, the Medical Superintendent of the Rozelle Hospital, who had the courage to volunteer his hospital for this important but controversial project.

In presenting the paper I would like to emphasise that the project has particular reference to matters concerned with some basic essentials of mental health legislation, in particular:

(i) The determination to be made when involuntary detention of a mentally ill person is necessary.
(ii) The question of who should decide mental illness. and
(iii) The question of whether lawyers should play any role in the proceedings or whether the matter should be left entirely to the discretion of medical practitioners.

In relation to (i), the patient representation project did have a demonstrable effect on the committal proceedings; that is on the decision making process of the magistrate when making an order for discharge, detention or deferral based on the medical certificates and opinions.

This effect was seen in four ways comparing the project period to the baseline period –

(1) doctors attended more inquiries in the project period (48% *v.* 5%) particularly Stage 2;
(2) relatives attended more inquiries during the project period (48% *v.* 5%) particularly Stage 3;
(3) there were more deferments during the project period (32% *v.* 8%);
(4) there were differences on final outcomes during the project period, there were:
    (a) more persons were discharged (8% *v.* 2%);
    (b) more represented cases were committed for one month or less (16% *v.* 2%);
    (c) fewer represented cases were committed for the maximum period of six months (50% *v.* 89%).

However it is necessary to emphasise that the number of represented patients who are discharged by the magistrate is small. This is a different experience to the New York Mental Health Information Service in which the outcome of legally represented patients show a significant discharge rate.[1]

It could be inferred from this data, that when patients have attended the magisterial hearing (and not been discharged or been made a voluntary patient) that for most, further care in hospital is necessary, although often for only a short period.

The Rozelle project importantly also illustrates that in relation to (i) (the question of determining when involuntary detention is necessary) there are other significant factors operative which influence the outcome of the committal proceedings. These are –

(1) The magistrate and his general attitude towards the inquiry and patient representation.

(2) The administration of the hospital and its organisation of the procedures surrounding the inquiry.

(3) The patients themselves, both in terms of their type of illness and their degree of social support outside the hospital; and the size of the hospital as reflected in the number of patients presented at a single hearing. (on this latter point frequently up to 25 patients would have to be seen by the magistrate in a single afternoon).

(ii) One of the basic jurisprudential and medical issues involved with involuntary care is concerned with the questions of who should decide the question of mental illness and whether lawyers should have a role or leave this matter to medical practitioners.

This issue became one of lively debate in the committee during the project. Traditionally the medical practitioners make formal recommendations for committal, but the magistrate as the community's legal representative makes the final decision. During the pilot project, in two of the three phases, for the first time on a general basis, legal officers provided representation for patients, which involved at the magistrates hearings, discussion of questions as to whether the patient was mentally ill (within the meaning of the Mental Health Act) or not. This was a particularly prominent feature during the second stage of the project, however whether this was a proper role of the lawyer in the hearing caused heated argument.[2]

> "– the legal officer often questioned the adequacy of mental illness. This approach was more threatening to hospital staff who attended more inquiries to ensure that the hospital view was defended

1. Kumasaka, Y. (1972) "The Lawyer's Role in Involuntary Commitment – New York's Experience". *Mental Hygiene.* v. 56 (2) pp. 21–29.

2. See page 24.

before the magistrate. The antagonism was evident in the responses of hospital staff to a questionnaire and in the suggestion made by some hospital staff that they too be given legal representation".

This concern that severe conflict and antagonism could arise in adversary type hearings was mentioned in the initial report of the Review Committee on this matter.[3] What would be important to know in spite of the considerable antagonism engendered with hospital staff, was whether the legal officer had been effective in representing the patient.

As has been mentioned, the project research data suggested "that patient representation does have a demonstrable effect on committal proceedings". However an important finding of the project was "that effects due to differences in the three representation schemes piloted are minor compared to the effects of introducing a patient representation scheme *per se;*" A minor difference was that more doctors attended Stage 2, more relatives attended Stage 3.

The importance of this result is that if a representation scheme is beneficial and there are no significant differences between legal and non-legal approaches, then it may be most advantageous to select the scheme likely to offer the least amount of conflict and antagonism with hospital staff who have the prime role in caring for the patient in hospital. However, it still may be possible to combine the best aspects of each of the three phases.

Turning to the role of the lawyer in representation, it was seen by a number of hospital staff as potentially usurping the medical role in determining whether mental illness exists. This point is made by Barclay on page 65.

> "One aspect of the report which raises an issue to be considered is that, by the introduction of legal practitioners, we may merely be substituting a legal opinion about the degree of mental illness of an individual for a medical opinion. This would seem to make about as much sense as substituting a medical opinion for a lawyer's opinion concerning a matter of law".

The project findings did not certainly resolve the respective roles of legal officers and non-legal representatives in this developing area of patients rights but did elucidate the advantages and disadvantages of the different personnel and the type of conflicts which did occur.

In deciding where the research project should go we have commented that both non-legal and legal representatives have valid roles to play. Non-legal representatives showed the advantage of being able to be more

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3. *Syd. Inst. Crim. Proc. No. 22.* Proposed Amendments to the Mental Health Act, 1958, Government Printer (1975), pages 97–105.

thoroughly involved with the relatives, to be able to supply simple and accurate information for patients and relatives as to the nature of hospitalisation, the magistrates hearings, their rights and responsibilities etc., to investigate after care or alternative care arrangements and to liaise with hospital staff. The presence of the lawyer with knowledge of legal rights and processes is able "to give 'teeth' and to a representative service", that is to present a thorough and if necessary forceful advocacy and representation.

However questions remain as to what relationship should exist between legal and non-legal representatives. It was felt this matter needed further consideration. Another question is concerned with which patients a legal officer should be concerned. As mentioned by Haselton and Barnes, the non-legal representatives to Stage 3, in a report to the committee.

> "Those patients who wish legal representation should be able to obtain it without difficulty and the solicitor so obtained should be conversant with the Mental Health Act and how psychiatric hospitals function".

This seems to the author one of the sensible guidelines to the role of the legal officer. Patients who positively object to involuntary hospitalisation and who request legal assistance should be entitled to it. However for all patients who come before the magistrate a non-legal information and representation service should always be available. This would use the legal officer's expertise for those cases in which there is a positive desire by the patient for legal assistance.

This course of action also raises questions as to the current difficulties of the 1958 Mental Health Act in operation. Many persons who come under the involuntary provisions are not truly involuntary (i.e. the elderly patient with dementia, the patient with severe mental handicap or brain damage) but can be "like children" and accept mostly without complaint whatever care is offered to them. These patients are regarded as informal patients under English legislation (Mental Health Act, 1959, U.K.) and similar recommendations were made in the final report of the Mental Health Act Review Committee. This would mean a smaller number of patients would come under the involuntary Mental Health Act provisions and they would mostly be patients with mental illness who have objections to hospital care and treatment.

In the final analysis of the Rozelle Project it advised that a further patient representation and information project be developed, but on a wider health regional basis, including both large psychiatric hospitals and smaller psychiatric units. It would employ both legal and non-legal staff and would further consider their functions and relationships with each other. Thus the question of the determination of mental illness and the lawyer's role in he process still remains controversial, although some important guidelines are developing, and Mr Mitchelmore will give his viewpoint on this question. Perhaps the most important need at this stage is "to focus awareness on the need for increasing the protection of patients' rights and to stimulate the momentum for reform".

One final point I would like to make is that we must not forget the lessons of history as we endeavour to enhance the rights of the mentally ill. The first Lunacy Act in 1843 with its detailed legal safeguards for staff and patients came into being after the famous Hyndman case. The facts are briefly: the patient had been admitted to Tarban Creek Asylum in a state of manic fervour with the delusion that he was the Captain of the Cabbage Tree mob, a secretly organized force of 7 000 men, whom he had with difficulty dissuaded from burning Sydney. He recovered quickly and sought legal redress under writ of habeas corpus with the aid of probably the most skilled barrister of the day in the colony, Mr Windeyer, and was awarded heavy damages – "a triumph of skilful advocacy".[4] However, the illness recurred and he required admission on another occasion to Tarban Creek Asylum. He again claimed he was being wrongly admitted and detained, and wanted legal redress as he had obtained previously. He saw his solicitor shortly after his admission (this was actually a statutory right under the Lunacy Act 1843 to have access to ones legal adviser). However, all did not go well for the solicitor – the interview was very short – for the patient got excited and threatened to sue his own lawyer when he got out: the solicitor left, observing to the master attendant as he went out; "Why, he is madder than I thought him!" Thus as we explore the role of patient representation (legal and otherwise) and pursue questions of the stated interests and the best interests of patients and how best to protect rights, the dilemmas and problems faced by patient representatives are not new nor the answers simple. I suggest we proceed cautiously in this field of patients' rights which are of such major historical and contemporary importance.

4 J. Bostok, The Dawn of Australian Psychiatry (Sydney 1968).

PRESENTATION OF PAPER

Dr L. J. Young

I would like to try and elucidate some of the extraordinary ambiguities in the *Mental Health Act* and some of the extraordinary complexities in hospital procedures concerned with committing patients.

In 1975, the last year for which we have statistics, twenty per cent of all admissions to psychiatric centres in this State were involuntary. If you look only at first admissions (that is, excluding readmissions) one in every four people going into a psychiatric hospital for the first time experiences that as an involuntary patient.

It might be felt that the safeguards that exist in the current *Mental Health Act* are more than adequate to ensure that such people receive the maximum care and consideration, and attention to their rights. I would like to consider very quickly some of those safeguards, and present some of the evidence not included in the paper that might indicate that all is not quite as well as it seems.

(1) *Entering the system.* If a person's commitment is initiated by a medical practitioner, the doctor is required to fill out a Schedule 2 certificate and that should state that he believes the person to be a mentally ill person and the grounds for that belief. I am sure that most of you are aware that when Dr Briscoe looked at 100 admissions that had been initiated by such a certificate he finally decided on the basis of the file that strictly speaking, only 34 out of a 100 were appropriate admissions within the terms of the Act[1]. More recently Dr Edwards has looked at 100 schedules from Parramatta and he judged only 31 of those Schedules to be satisfactory. Many Schedules, in fact, contain no information and certainly insufficient information to make a decision about a person as to whether or not he is mentally ill.

(2) The Act stipulates that the Schedule is in force for only ten days and, to the best of my knowledge, people do not present at admission centres outside the ten days.

(3) As soon as practicable after admission the scheduled person should be brought before two independent doctors who have to recommend that further observation or treatment is necessary. They fill out what is known in the hospital system as Form 370. That is the only written evidence apart from the Schedule that the medical staff are required to put in the patient's file.

(4) *Notifying relatives.* As soon after admission as is convenient a patient is brought before a magistrate with the requirement that due notice should be given to relatives or a friend of the patient should they wish to appear

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1 A.L.J. 42 (1968) p. 207.

at the hearing. On the question of notifying relatives it is possible to meet the terms of the Act, which does not specify the content of the message to be given to the relatives, in a way that is not very meaningful. In many cases the notifying of relatives is not given such high priority that it is formally done but is rather left to ward staff who may do it on the telephone, or if the person's relatives do not have a telephone, may send a terse telegram simply informing the relative that the hearing is to be held. Often the implication is "Don't bother to come along!" and the message contains no information as to the purpose or the nature of the enquiry that they are being invited to attend.

(5) *The Enquiry.* The Act provides that a magistrate hold an enquiry, but it is very unclear to me and seems to be unclear to other people, as to the exact nature of the enquiry. From my own observations, I believe that in most cases the magistrate acts purely as a "rubber stamp" for decisions that he seems to feel have been made previously by medical staff. If you look at the length of the enquiry at Rozelle Hospital, an average of just over five minutes, you get some idea of the degree of comprehensiveness of looking at the evidence. That five minutes would include time spent reading (or thumbing) through a file which might be quite thick. In timing hearings, because of their extreme informality, it is very difficult to tell when they start and when they finish. I remember very vividly early in the scheme when I took my task very seriously waiting for the magistrate to finish chatting to the charge nurse to realise that I had just missed an enquiry!

(6) At the enquiry the magistrate is to consider the recommendations by the medical practitioners and other such evidence that may be put before him in making his determination. If we look at what other evidence he is likely to have it would probably come from relatives, but if you look at Table 6(a), page 52, you will see that relatives in some hospitals practically never attend and in no hospital did the attendance of relatives exceed 43 per cent of hearings. That would leave the evidence of the doctors and the evidence contained in the file. Doctors attend even less often than relatives, usually about 20 per cent of hearings, and that means that the magistrate is left with the task of making a decision based on a medical file and containing the Schedule and the two forms signed by the doctors which include their statement that they believe the person should be detained for observation or treatment and indicating that he is a mentally ill person.

I would like to read two pairs of such forms that we have collected. We are doing a study of these forms and we want to examine whether introducing this project has increased the care that has gone into filling in the forms. For people who might not be familiar I will give two examples to indicate the brevity of the information and the concentration on supposed symptoms of mental illness.

CASE A

First Doctor. Very poor memory. Disorientation in time and place. Thinks it is 1940. Has no idea where she is.

Second Doctor. Disoriented in time and place. Can't recall age or date of birth. Short term memory almost existent. No insight into condition. Paranoiac. Thinks people are going to operate on her brain and wants to go home.

CASE B

First Doctor. She is over active, over talkative, over confident and interfering. She becomes irritable and very easily swears profusely in a manner which seems unlikely to be normal for her. She appears to be suffering from a manic phase of a manic depressive illness and needs treatment in hospital.

Second Doctor. The patient is aggressive, garrulous, cannot stop talking. Flight of ideas, hyper activity, hyper sexuality, unrealistically confident, unable to sleep, a clear case of manic depressive illness.

From my reading of the Act there seems to be a distinction between a person suffering from a "mental illness" and a person who is a "mentally ill person" A person who is a "mentally ill person" according to the Act is a person:

> "who owing to mental illness requires care, treatment or control for his own good or in the public interest and is for the time being incapable of managing himself or his affairs. . . "

It is my observation that the gist of the submissions made by doctors either in written forms, 370's or in their attendance at hearings, is to establish in fact that a person is suffering from "mental illness" and once that has been established, then the fact that a person is a "mentally ill person" in terms of the Act is assumed, and the fact that the hospital is the most suitable environment is also assumed. Once a clinical diagnosis is made everything else follows automatically. To my mind that is not the intention of the Act. To support my contention that many doctors see the issue as simply a matter of medical diagnosis, I would like to quote from a letter received by the committee from a hospital psychiatrist. In part it said:

> "If I request that a patient be detained in hospital it is because I am a physician caring for the patient's health and not a kind of public prosecutor attempting to get him locked away. It is high time that the public and politicians were made to realise that psychiatrists are physicians who are concerned about the health and welfare of their patients in the same way as the general practitioner, cardiologist or surgeon. The difference in treatment technique is necessary because the brain is sick and not the heart or lungs. There is no more reason for a solicitor and a committee to challenge a psychiatrist's methods than there is for a similar committee to question why a heart specialist orders hospitalisation".

I think that that attitude is one of the big problems in trying to run a scheme such as ours. I do not think we have succeeded in overcoming this problem, and I do not believe that we have developed an effective method of helping patients through what must at least be a very trying and very confusing time for them.

(7) The Act also allows that the magistrate may discharge the person to the care of a friend, even if he is a "mentally ill person". Tables 2(b)3(b), 4(b) and 6(b) show that the number of times that a magistrate has exercised that discretion is even fewer than the number of times when he has authorized an outright discharge. There is a whole area of care that is sadly neglected both in terms of the provision of alternatives, which usually do not exist if the relatives cannot take the person, and in term of the amount of attention that is paid to finding out whether any alternatives do exist.

We might feel that we are dealing with people who are so hopeless, so hopelessly mentally ill, that any attempt to represent them is somewhat of a farce. That this is not so is indicated by the fact that even after committal for the maximum period most people are kept in a hospital ward for a relatively short period of time. Table 6 (b) shows the figures for committal and in some hospitals 96 – 98 per cent of persons appearing before the magistrate were committed for six months (the maximum period allowable). At Rozelle 65 per cent were committed for six months. We investigated what actually happened to a random sample of fifty of these people after the hearing: – half of those people had been discharged within two months and these people spend on an average less than thirty days actually in the hospital. People do not actually spend six months in hospital, and whilst under committal spend over 50 per cent of their time in the community, not in the hospital.

COMMENTARY

W. A. Barclay, M.B., B.S., M.Sc., D.P.M., F.R.A.N.Z.C.P.,
Consultant Psychiatrist

This is a preliminary comment based on only one reading of the paper and is subject to further consideration and possible amendment.

It seems doubtful that the provision of legal representation for patients involved in commitment procedures provides a sufficient benefit to justify the cost. The cost of such a service, if extended State wide to all psychiatric hospitals, would be very substantial and very difficult to properly administer.

Some justification has been made for the employment of a non legal "patients friend" to investigate social circumstances and alternative methods of care prior to commitment.

It may be possible to obtain an equally desirable result by careful attention to the legislation governing compulsory admission and commitment procedures. In many cases a 72 or 96 hour observation period will enable an acute psychiatric crisis to be properly dealt with and the patient converted to voluntary status. There would appear to be a case for significantly shortening the initial commitment period to say one month. Since commitment is now required so quickly after compulsory admission if a patient is to be detained and treated, a longer period of commitment than one month would seem unnecessary in the majority of cases.

It is possible to adopt a theoretical position with respect to the protection of the civil liberties of individuals which denies people effective psychiatric treatment both in an emergency and in a slightly longer term period of illness. Unless it is shown beyond reasonable doubt that an additional legal super-structure is necessary in the mental health field such "legalism" should be avoided at all costs. Under no circumstances should procedures be introduced which prevent the rapid initiation of psychiatric treatment. It should be remembered at all times that psychiatrically disturbed patients are ill and that one is dealing with a medical problem as well as a social and legal problem. A clear distinction should be drawn between the procedures that are necessary to compulsorily detain a patient in an acute psychiatric crisis and treat him effectively over a short period of time and those procedures which are involved in the prolonged control of an individual for social reasons. Those reasons may be either the necessity to protect the individual from harm, the necessity to protect the community from the individual or the necessity to exercise control over the individual's financial affairs in his own interests.

These latter processes are much more amenable to the slower, more pedantic processes of the legal system than are the problems of acute medical treatment. Much of the argument which goes on about commitment procedures fails to distinguish between these separate components. If these

distinctions were made I think the majority of psychiatrists would be much happier about the development of legal processes with respect to the care of patients in the long term. One aspect of the report which raises an issue to be considered is that, by the introduction of legal practitioners, we may merely be substituting a legal opinion about the degree of mental illness of an individual for a medical opinion. This would seem to make about as much sense as substituting a medical opinion for a lawyer's opinion concerning a matter of law.

PRESENTATION OF COMMENTARY

Dr William Barclay

I would like to congratulate the people who wrote the report. I think it is a valuable document and I am sure a lot of worthwhile things will come out of it.

After re-reading the document several times I probably lean now towards the provision of representation for patients and to an extension of the experiments that have been proposed. However I would like to make a few points about the issues surrounding the provision of representation.

There is a tendency in some of the comments that have been made for people to subscribe to some sort of conspiracy theory on the part of doctors who lock patients up and keep them in hospital. I think that is very far from the truth. I work as a consultant to a psychiatric hospital one day a week and commitment is not entered into lightly by the doctors. It is usually only entered into when other methods, such as persuading the patient to stay as a voluntary patient, have failed, or where it is believed that the patient requires compulsory care in order to secure the necessary treatment. I agree that there is a lot of sloppy thinking and also a lot of sloppy certificate writing on the part of doctors and it certainly could be improved. I agree that many doctors fail to distinguish between defining a person as having a "mental illness" and being a "mentally ill person" under the terms of the Act. Those of us who work with the Act know that it does not follow that just because you have "mental illness" that you ought to be detained or that you ought to be treated. In this regard I think a great deal of confusion creeps into these arguments because people fail to distinguish between the problems of short term acute psychiatric illness which needs treatment now and longer term custody, control and attention (see page 64). If these two areas are distinguished there could be more agreement between the doctors and the lawyers about these issues. In this regard I would refer to Mr Callaghan's comments (pages 87-8) which provide a very accurate description of what confronts people working in mental hospitals from day to day with acutely ill people.

I did not find Dr Young's certificates all that strange. One of them describe very nicely what was almost certainly an alcoholic Korsakov state with some paranoid delusions. The other one a manic state. The second certificate was deficient in that it used too many technical terms and it did not stick to a description of the facts. But just as the 70 per cent of Schedule 2's that are defective because the certificate is badly written by an incompetent doctor or one who has not yet been trained properly or by a general practitioner who does not fully understand, it does not mean that the admission was not required. I see a large number of admissions to psychiatric hospitals and I do not find that many schedules are defective, and I certainly find very few of the patients that did not need to be there at the time the schedule was written.

I would like to emphasise that I consider that the six months commitment period is clearly too long. Part of this study might well be to have a look at what is the average length of time that people need to spend in hospital with an acute psychiatric illness and reduce the period of temporary commitment or first commitment to something approximating to that time. The month I suggest in my commentary may be too short, but I am sure that six months is not required. I agree wholeheartedly with the proposition to separate the property considerations from the mental illness treatment considerations.

I also believe that just because some doctors are pompous and do not like to have their opinions questioned it does not mean that they are not offering good opinions. Their medical opinions may be very sound. Personally, I do not object to attending a hearing and having my opinions questioned – if they are sound opinions I'll win and if they are not sound opinions I ought to lose. However, you cannot ignore, as some of these papers seem to, the administrative considerations. Some of the suggestions are not going to work. If there is to be representation I agree with the view that it should be a full time legal officer, but that won't be possible in the country. Part time people will have to be employed on a sessional basis, or a legal officer may have to be flown up from the city for the hearings. I think it is essential that representation should be independent of the hospital.

One of the valuable contributions that has been made in the papers is in pointing out that there is not sufficient exploration of alternative methods of care. I think the reason is that the people in the wards admitting patients simply do not have the resources or the time before the patient has to be brought before the magistrate. Again, it will be administratively and practically impossible for the doctor who wrote the certificate to attend the enquiry all the time. These are all practical issues which I believe will make the difference between whether any new scheme will or will not work.

I agree that the nature of the enquiries could be considerably improved. I would be anxious that those enquiries should not become too formal, the informality is in fact their strength. However, that does not mean that a transcript and accurate records should not be kept.

Finally, so much of the criticism that is made of the medical profession in opposing the introduction of legal procedures into the commitment of patients is I think based on ignorance of what actually confronts the doctor when he is confronted with a psychiatrically ill person. When I go to a mental hospital or when I see acutely ill patients in their homes, I find a very acutely ill, a very disturbed person, clearly in need of some urgent intervention. Perhaps they are dangerous to themselves or dangerous to others. I do not believe it is proper to allow a man to completely dissipate his wealth in a manic episode. Whatever one's own attitude towards property may be, that man usually values his own property and is extremely grateful when he recovers if you have stopped him throwing away his money. What I see in this situation are acutely sick

people who need treatment. That is what I know, and that is what I believe is my job to get on and do. I do not think that is pompous, I do not think that it is reinforcing my power base, or expressing my political views, in order to preserve the existing social system. I think it is just plain damn good medicine and I would regard that to behave otherwise would be medically negligent so far as my patient is concerned. I do not stop treating people because of the legalities, where these people need treatment they should be treated. I think it is entirely different when it comes to a paranoid schizophrenic who has delusions but who does not trouble anybody except himself, where the acute treatment stage is finished and the decision is whether this person needs to be in hospital or needs to be out; where the decision involves a long term control under the *Mental Health Act.* Let those opinions be legally tested and properly so. I think it is this failure of the lawyers on the one part to understand the doctor's problem when confronted with an acutely ill patient and the doctors' failure to understand the issues of property, long term control and civil liberties that leads to these differences of opinion.

I support providing representation, both legal and non-legal as was stressed in the paper, keeping it none the less informal and distinguishing between the short and long term problems, distinguishing between the medical treatment *now* and the control of property and civil liberties *later.* If that can be done then both sides will be satisfied. I do not think you will ever solve the problem of some doctors who simply do not like to have their opinions challenged – they have simply to learn to offer better opinions and to defend themselves better in court. But as I said in my paper, and I make no apology for it, I would think that it would be entirely undesirable to introduce a set of procedures which prevented acutely ill people being treated "here and now".

ASPECTS OF REPRESENTATION UNDER THE MENTAL HEALTH ACT 1958

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Under the Mental Health Act a magistrate is obliged to hold an enquiry in relation to patients newly admitted to a mental hospital *(Mental Health Act 1958* s.12(9)). There is no direction in the Act as to the type of enquiry or the method in which it should be conducted.

In 1972 a Committee (known as the Edwards Committee) was set up to review the N.S.W. Mental Health Act. The Committee thought it desirable that persons coming before the magistrate at an enquiry should have legal representation. For this purpose a pilot scheme was later set in motion by the Legal Representation Committee (see joint paper of Doctors G. A. Edwards and L. Young)

Under the pilot scheme the writer attended on ten occasions at Rozelle Psychiatric Hospital where magisterial enquiries were held. Approximately fifteen individual enquiries took place on each occasion. Not all patients were offered legal representation and assistance was given to about half the patients coming to the enquiry. In all, approximately one hundred patients had my legal representation.

Details of the pilot scheme are set out more particularly in the paper by Doctors Edwards and Young. Suffice to say that the service to patients was free, a full-time social worker assisted the lawyers by conducting preliminary interviews and providing and testing background information, and the work and approach of the lawyers concerned in the pilot scheme was untrammelled by any direction from the Legal Representation Committee or the hospital authorities.

As will be seen from the following examples, the role of the social worker in the pilot scheme was very important.

There is provision in the Act for the magistrate at any enquiry to order the discharge of a patient into the care of any relative who satisfies the magistrate that the patient will be properly taken care of (s.12(9)(b)).

Patients would frequently instruct the lawyer that there was a home available to them, when in reality there was not. For example, one male patient had been living with his mother who was separated from his father. His mother would not accept him back to her home. However the patient stated that he was welcome to go to his father at any time. Enquiry by the social worker established that this was not so. The father and his *de facto* wife emphatically denied any offer of accommodation

In another case, a female patient said that she could resume living with her sister in a large block of home units. Enquiry by the social worker from the patient's sister proved that this was incorrect. She might have

offered the patient care and accommodation if her home was not in an apartment building. The patient's sister complained that the patient rang doorbells at all hours, accepted and appropriated delivery of goods to other flats and regularly shuffled the mail and milk deliveries, much to the annoyance of the other unit dwellers.

It will be seen from this case that, without the assistance and investigation of the social worker, the patient's sister, when called to the enquiry, would have been obliged to state (in front of the patient) her inability to offer or promise care and lodging. Such an episode would not only waste the time of the enquiry but – more importantly – the public disclaimer of an offer of care in front of the patient, without time or opportunity to explain in detail and discuss the reasons for such disclaimer, must appear to the patient as an abrupt rejection. This could only be detrimental to the patient.

The magistrate conducts enquiries at Rozelle Hospital every Wednesday afternoon. In February 1977 when the pilot scheme began, the writer reported to the Committee: "The magistrate goes from ward to ward conducting his enquiry in small offices, waiting rooms or staff common rooms. The wards are in many buildings throughout the complex and one travels about a mile during the afternoon visiting the various ward blocks".

Whilst the position regarding venue has improved a great deal since February 1977, there is scope for yet further improvement. It is far easier to represent patients effectively in a proper atmosphere in a comfortable spacious room. Formerly enquiries were held in tiny offices without sufficient seating. Hearings would be half over before one found a seat and somewhere to put one's notes. Ideally, proceedings should be uninterrupted. In the early months of 1977 hospital staff came and went whilst enquiries were in progress. On one occasion a hospital employee answered the telephone and proceeded to carry on a conversation in the same room during the enquiry proceedings. However, some improvement was noted at later attendances at the hospital.

So far as venue is concerned, the judicial aspect of the enquiry would be enhanced by a more formal location, and some effort has now been made in this regard. If a "home base" were to be established, then outside solicitors would at least know where to go at the commencement of proceedings. Any solicitor unfamiliar with the methods used at Rozelle Hospital would have difficulty representing a client efficiently. All he could do would be to go to his client's ward and stay with the patient until the magistrate arrived. At present there is difficulty in knowing specifically where to go in order to represent a patient.

As stated earlier in this paper, the magistrate has in the past gone from ward to ward to hold enquiries rather than have patients taken to one or two central places. This system was probably convenient when the magistrate and his secretary (provided by the hospital) were the only people to move around. However the entourage is now bigger with the addition of

a solicitor, social worker and research psychologist (who acts as evaluator). Obviously some patients present a security risk in being moved. Others, through physical infirmity or old age, would have difficulty leaving their wards. For the sake of efficiency, however, a compromise should be considered.

The procedure for the enquiries is as follows:

Equipped with the social worker's report the solicitor, upon arrival at the venue for the enquiry, announces his appearance and the enquiry commences. Proceedings are informal and there is no set order. All parties remain seated. Witnesses do not go to a set place or witness box to be heard; nor are they sworn. There is no routine procedure for placing documents before the magistrate. In fact, the first step the magistrate takes is to read the patient's file, which is usually voluminous. It contains records not only of the circumstances of the patient's present entry to the hospital, but of his earlier visits as well. Most patients have been at the hospital previously.

In each patient's mental health file there are at least two reports from separate doctors, as well as a detailed analysis of his physical state and a short summary of the circumstances which brought him under attention. The medical reports contain basic statements and are generally quite short – e.g. "Completely disorientated in time and place – also no memory – he does not know where he is, what age he is or what month it is."

In the front of the file there is a printed form of Direction under s.12(6) of the *Mental Health Act.* It has been typed out ready to be signed by the magistrate after the enquiry. The procedure obviously contemplates that it would be highly unusual for the magistrate not to sign the Direction, which is completed except for his signature. It has been argued that practicality suggests that, since an order is almost invariably made, it is common sense (and saves time at the enquiry) if the Direction is included in the file.

The doctor looking after the patient sometimes attends the enquiry. On occasions one of the medical practitioners, who has recommended that further observation and treatment in a mental hospital is necessary, has attended. Towards the end of the pilot scheme the presence of doctors at the enquiries was more frequent than at the beginning when their appearance was rare.

The solicitor makes his submission and the magistrate then asks the patient some questions – or the doctor may make some comments. (The writer noted, on the occasions of his attendance at enquiries, that the magistrate made no attempt to cut a patient short, even in the latter's most irrelevant ramblings.)

Hearsay evidence is freely admitted. There is no obligation to take a record of proceedings, nor is there any effective right of appeal. Any right of appeal would be on the point of law only and, since there is no transcript, no one could make an assessment of whether an appeal was merited or not. There is no formal conclusion or final address at the enquiry.

In an early report to the Committee in March 1977, I stated: "From a jurisprudential point of view, it could be argued that the proceedings leave something to be desired. On the other hand, a strong argument could be run that the practicalities of the situation and the number of patients to be seen necessitate a fairly informal and speedy hearing".

R. H. Woellner, in an article published in the *Alternative Criminology Journal* Vol. 1 No. 4 (1976), commented on some of the above matters. Although based on only one appearance at an enquiry under s.12 of the *Mental Health Act,* it would seem that a number of his observations accord with the views set out in this paper. Concerning the hearing he comments:

> "The surroundings and conduct of the hearing were markedly informal. As mentioned, the hearing itself was held in a very small, ordinary room at the institution which had no distinctive furniture or other fittings which would suggest a formal or "judicial" setting. The magistrate sat on a swivel chair at the only desk (facing the near wall), while the defendant, her lawyer, witness and the social worker sat in reasonably close proximity to one another around the rear and side walls, the defendant only some 5 or 6 feet from the magistrate, and slightly to his left. Similarly, the proceedings themselves were conducted quite informally – witnesses were not sworn, procedural rules relating to the admissability of for example, hearsay evidence, were totally relaxed, and submissions and other discussion conducted in conversational rather than formal courtroom style."

The fact that the medical profession attributes little significance to the enquiry was commented on by Woellner thus: "Enquiries revealed that certifying doctors rarely attend such hearings."

The matter also caused concern to the Edwards Committee which set out its views as follows:

> ". . . It might be seen as a weakness of the present system that the medical evidence is presented by way of a written certificate, rather than in person. The certifying doctors are sometimes present, but considerably more often than not are absent. Taking into account the fact that magisterial enquiries are normally held physically within the mental hospitals, and that there is no geographical obstacle to appearance, this appears unfortunate. Presumably in the event that legal representation were generally provided, it would become the practice for the certifying doctors to attend the hearing for possible questioning about the case. This would reduce the possibility that incorrect information (which could, with the best will in the world,

sometimes creep into the certificates put before the magistrate) would be acted upon in determination of the matter. Since much of the information which the doctor obtains in the first place is hearsay, the fact that it is usually untested by questioning might appear to be a double weakness." *(N.S.W. Health Commission Report,* December 1974 at p. 149.)

Woellner also agrees with my earlier statement that the magistrate granted a fair hearing and listened patiently even when the evidence seemed to bear little or no relevance to the issue. He states: "The magistrate was clearly at pains to ensure that all parties had a fair hearing allowing the parties to exhaust all their arguments or views no matter how hare-brained."

At the outset it is well to stress the complexity of the problems dealt with in the Mental Health process. Considerable force can be attributed to diametrically opposed propositions and there is scope for widely divergent views. A summary of two American cases illustrates this. One was *Heryford* v. *Parker (U.S. Court of Appeals,* Tenth Circuit, 1968, 306 F.2d 393). This case came before the Court after denial of a writ of habeas corpus sought by a mother as natural guardian on behalf of her mentally deficient son. The complaint was that the son was committed to the Wyoming State Training School for the feeble-minded and epileptic under applicable Wyoming statues without due process, and particularly that he was denied his right to counsel. In upholding the child's right to the guiding hand of legal counsel at every step of the proceedings, the Court in its judgement said:

> "It matters not whether the proceedings be labelled 'civil' or 'criminal' or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration – whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent – which commands observance of the constitutional safeguards of due process."

Contrast Judge Bergan's dissenting views in the case *People ex Rel. Rogers* v. *Stanley (Court of Appeals of New York,* 1966 17 N.Y. 2d 270, N.Y.S.2d 573, 217 N.E.2d. 636). In that case, dealing with the necessity or otherwise of legal representation, the Judge said:

> "The effect of the decision now being made is that it will become the mandatory duty of a Judge before whom is returnable a writ of habeas corupus sued out by a patient in a State hospital for the mentally ill to assign counsel to prosecute the writ. Presently such assignment of counsel is a discretionary matter with the Judge; and it should remain that way.
>
> There are some adversary trials with counsel now in cases where it is indicated to be necessary; but the new rule will greatly enlarge their number.

> There is no possible hope that any good can be accomplished by the procedural innovation now being fashioned. The legal profession will be burdened by a frustrating and futile extension of its responsibilities in attempting to review by many new adversary trials current medical judgments of psychiatrists; the physicians themselves will be interrupted in their heavy schedules to prepare running forensic justification in a court for their medical judgments; and no one could pretend that a mentally ill patient could be helped by all this, or that it would be conducive to good hospital management.
>
> The view has been expressed in some intra-professional legal discussions that every patient should be represented by counsel in judicial enquiries that test his need for new or continued medical treatment; and there has been some judicial expression, too, in this direction.
>
> The basic concept in these contentions is that a mental hospital is equated to a prison. The two ought not be equated. They are totally different. The fact that a temporary deprivation of freedom exists in both does not make them alike.
>
> A man is put in prison to punish him. A patient is in a hospital to help him. He is there to treat his illness because in the present state of science no better way to treat him has been discovered."

I am conscious of these complexities, but as a result of my involvement in the pilot scheme (having appeared for over 140 patients during the course of the scheme, and had the benefit of discussions with other solicitors also involved, namely Warren Ball and Des Fisher I make the following observations.

Right of Representation for Patients:

On a number of occasions it has been noted that patients seem to obtain comfort from legal representation. With a solicitor present prior to the hearing a patient is not dominated by his relatives. Patients appreciate having someone there who is trying to help them.

It could be argued that, by the very nature of the proceedings and since the patient (being thought of as mentally ill) cannot present his version of affairs accurately, he requires some assistance and help in his dealings with the magistrate. It is possible that the advice and assistance of the solicitor and social worker can also help the patient in relation to his affairs generally and in his liaison with his family. When admitted, a patient is confused about his rights at the enquiry. My experience has been that many patients consider they have no say in their own affairs once three psychiatrists have recommended admission for further treatment. Reviewers of other psychiatric hospitals have reported that they are very pleased to learn of the approval given for the provision of legal aid to persons

appearing before the magistrate at Rozelle Hospital. No doubt in many cases the condition of the person concerned may make such legal aid almost unnecessary, but in the majority of cases there may be much profit for the person concerned in having skilled assistance available.

Type of Representation (i.e. Legal or Other):

It is probably desirable to have legal representation. No doubt para-legals could be trained for this particular task in much the same way as police prosecutors are trained. There is, however, need for legal expertise and training. The magistrate is legally trained and any contest would be unequal unless the patient's representative has at least the same qualifications. As a legal representative is less likely than a lay person to be overawed by a magistrate, legal training assists in the assessment of a case, in proper preparation and in presentation of the patient's side of the story.

Type of Enquiry:

Whilst it is not felt that a formal enquiry is in fact necessary, a degree of formality tends to add to the proper atmosphere of the proceedings.

It should not be necessary for witnesses to be sworn, nor to stand up when they address the magistrate. However, as with the Local Government Appeals Tribunal where formality has been lessened and where the strict rule of evidence do not apply, there is nevertheless a calm judicial atmosphere which enhances the quality and integrity of the proceedings. The enquiry should be "judicial" with the consequence that not only should an opportunity be given to both sides to be heard, but the requirements to act impartially and to give reasons for a particular decision will be met.

Frequency of Hearings:

The practice whereby a magistrate attends the hospital on a Wednesday afternoon when his other court finishes is an entirely wrong approach to the enquiry. It should be the converse situation, namely that the magistrate has a primary duty to attend at the hospital. If his work there cuts out then he can go to another court. Usually one visit a week should be enough. A real effort should be made to ensure that the terms of s.12 of the Act (whereby a patient is to attend before the magistrate "as soon as practicable") are adhered to.

Notification of Relatives:

More detail should be given to notifying patient's relatives.

There is about half a line on one form which says: "Have the relatives been notified – and how?"

At the enquiry the following answers were noted –

(i) "Informed by the ward";
(ii) "No relatives";
(iii) "Sister phoned".

On the form for one specific patient the question and answer appeared: "Have the relatives been notified – and how; – Nil." At the enquiry the patient not only had relatives present but private legal advice as well.

On another occasion a Polish lady was being dealt with when her relative arrived to visit her in the ordinary course of events. However, the enquiry form had indicated that she had no known relatives at all. The patient had been in a convalescent home for a period before she became violent and apparently had been visited frequently there from time to time by various people.

Manner of Patients' Dress at Enquiries:

It is best that patients appear before the magistrate in civilian clothes if at all possible. Although the appearance before a magistrate of a patient in illfitting pyjamas and sloppy dressing gown should theoretically have no effect, in actual fact such appearance cannot assist the patient's discharge – particularly in the case of women patients. Also, if the latter have access to cosmetics they are able to present themselves more attractively. Seeing a patient in street clothes allows the magistrate to assess how the general public will see the patient if in fact the magistrate decides to discharge him.

Extent to Which Patients are Drugged;

This is a difficult and complex question. It has been said by some medical people that the worst service a doctor can do the patient's solicitor would be to refuse the patient any medication prior to an enquiry. However, in specific cases where I have acted for a patient over a period of weeks I have noticed that on the second occasion when appearing before the magistrate the patient has been heavily drugged and has at times fallen asleep halfway through the proceedings. Perhaps in the previous week the patient was bright and animated. Obviously the best result can be achieved if the patient is able to speak alertly and rationally to the magistrate. This is difficult if the patient is half asleep. However, it is appreciated, after instances of physical violence in the actual enquiry, that a degree of medication in some cases is desirable.

Record of Proceedings:

It is highly desirable that a record be taken of proceedings. In many cases there would be no need for such record to be typed. However, as has already been commented, no appeal can be made with any degree of certainty if there is no record of the proceedings appealed against. Also, it is

felt that the recording of proceedings would add to the judicial atmosphere of the hearing. It is trite to say that all parties would act with more thought and caution if they knew their words were being taken down.

Appellate Tribunal:

An appellate tribunal is desirable and should be readily accessible. It should be ready to sit and deal with appeals without delay. The membership could be a lawyer, a doctor and a social worker. The writer has no strong feelings on the topic of membership other than to say that the appellate tribunal should meet frequently and provide a speedy review of the earlier enquiry.

Importance of Magistrate's Attendance:

At Rozelle Psychiatric Centre there appears to be lacking any real appreciation by hospital staff of the importance of the magistrate's visit. In an ordinary enquiry, if the magistrate wanted to ask questions of a witness, there would be an obligation on someone to have that witness available and failure by the witness to attend would be subject to adverse comment by the magistrate. The magistrate's remarks would be heeded and efforts made to ensure that there was no future transgression. However, at Rozelle Hospital no one worries about explaining to the magistrate why it has taken a fortnight to bring a patient before him, even though the terms of s.12 of the Act state that this should happen "as soon as practicable". Again, if a patient is listed to enquiry and has been taken to an outside hospital for x-rays or other treatment, no one feels obliged to tell the magistrate that the patient will not be available. In the past there appears to have been an ingrained awareness by the magistrate that the hospital staff have a difficult task under depressing circumstances. For this reason possibly too many allowances have been made to the staff to the detriment of the effectiveness of the magisterial enquiry.

As the role of the magistrate is explained to patients by the hospital staff, the patients consequently do not understand the enquiry and do not realise that they can ask for a discharge. Certainly they do not appreciate that it is a hearing for the primary purpose of protecting their rights.

This ignorance of the function of the magistrate has resulted in some vague distrust or general uneasiness. For example, in the past liaison between the magistrate and the doctors has apparently never been so good that the doctors felt they could enquire from the magistrate if it were possible to recommend a specific period of detention rather than the usual "after six months".

Obviously there is a need for better liaison with the hospital staff. It is probably fair to mention that the Mental Health Organization is being looked at by the Letts Report and is at present involved in the Psycho-Surgery Committee. Now, independent Legal Aid solicitors appear for the patients, which is a radical innovation. Also, some of the hospital

staff apparently feel that the solicitors might seek loopholes to free patients who clearly should be detained and will strive vigorously for a discharge. If the hospital staff were to be adequately informed of the general function and attitude of the legal profession, then it would be of value to all concerned.

Role of Solicitor:

If it is acknowledged that some form of legal aid is desirable and that a solicitor is the best person to provide such legal aid, then the question arises as to whether the solicitor should be a full-time employed solicitor or a part-time private practitioner.

There are certain disadvantages in having a full-time solicitor in that he may become institutionalized and lean more readily towards the hospital and its staff and the job they do. It would be fairly difficult to test a psychiatrist's testimony with any degree of vigour if in fact he and the solicitor are in daily communication. If a full-time solicitor is to be employed then (as in New York) every effort must be made to preserve the independence of that solicitor. It is felt that a full-time employee would be more efficient in his task to the extent that he would not be trying to cram his work into a schedule with other commitments. It is trite to say that a full-time employee at any task must be more efficient than a part-time employee. Obviously a full-time employee would have time to research an enquiry. The practicalities suggest that private solicitors would not be motivated to do research and equip themselves in quite the same way as a full-time solicitor. However, it should be stressed that the independence of the employing authority must be preserved. It may also be desirable for a full-time solicitor to operate from outside the hospital (although necessarily nearby).

Training the Solicitor:

The College of Law could, in the usual way of "curriculum development", establish proper training for solicitors to appear at mental health enquiries. Such training could be by way of theoretical and practical approach. Simulated hearings in which the new solicitors appear could be set up. An invitation could be extended to members of the Magistrates' Bench to take part in such training and to offer evaluation and advice to new solicitors.

The Continuing Legal Education Department of the College of Law could also provide a course for 'old' solicitors wishing to become involved in this type of representation. This could be along the lines of the successful advocacy course based more on 'learning by doing' rather than 'learning by lectures'. A committee, consisting of the Legal Aid Manager, a magistrate, Dr Edwards and the solicitors who have participated in the pilot scheme, could formulate the aims, objectives and devices for the proper presentation of such a course.

Status of Patients:

Finally, it may be appropriate to mention the consequences on the status of a person who is committed at a mental hospital. Committal involves his property and business interests being looked after by someone other than himself. It can also have repercussions in relation to any transactions and legal dealings which he has entered into in the past or which he may wish to enter into in the future. Assessment of the results of this experimental pilot project involving the solicitors (particularly in the light of actual experience gained in specific cases) is a far more accurate and thorough method of dealing with this problem than recommending changes based on suppositions or conjectures.

The observations contained in this paper are subject to the reservations referred to earlier about the complexity of the Mental Health process.

The valuable paper presented to this Seminar by Doctors Edwards and Young concludes that a further pilot scheme on a broader basis is warranted. With this conclusion I respectfully agree.

May I indicate that, other than to report to the Legal Representation Committee, I took no part in that Committee's deliberations. In so far as this paper contains suggestions for review or for change, they are entirely the views of the author.

The Legal Representation Committee has not yet concluded its deliberations. The report of the Committee, when its views are formulated and made known, will be a most informative and valuable document.

PRESENTATION OF PAPER

C. A. Mitchelmore

My involvement in the project was to appear each Wednesday for about six weeks and represent these patients at the Rozelle hospital. One of the preliminary questions that disturbed me was to how you satisfy yourself as to the adequacy of your instructions. We talk about representation of mentally ill people. How then can those mentally ill people adequately instruct you? We know in general law, for example an infant has to appear by his next friend, he has to defend proceedings by a guardian *ad litem,* yet in these particular proceedings at Rozelle we announce appearances on behalf of patients who are indicated by three doctors to be mentally ill. There is a section, as Dr Young mentioned, where if the magistrate finds that the person is mentally ill he can still discharge him into the care of his relatives. What I am suggesting in that situation is that the solicitor who appears for the mentally ill person virtually admits that the person is mentally ill, and seeks a discharge into the care of some relatives. I think that probably many people in the professional worlds would question the adequacy of those instructions. To talk of "representation for mentally ill people" is in fact to some extent a contradiction in terms. For those of you who want to pursue the thought further there is an opinion available by Mr Justice Powell given to the Legal Aid manager to cover an analogous problem of children between 8 and 14 in the Childrens' Court proceedings where again the question of adequacy or otherwise of instructions could in fact be challenged. Obviously the usual instruction between a solicitor and his client is possibly one of contract and in the case of a mentally ill person who has not an ability to enter into a contract there are problems initially about representing mentally ill patients. It could perhaps be overcome by the solicitor appearing as *amicus curia.*

Having mentioned that initial problem in the paper I dealt with what appears to me the utter basic problem – whether lawyers ought to be involved or not? Of the four quotations on page 12 two are for and two are against representation. Each one, be it for or against is very convincing and yet, each one is in utter contradiction with the next one. The two quotations in my paper (pages 73-4), on the one hand suggesting that keeping people in a mental hospital is a deprivation of liberty, a detention without redress, and that they ought to have legal aid and legal assistance, and on the other hand (and as Dr Young stated) that doctors and lawyers feel that treatment in a mental hospital is of the equivalent of treatment of a heart attack. But two or three days after admission to hospital for a heart attack someone does not come along and say: "I am a magistrate, I am here to ascertain whether you ought to be detained in this hospital or not". There is one salient difference, one that we ought to keep in mind, in relation to this analogy of the heart attack or the hospitalisation of the ordinary physical illness, all your property does not vest immediately in the Receiver or the Master of the protective jurisdiction. I do not think we ought to lose sight of those property provisions whereby immediately after a person is made a patient he no longer has control of his own affairs. His

assets vest in the Receiver and are in fact dealt with by him. If one is fortunate to obtain a discharge the patient is discharged then and there and this itself presents tremendous social problems. Quite frequently he has no money, nowhere to go, and is probably waiting on an unemployment relief cheque later in the week.

I suggest in the paper that the enquiry itself ought to be improved (pages 75-8). I think that there may be merit not so much in a prosecuting officer appearing for the doctors at the hospital but for someone to appear to assist the magistrate, in the same way as assistance to the coroner in coronial enquiries or to the Royal Commissioner in Royal Commissions. It would provide a contact point for solicitors, it would ensure that the records are properly kept. I feel strongly that there ought to be a transcript of these proceedings. It is very difficult to give advice if the proceedings have been held and you do not know what went on at those proceedings. All that the person can tell you on the particular day is that he was committed for a period of say, two months, and you have no idea why and no idea how it went on. Another advantage is that the doctors themselves feel that it is not one sided, the patients have lawyers, the doctors also have someone to whom they can refer to. On the other side I agree with Dr Edwards that it has certainly opened up the adversary system into these legal aid proceedings. In the paper I suggest that the enquiry ought to be regularized. I agree with Dr Young–sometimes the proceedings are virtually half over before you have found a seat! There is no formal court room, you often meet in small offices, sometimes phones ring and people conduct a conversation in the middle of the enquiry. This is not a proper judicial enquiry. The Act itself (s.12) provides for an enquiry, the plea in my paper is to improve that enquiry and to make some right of appeal available from it. That would, of course, involve a transcript being available.

I never cease to be amazed in relation to these enquiries made by experienced practitioners, people who are in court probably four days a week, who have no idea what to expect when they go to an enquiry. I tell them, much to their surprise, that there is no specific order of proceedings, there is no way of calling witnesses, witnesses are not sworn, there is no order of addresses, that there is no formality whatsoever, there is no tender of documents, hearsay is readily admitted. For example, a person has come in originally from a convalescent home because he became violent: The nurse told the matron, the matron told the police officer, the police officer told another police officer, that police officer reported it to the doctor and by the time it gets to the magistrate it is hearsay six or seven times over.

I have searched through the various books for any decision on the *Mental Health Act.* Although the Act has been in operation for many years there has certainly been no *habeas corpus* or similar proceedings. The only case that I can find is a case *Ex Parte Fitzgerald Re The Medical Board* which was decided in 45 State Reports. It is quite an amusing case and was on a peripheral question of a doctor certifying a patient under the then *Lunacy Act.* It does appear strange that to get a definition of "Mentally Ill" Equity cases, cases on Wills and Probate and other matters have to be consulted.

To summarize my position, I think the question of whether representation is available to mentally incapacitated people does in fact present a problem. I cannot assist on the basic issue of representation or no representation as to whether or not it is analogous to the "heart attack" situation. I do make a strong plea for the improvement of the nature of the enquiry and for the taking of a transcript. I agree with Mr Callaghan that the determination of "mentally ill" and the determination of property ought to be separated and taken at different times rather than on the one occasion.

COMMENTARY

G. D. Woods, LL.M., Dip.Ed.,
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Mr Mitchelmore has clearly taken his duties in providing legal representation for patients over the period of the pilot study very seriously, for he has conscientiously identified the paradoxes and difficulties inherent in the task. I congratulate him for his concise and useful paper and for the year's effort it represents.

It was inevitable that this project would provoke argument and conflict of a territorial nature between lawyers and health care professionals. Mr Mitchelmore has adverted to the genuine differences of opinion which may be held about the desirability of legal aid for mental patients, but he says finally: "The valuable paper presented to this seminar by Doctors Edwards and Young concludes that a further pilot scheme on a broader basis is warranted. With this conclusion I respectfully agree".

And with that conclusion I respectfully agree. My reading of the material suggests that, some honest opinion to the contrary notwithstanding, legal representation for persons facing a magisterial inquiry under s.12 is necessary and desirable. I agree with Mr Mitchelmore that the lawyer should generally be engaged full time, and independent of the hospital.

A political decision must now be made to provide funds for a wider programme. This should, as Dr Edwards and Dr Young point out, be on an area basis and still semi-experimental. The pilot study to date has shown that the enterprise is basically worthwhile and desirable, but that there are still problems to be solved. I have no doubt that with goodwill and patience a wider system can be put into effect and made to operate soundly.

The Minister for Health, Mr Kevin Stewart, is to be congratulated for his recent announcement that funds would in due course be made available to do away with the present archaic and unfair sytem whereby persons can be detained involuntarily under the *Mental Health Act* and yet charged for it without recourse to any medical insurance. It is excellent news that this disgraceful administrative arrangement will be abolished.

Mr Stewart has also acted firmly and wisely in relation to controls over psychosurgery, introducing sensible reforms.

The Minister can further add to his reputation as a reformer of the mental health care system by looking with favour upon the interim papers presented here this evening, and upon the report of the Legal Representation Committee when it is presented in due course.

As others will no doubt point out, legalism and an excessive belief in "civil liberties" will not solve all the problems of mental illness in our society. Lawyers in general are a pretty bad lot, in my opinion. Like most doctors, they are overly concerned with status and financial rewards. They are dead set villains for tax avoidance and owning a Mercedes. They are generally reluctant to upset the status quo (unless paid fairly handsomely for doing so) and they generally established themselves in practice in areas, not of the greatest human need, but of the maximum financial reward. There are exceptions, of course, but that is an accurate broadbrush picture. You cannot expect lawyers and doctors to initiate and carry through basic reforms in society, because they belong to a class which does very well out of keeping things as they are, thank you very much.

But if reforms *are* carried out, the professional expertise of doctors and lawyers should be utilised and recognised. Lawyers are good at investigating facts and presenting arguments, and as Mr Mitchelmore points out in his paper, these are tasks which, failing representation of the patient, may not be carried out at all, or may be carried out badly.

Many of the problems of mental hospitals are problems caused by basic flaws in the social structure. For example, the problem of unusually high rates of paranoia among migrants is no doubt due to racism and discrimination. The problem of the geriatric wards is the political problem of a social system where old people are disregarded, cast-out and downgraded. The problem of alcoholism is the result of social alienation, and the failure of family and community life.

In my view none of these problems will be solved unless there come about fundamental changes in the Australian social and political system, away from a system of classes based on the profit motive, to a system of democratic socialism where the basic problems of people (and in particular the problem of obtaining adequate health care, food and employment) are firmly addressed as a first priority.

I hope and expect that the present Labor Government in New South Wales will get its priorities right and in due course set out on a programme of thoroughgoing political reform in this state. Without such an effort the vices apparent in the mental hospital system will continue. As I have said, the present Minister is to be congratulated on his recent announcement about fees. I hope that in due course he supports a wider system of legal representation. It would be a small step but an important one for protecting human rights.

DISCUSSION PAPER

J. M. G. Callaghan,
Stipendiary Magistrate, N.S.W.

I am at present the visiting magistrate to the Rozelle, Gladesville and North Ryde Psychiatric Hospitals, although I was only involved at the end of the Rozelle programme. It seems to me that the paper presented by Dr Edwards and Dr Young does not get to the real problems and like so many statistical analyses is wasting its substance on figures rather than issues.

The problems associated with the decisions I have to make, stem as much from the lack of proper guidelines in the *Mental Health Act,* as from the nature of the evidence presented to me. There seems to be no real distinction between the evidence given to support a diagnosis of mental illness and evidence going to show the necessity for a suspension of a patient's civil rights.

The present definition of a "Mentally ill person" is anything but precise.

As a magistrate who is presented with a patient and a file and asked to make a decision, I am perhaps seeking to share some of the responsibility by my proposals. I am conscious that the requirements of the *Mental Health Act* are not particularly relevant to most treatment, as the treating doctors are confident that they are acting in the best interests of their patients. The question I have to decide is when is a person entitled to have control over his body, or perhaps when is he incapable of exercising that degree of judgment, which is necessary for him to be able to decide what is good for him.

Amendments to Mental Health Act

I think the Act should be amended to leave the diagnosis decision to the psychiatrists, and the civil rights decision to the visiting magistrate.

I would propose a definition of "mentally ill person"* along the following lines:

> A "mentally ill person" is any person who suffers from a significant impairment of his powers of perception, conception, reasoning, memory or self-control.

**Mental Health Act 1958*
s.4 "Mentally ill person" means a person who owing to mental illness requires care, treatment or control for his own good or in the public interest, and is for the time being incapable of managing himself or his affairs and "mentally ill" has a corresponding meaning.

I would propose that s.12 (6)* be amended as follows:

If the patient has been certified by three doctors as aforesaid to be a mentally ill person within the meaning of this Act, and is not considered suitable to be treated as a voluntary patient by the superintendent of such centre, he may apply, as soon as convenient, to a stipendiary magistrate, for such patient to be classified as a temporary patient.

The grounds on which such application may be made are as follows: the patient is –

(a) a danger to others
(b) suicidal or likely to do substantial bodily harm to himself
(c) incapable of caring for himself properly
(d) incapable of managing his affairs
(e) unable to understand the nature of his illness or the nature and purpose of his proposed treatment.

These proposed grounds for application accord with what I consider to be the more or less unwritten law at the present time. However (e) is not envisaged under the present Act, and I doubt whether when the Act was drafted that the present concept of "care" (c) was envisaged.

I have approached the problem from two aspects. Firstly, I would envisage that no person be admitted into a mental hospital or admission centre unless he is mentally ill within my definition, or as a voluntary patient. My definition is not meant to include all types of psychiatric illness. For various reasons, not the least of which would be frustration of the professional staff, I would not wish to limit the intake of any psychiatric hospital by legislation. Rather, the definition is my idea of the parameters of those cases whose treatment can be most appropriately undertaken in a mental hospital.

I would certainly not be adamant that I have proposed an exhaustive, nor indeed a particularly accurate definition of "mentally ill person". I do think, however, that it is somewhat better than a "person suffering from mental illness". I am sure that some of the doctors, with much more

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Mental Health Act 1958

s.12 (6)
If after examination as aforesaid two medical practitioners recommend that further observation and treatment in a mental hospital or authorized hospital is necessary, such superintendent shall cause such person to be brought as soon as conveniently may be before a stipendiary magistrate. Such recommendation shall be in or to the effect of the prescribed form.

experience than I have had in this field, could suggest more accurate phraseology. I am reminded of a paper presented by Dr O. V. Briscoe* where he set out some of the difficulties encountered by practising psychiatrists.

Whether or not a patient came within that definition, would be a matter for the examining doctors to decide. I see nothing wrong with the present procedure whereby the patient is seen by at least three doctors, except perhaps to give a right to a patient to be seen by a suitably qualified practitioner of his own choice. At present, where a diagnosis is disputed, I have always adjourned the hearing to enable the patient to be examined by a doctor of his own choice. I think, in practice, we could get a consensus between the doctors as to whether a patient came within the terms of the definition. It would be a condition precedent to any application for loss of status that the requisite certificates be given.

What is of more importance to me, is the second part of my proposal. This would bring the hearing more in line with court procedure, in that we would have an application, with the medical superintendent, or his nominee, responsible to present his case. It could well be advisable for the Health Commission to appoint one or more persons to prosecute these applications as I do not envisage the medical superintendent doing so in person, nor do I think it advisable for a doctor, particularly the treating doctor, to be cast in such a role. I think the task should be undertaken by a person of some responsibility and experience as I would expect each case to be reviewed with the medical personnel involved before the application was made.

Types of Patients whose Committal as Temporary Patients is Requested

1. The largest number would be old people suffering from senile dementia and the various disabilities usually found in geriatric patients. Allied to these are those suffering from pre-senile dementia, alcoholism which has progressed to the extent of severe deterioration of the brain, liver and nervous system, brain damage from strokes, tumours or injuries and other conditions which in the main render persons incapable of looking after themselves. Many suffer from loss of memory, confusion, lack of orientation, lack of muscular co-ordination, incontinence of faeces or urine, immobility and so on. Any person familiar with nursing homes for the aged will appreciate the range of problems these person present. Prognosis is poor and full-time care is essential.

2. The second most common category are the schizophrenic type patients. I include with these paranoids, paraphrenics and others whose symptoms include a detachment from reality, with or without

*"The Meaning of 'Mentally Ill Person' in the Mental Health Act 1958-65 of New South Wales" A.L.J. 42 (1968) p. 207.

delusions. The symptoms are episodic in most cases, and control is now mostly by means of psychotropic drugs. Doctors begin treatment as soon as a patient enters hospital. I may not see them until a week later. The problem is whether to make an order if the symptoms have subsided but are likely to recur. It is quite often impossible to persuade patients that this is likely and they request immediate discharge.

3. A third group are the hypomanics and manic depressives. Whilst they can be floridly psychotic at times, quite often their condition is evidenced by irresponsible behaviour, rather than any perceptive delusions. Many have been known to waste assets, bring great distress to their families, or to run up debts which they have no hope of paying. Some are quite plausible and will tell lies with the greatest sincerity.

4. Patients suffering from endogenous and other forms of depression are a special worry. Many suffer considerable distress. When drug therapy is ineffective, many cases respond to E.C.T. Most of the patients are incapable of agreeing to any treatment, let alone E.C.T. They are so involved with themselves that they are completely without hope for recovery.

5. There are a number of patients whose mental impairment is related to recent injuries, poisoning (including drug overdosing) or disease. Here, time is the element which is important. Many such conditions subside quickly with treatment and have little likelihood of recurring. It is essential for a magistrate to have a discretion to defer a decision in such cases, whilst authorising treatment in the meantime.

6. Mentally retarded persons, often with phsyical deformities, being cared for in Psychiatric Hospitals are brought before me from time to time. My own impression is that these unfortunate people should not be dealt with under the *Mental Health Act*. Their problems are such that nothing short of their own system of care is sufficient.

7. Drug addicts and alcoholics pose special problems. I am firmly convinced that they can only be helped if they are prepared to help themselves. Unless or until they have deteriorated to the extent that they are no longer in full control of their faculties, they are not within my idea of persons suitable for classification as temporary patients. It might be of some help if the *Inebriates Act* were widened to include all drug abuse and perhaps other alternative means of treatment might be ordered under that Act. In view of the present widespread misuse of drugs I think the *Poisons Act* should be supplemented with an Act to facilitate the treatment of alcoholics and drug dependent persons.

Conclusion

The difficulty is always to strike a balance between the need for protection of civil rights and the need for treatment of the mentally ill. Whist I am firmly committed to the proposition that it is every man's right to go to hell in his own way, in nearly all of the cases presented to me, the patient has no real knowledge in which direction he is headed. I have sought, therefore to frame a set of principles outlining those circumstances in which I consider it essential, in the interests of the patient, his relatives, or the public, that his freedom of action be curtailed. I hope it is apparent from the brief description of the types presented to me why I chose the grounds as stated.

PRESENTATION OF DISCUSSION PAPER

J. M. G. Callaghan, S.M.

I would like to thank Mr Mitchelmore for the suggestion that perhaps we should have somebody to assist the magistrate rather than have somebody who "prosecutes" these particular hearings (see page 87 of my paper). What I had in mind was somebody who would discuss with the patients the proposed application and its likely results, who would also discuss the same with the relatives, who would be prepared to go through both the file and to discuss with the medical personnel to work out psychiatric and medical history of the patient, who could give me the reasons for the admission in the first place (various people have pointed out the deficiencies in the Schedule 2 especially in providing background information) and the diagnosis, treatment and prognosis since admission. Lastly I would like this person to be responsible for the presentation of the actual documentary evidence. At the present time any magistrate who has to do these things is cast in the role of investigator and he is also cast in the role of judicial officer. But our training is such that we much prefer it if we can sit back and let somebody else do all the hard work while we just make the final decisions.

I would like to make further comment on "Discharges" and "Deferrals".

Discharges

There are at least three common causes of discharges.

1. The first is where you actually over-rule the certificate, and I have only ever done this once in my life where I was perfectly satisfied that this particular person was not mentally ill. He was a difficult character, prone to violence, but I was convinced by the end of the case that that particular person did not come within the definition of mentally ill under the Act.

2. The second cause which is more frequent is discharge after some degree of treatment. This is referred to by Dr Barclay in those cases where the patient is not seen by a magistrate for say a week or ten days. By that stage he is presenting very well and the only real question is whether treatment has progressed sufficiently for him to be discharged. I think that his wishes have to be taken into account provided that he knows exactly what he is doing.

3. The third full discharge is "discharge to other care", not necessarily to an authorised institution under the *Mental Health Act* or to a relative officially, but, particularly with senile patients, when they can be admitted to a nursing or convalescent home. Frequently such a patient is on a pension only, the next of kin has power of attorney so that

there is no need for any intervention by the Protective Commissioner in regard to property. In these cases you do not discharge the patient to the convalescent home, but discharge him completely.

Deferment

Deferment can be for various and sundries reasons:

1. Firstly there is deferment at the request of the patient. This may be in order to consult a solicitor or seek advice. This is no problem and the enquiry is adjourned to the following week.

2. To obtain other placement. Again this is more particularly with the aged person but it may also occur if the patient wishes to go into a private hospital. Again, the enquiry can be held over for a week.

3. For further observation for people with acute medical states where I do not consider that I should make a decision immediately.

4. It may be necessary to obtain further evidence, in particular where the diagnosis is disputed, and the patient requests an examination by a private psychiatrist. It may be some specific request by the patient for an adjournment to produce evidence, or in the case of geriatric patients, I may ask to see the person whom the patient suggests will take care of him.

These are reasons for deferment which I thought were relevant. Probable it should be written into the Act that the magistrate has got a discretion to order either that the patient does not receive treatment, or that they be allowed to go home, or that they be kept in hospital during the period of the adjournment. I have had very few specific requests along these lines, and although I have not allowed a patient to go home before I made an order, I have made orders for a patient to be allowed out to seek private consultation or to go home to look after property or to go out for a particular reason provided they are accompanied by a nurse. I feel these incidental matters are quite capable of being properly resolved without making any final diagnosis or final decision.

The Act at present refers to "suspending the execution" of an order. I have done that at times when a patient has a placement. I will order a discharge but I will defer it for a short time, but, by and large, I do not rely on the provisions of the *Mental Health Act* for an adjournment. Every tribunal has to have a power of adjournment to make things work. It is completely impossible at times to give a decision on the first occasion that you see or are presented with a case. I follow the example of many of my predecessors and take it upon myself to adjourn the matter. The hospital sees the necessity for it, and agrees with it. They are only too happy to have some sort of legal backing for what they consider to be an eminently reasonable thing.

Legal Representation

Finally, I agree with 99 per cent of Mr Mitchelmore's paper, but I do not agree that the majority of patients should be legally represented. I do not think that this is necessary at all. They should be fully informed of all the consequences of an enquiry but the actual representation should be limited to those people who are capable of giving instructions to a solicitor where either they (or their relatives) wish to be legally represented.

DISCUSSION PAPER

Gill H. Boehringer, B.Sc.(Sociology), LL.B., LL.M.,
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Pat O'Shane, LL.B.,
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The sub-title of the topic of this seminar is "Representing Patients at Mental Health Act Hearings" – this raises the need to look at the provisions of *The Mental Health Act,* 1958.

Section 12(9)

The legislation is very poorly drafted. In particular, so far as this seminar is concerned, s.12(9) which sets out the duties of a magistrate who conducts the committal proceedings à propos involuntary patients.

Some of the problems about the hearings, not clarified in the Act are:

* What sort of proceedings are these?
* No right to legal representation of patients.
* Total lack of records of proceedings.
* What standard of proof is required? (Magistrate is required to be "satisfied" that person is mentally ill).
* Status of person whose matter has been deferred (adjourned) – right to refuse treatment in the period of adjournment?
* Magistrate may suspend execution of an order – including an order for discharge?

These problems are not considered in the proposed changes to the legislation as considered by the Edwards Committee.

Section 4

The proposed amendment to s.4 definition of "mentally ill person" as set out in the Edwards Committee Report* is no closer to clarifying the issue of what is a "mentally ill person".

Representation

It is clear from the papers given that whilst representation of patients is advocated (we agree with this, and in fact believe that *legal representation* is what is needed) yet there is a concentration on the needs of the administration of the hospitals rather than on the needs of patients. In the course of the project, particularly during the time when the full-time legal officer was engaged on it, it became evident that an appalling state of affairs exists (within Rozelle hospital at least) in relation to the treatment and handling of patients awaiting magistrates' hearings. It is true to say that many activities of the staff approach the illegal if they are not in fact illegal.

We consider that there are some dangers in the use of social workers as patient representatives. Social workers are members of the helping professions and therefore tend to greater support of medical authority rather than the needs of the patient, as *the patient* sees them. This is borne out by the paper of Drs Edwards and Young, see page 35 para (ii), reference to assistant to the magistrate, page 26, *Discussion* reference to non-legal representatives being unable to contest adequacy of evidence for mental illness. It is obvious that in such circumstances the rights of patients being overridden, because presumption of mental illness accepted as inviolate.

Present Provision

* (From)–Section 4.

"Mentally ill person" means a person who owing to mental illness requires care, treatment or control for his own good or in the public interest, and is for the time being incapable of managing himself or his affairs and "mentally ill" has a corresponding meaning.

Proposed Amendment

To the definition of "mentally ill person" in s.4 there should be added a proviso in the following terms:

Provided that no person shall be considered to be mentally ill for the purposes of this Act by reason alone of the political nature of any activity or the expression of any political opinion, by reason alone of sexual deviance or promiscuity, by reason alone of the immorality or illegality of any conduct, or by reason alone of drug taking. Notwithstanding this proviso, the physiological, biochemical or psychological effects of drug taking may be regarded as indications of mental illness.

Magistrates

Magistrates, generally, showed marked propensity to accept that people coming before them are mentally ill persons. There is no questioning of medical authority, see, e.g. Mr Callaghan's comments. It is obvious that patients' rights cannot be left to magistrates in such circumstances. There is also a marked lack of the knowledge and understanding of the requirements of the Act, e.g., availability of different forms for the making of different orders, standard of proof, etc. There is a marked tendency on the part of many magistrates to be paternalistic and judgemental in terms of their own value-systems. (Many people being admitted to state psychiatric institutions are from lower socio-economic strata, or foreign cultures.)

Doctors

Attitudes of doctors are not conducive to protecting the rights of patients, but rather tend to reinforce their own bases of authority. In the process they tend to intimidate not only patients but also social workers and others.

> "We don't know what their rights are prior to the Magistrate's hearing but these are people in need of treatment and that is our responsibility as doctors". (A Doctor).

> "Under no circumstances should procedures be introduced which prevent the rapid initiation of psychiatric treatment". (Dr Barclay).

It is questionable (highly questionable) that people who are classified as being "mentally ill persons" are incapable of managing their own affairs, and in particular this question is important when considering the rights of patients to *refuse* treatment.

The question of mental illness very quickly is reduced to a question of protection of property rights (e.g., see Mr Callaghan's paper page 86). Reference to persons wasting assets, thus "bringing great distress to their families". This same argument is often used by medical practitioners to justify their treatment of certain people.

Conclusion

We agree with the remarks made by Mr Woods when he says:

> ". . . an excessive belief in 'civil liberties' will not solve all the problems of mental illness in our society . . . (We) cannot expect lawyers and doctors to initiate and carry through basic reforms in society, because they belong to a class which does very well out of keeping things as they are, thank you very much".

We reiterate our belief in the need for a scheme of *legal representation* for persons appearing before magistrates pursuant to s.12 of the *Mental Health Act* 1958, and support the proposal that such a scheme be implemented in New South Wales.

PRESENTATION OF DISCUSSION PAPER

Gill H. Boehringer

I agree with much of what Edwards and Young have put in their paper but I would like to emphasise that it is a paper from two private individuals who happen to be members of a committee. It is not in fact correct to refer to it as a report. There are some differences of opinion which I am sure they realise having sat across from me at the table for about a year thus far. Both Pat O'Shane and I would clearly agree with much of Greg Woods' paper, particularly some of the paragraphs towards the end. Mr Mitchelmore emphasises some of the problems about the way in which people are perceived who come to mental hospitals. He is talking about legal representation for "mentally ill people". These people are labelled prior to the time they come to the magistrate's hearing. Sometimes they come heavily drugged, and in pyjamas so that the whole phenomenology of the process of getting them before the magistrate is one in which there is a conception of people being mentally ill. I think that that is proof of the strength of the ideology of psychiatry and of the concept of mental illness which underlies a great deal of the practice which goes on in the hospitals in this State. While I do agree with Dr Barclay about representation for people, and I do agree that it should be legal representation, it seems to me that he, in his comments about the doctors' responsibility in society, once again underlines the strength of the medical ideology. I am not saying that psychiatrists or others are in a conspiracy or that they are evil people, but as Brandeis said "We have to beware of the good men of zeal, and the good women of zeal as well".

Having said that I want to move on to the question which is raised by Edwards and Young on the kind of representation because it seems to me that raises a number of issues that have to be faced quite openly and honestly. They suggest that there was not much difference between the three types. I reject that view.

Firstly, on empirical grounds, I do not think that their own data suggests that there was no difference. I think that we can argue on whether or not it was a substantive difference but to me the evidence suggests that it was a considerable difference in favour of having a full time legal representative there. But even more importantly it seems to me that empiricist methodology very often hides more than it reveals. The simple presentation of statistics cannot tell you what was going on in those hospitals, and I must say as a lawyer and as a teacher at law I was appalled when I went to see these hearings and found out how the *Mental Health Act* was being implemented in this State. I would say that anyone who was on that committee, any of the solicitors, the full time legal officer, the social workers, research assistants, or anyone who was involved would have to say that they were appalled. It was nothing like anything that we would consider a legal process. It seems to me that we ought to tie these things in together. The point is we have *strong* medical ideology which can justify doing things to people against their consent in all kinds of circumstances

which we would object to as human beings and certainly as people interested in protecting rights. When the full time legal officer got into action she opened up that system like someone opening with a tin opener. Her effect cannot be measured in terms of statistics, but the impact that she had on the system was just incredible. The hearings had become so informal as to really be a travesty of justice, if they had been held in a prison or in a court it would have been said to be a "Kangaroo court". But these are closed hearings held in private, in hospitals. They deal with the mentally ill people and the people who have the medical expertise pretty well called "the shots". I have quotations from legal people who defer constantly to psychiatrists and doctors because it is an area of expertise which they do not understand, and, of course, they can shift the burden to the medicos when anything happens as a result of a decision that they have taken.

It seems to me that the lessons of history suggest that there are going to be more and more people brought through this system: women, working class people, migrants, socially isolated people, the unemployed, the socially discarded by society. They, in fact, do need legal protection. They have not been getting legal protection and the reality is that they are being given drugs, they are liable to E.C.T., they are liable to psycho surgery. The basic problem is surely the initial detention of people in mental hospitals with psychiatric illness, and once that happens then people are labelled. What we have to realise is that there is a spectrum of treatments that are being used and they would not be used improperly against people if there was a proper legal procedure with proper legal representation. It seems to me that to give the kind of protection that we give to people who are in a normal criminal court and to deny that to a person in a closed psychiatric hospital is to really stand reality on its head and to ignore the abuse that is inevitable in a system which has such a powerful ideology.

Pat O'Shane

I want to comment about Sections 4 and 12 of the Act as they stand at present and the proposed amendments to both sections.

In some of the comments in respect to how "mental illness" ought to be defined in the Edwards Committee Report, the point it made that "mental illness" ought not to be defined in terms of the legal or moral norms pertaining at the time. In fact any classification of any sort of behaviour is always made in terms of the way people interact with each other. I am totally opposed to the idea that "mental illness" arises as the result of individual pathology. Whatever is called "mental illness" (and I would take issue with the term itself) arises by reason of the way we relate with each other in society, and specifically, in my view, it arises basically out of the way that the whole society is structured in terms of social relations of production. I think we can never get away from that. The suggested amendment to s. 4 in the Edwards Committee Report does not help to clarify a definition of "mentally ill person". Rather in our view the terms "sexual deviance" "political activity" "immorality" etc. imply that those particular behaviours are in fact evidence of mental illness.

I want to make some comments about s.12 (9) of the present Act which sets out guidelines for a magistrate's hearing. Dr Young has already pointed to the anomalies that exist in that part of the Act, and I just want to ask the question: "Are magistrates, in fact, the best people to conduct hearings?". Some of the earlier comments must raise some very serious doubts about the ability of some magistrates to conduct hearings by which people's basic rights are very seriously infringed, not forgetting, as one of the panel has already pointed out, the property provisions that exist in the Act.

Included in Mr Callaghan's proposals with respect to the grounds upon which an application may be made to have a person committed as a mentally ill person, is that "the patient is a danger to others". The whole question of when a person is a danger to others, and how that might be determined, raises some very serious issues of civil rights in my mind, and we ought not to press that line at all. In fact we ought to consider it very seriously and then reject it. Similarly such criteria as (b) "the patient is suicidal or likely to do substantial bodily harm to himself" (c) "the patient is incapable of caring for himself properly" or (d) "incapable of managing his affairs" are popular with psychiatrists. But in my experience in discussing the whole issue of what is "mental illness" or how a person is to be defined as a "mentally ill person" those issues are raised in very vague terms and very seldom are the treating doctors able to point to specific acts done by the particular patient at the time to indicate that this state exists.

DISCUSSION

John Parnell, Stipendiary Magistrate, N.S.W.

On a visit to Callan Park as magistrate I was invited by the patient's representative to say whether or not the representation had assisted my enquiry in the individual cases. Was such part of a general investigation? If so, what is known of the results?

Dr L. J. Young

We routinely asked the magistrate after each case whether he found the representation was helpful or not and, from memory, whether he would have made the same order if alternative sources of care existed for the patient. We will certainly attempt to analyse the results but unfortunately in the majority of cases the magistrate did not complete the form correctly or did not answer the question.

John Parnell

Did you see any particular formalities presently associated with courts which might be detrimental to the health of individual patients at an enquiry? What specific minimum formalities would you set?

C. A. Mitchelmore

It is a delightful situation to be able to object to a magistrate's question! The word formalities suggests that what I am asking for are, in fact, "formalities". I think they are just the basic requirements of fairness. For example, there ought to be a transcript; there ought to be somewhere to sit; there ought to be an insurance that the patient in fact turns up. If the patient is away having treatment no one worries and you go on to the next case. I spoke earlier about giving advice to seasoned practitioners as to what they ought to do at an enquiry. The former advice that I used to give them was: "Go to Ward 13 on a Wednesday and go at 2 o'clock". I was asked to do an enquiry a fortnight ago and following my own instructions found that the magistrate now sits on a Tuesday and Ward 13 has been closed down completely.

I agree there are strong arguments about the adversary system, but in the Local Government Appeals Tribunal and in the Coroner's Court there is some degree of informality, e.g. the courts are not bound by the strict rules of evidence, and those of you have had experience of the Local Government Appeals Tribunal would probably agree with me that as an informal tribunal it is doing an excellent job.

I do finally make a plea for review by having a transcript; if there is no transcript, no judge later on can assist in relation to questions that are raised.

Dr G. A. Edwards

On that question of informal enquiry, I would like to make clear that I feel strongly that the informal enquiry is what it should be and I would hate to see excessive formality. I would like to comment on the claims that there are some basic minimums that one would like to see. One must remember, particularly in preparation of transcripts and collecting of information etcetra that a hospital like Rozelle often works under terrific pressure. In the latter part of last year the hospital expected to have a 10 per cent cut in staff across the board, such cuts must put pressure on hospitals in providing basic minimum services. The hospitals do the best they can but they do need support at that level which is quite often forgotten.

Dr Scott-Orr, Psychiatrist from Central Coast, N.S.W.

Firstly, I think there has been a good demonstration in the Royal Commission on Human Relationships of the capacity for a court to have informality and still meet the requirements at law.

Secondly, the *Mental Health Act,* in my mind, has very little to do with mental health. I have tried to persuade the Mental Health Act Review Committee to consider that concept but I have had little response to that idea in any way that satisfies me. I believe that it is a "Behavioural Restraint" Act and I think we should be more honest about what it is about.

Thirdly, as a psychiatrist who is committed to a community but who considers his training has been institutional, we need to rethink the business we are in and to deal with people where they are both physically and otherwise. This whole area has been ignored in the concentration of discussion on the institution in connection with the so-called *Mental Health Act.* The same problem arises if a person is mad wherever he is. Why do we worry about the procedures of admission to hospital and what happens in the hospital and not deal with the situation if a doctor is wanting to offer his help in the home, in the workplace, or in the recreational area, and there is some intervention that is required to do with behavioural restraint or mental illness? I feel very vulnerable at law as a psychiatrist doing my job where the law and the discussion about it is concentrating merely on the institution.

Dr I. A. Listwan, Psychiatrist and a member of the Mental Health Tribunal

I feel a stranger in discovering that no mention was made about mental health tribunals. We are very frequently called upon to dispose of the dead bodies left by the magisterial enquiry, and I feel that we acquire over the years a fair knowledge of what is going on in the magisterial enquiry.

I am against legal representation at the magisterial enquiry unless it is specifically requested by the patient or his family, and that is extremely rare. The reasons that it is not necessary are:

Firstly, I do not think that a five-minute enquiry by a magistrate is more than a farce, with all respects to the magistrates concerned. Why is it that in all common law courts a case goes on and on, I am called and sent home, called again and sent home, and then deferred for several days and possibly months, and yet a magistrate is so powerful and omnipotent that he can decide in five minutes? This worries the defenders of civil liberties and it worries the families because they know that another 25 cases are disposed of in an hour.

Secondly, the magistrates invariably make the patient a "temporary" patient for six months. Why is this? Because there is a loophole in the law that if you make it for two months the patient is later suspended in the air. What happens after two months if he is still sick? The Mental Health Tribunal cannot see him before six months so either he has to be re-certified and go again through the pain of magisterial enquiry or he has to be released because the magistrate thought that two months is enough.

I would suggest you come with me through the journey that a poor weakling on admission to hospital goes before he reaches the magistrate. Firstly, a friendly neighbour says that the woman next door is bizarre, then a friendly husband agrees and he calls a friendly doctor who signs a friendly form, then two friendly ambulance men arrive, they cannot cope with the case so they call in a friendly policeman (already six or seven people are involved). This friendly policeman takes the patient to a hospital and she is received by a friendly attendant and staff, then she is put to bed, under heavy sedation of course, and then the next day she is seen by two friendly psychiatrists and later she is seen again by the friendly magistrate. Why do we need the friendly lawyer as well?

My suggestion is that the Act should be amended to give the poor devil psychiatrist a chance to treat this patient for a month or two. Nothing will happen to his estate, there will be no damage done, but allow the patient to be treated and call in the magistrate only two months later. That will solve a lot of problems.

The Act should be further amended to allow the magistrate to have the power to commit the patient (he has the power but he never uses it) for one, two, three or four months, and the Mental Health Tribunal could then come in after one, two, three or four months.

I have been called to magisterial enquiries as a private psychiatrist. It should be in a dignified atmosphere, in a specially prepared room, but it could be informal. When it happens after two months it should have "teeth", the magistrate should have the right to call witnesses and swear them in, to call the family on more specified reasons and not just notify them that the enquiry will be on. The time allowed should be as much as the magistrate wants and there should be a stenographer who should take

the transcript. In our Mental Health Tribunal my legal colleague kindly took over the work of the stenographer and we have very good reports of every determination, which we can justify because we braced ourselves against litigation. In this State there has been no litigation yet but it may happen anytime, and I am curious to know what a poor magistrate will say if he will be sued and will have to defend his case when he did not put anything in writing.

Again with migrants at an enquiry there is never an interpreter present. We just stumble along, and cannot discover what is wrong with them, the family cannot be seen. We know a number of migrants are mentally ill because of social and cultural deprivation in their lives.

Mrs Jo Melville, Probation and Parole Service

My work is involved with Life Sentence Prisoners and Governor's Pleasure Detainees.

Thinking in terms of those people who have sometimes never been to a mental institution since they have received their Governor's Pleasure Order and those who have been in a mental institution but have been declared fit and well and have been returned to the prison, I am wondering whether they should not come under this same umbrella and have legal representation when their case is put before the Parole Board for a recommendation to the Minister. Each year, in some cases, the same psychiatrists give the same recommendation and the onus rests upon a person's name rather than a Tribunal. These reports then go forward to the Board and here again I wonder whether legal representation should be considered for these people.

G. D. Woods

I must say that I agree with the amusing comments of Dr Listwan about a number of matters: the difficulties that migrants have in mental hospitals, the difficulties that confronted him as a member of the Tribunal attempting to do a job in adverse circumstances, and so on.

But I found his comments about the "friendly" ambulance officer and the "friendly" husband and the "friendly" psychiatrist rather odd. At first I thought he was being ironic when he cited that list of "friendly" people, because it struck me that in almost all of those cases the people he referred to may be precisely those who would have a motive in many cases for being unfriendly. There is an element of bias in the kind of situation he described – one can hardly suggest that people like the "friendly" ambulance man, the "friendly" husband or wife, the "friendly" neighbour, are independent persons who are able because of their position to state a clear case against the proposition that one ought to be incarcerated involuntarily. And yet it seems to me that this is what the lawyer can do.

My subsequent impression then was that Dr Listwan was being quite serious when he referred to his list of "friendly" people, meaning that their presence and efforts would obviate the need for legal representation.

I teach a course on criminal law, and starting lectures last week I felt obliged to point out to my students that, apart from the 3 500 people who are detained involuntarily in prisons, there is another incarcerative system in operation in New South Wales (of which they will hear very little at the Law School) where over 2 000 people are detained involuntarily – the mental health system.

I do not believe for a second that legalism is the whole answer to the problems of the mental hospital. It is certainly not the whole answer. It is but one small step towards achieving justice for mental patients. I do not subscribe to the view that simply because there are a lot of lawyers out of work at the moment they all ought to be given jobs in the mental hospitals protecting the mentally ill from being locked up. As Dr Barclay pointed out the system we have of mental health is very complex. The practical problems that confront those in it every day are very difficult. They impinge on administrators very heavily – note Dr Edward's anguished cry about the 10 per cent funds cut. One can see that this is a matter which has concerned him very greatly.

Yet it seems to me very important to recognize that the mental hospital is part of the total community, as Dr Scott-Orr said. I wouldn't recognize that his particular approach to it is wholly correct. The Mental Health Review Committee rejected his basic contention that powers of involuntary treatment ought to be devolved from the mental hospitals out into the community. That was rejected but nonetheless the mental hospital is part of the community.

Lawyers and doctors generally qualify as being among the upper third of the community in financial terms. We do not know the pressures that the working class face. It always strikes me as a good test on a particular social issue to ask: "Would people who are middle class let this happen to members of their family, or would they seek some alternative?". The wealthier sections of the community make alternative arrangements for special treatment and private hospitals when people in their families go crazy.

The sense of outrage that was generated by Mr Boehringer and Miss O'Shane in relation to their experience in mental hospitals seems to me to be entirely genuine. When one goes around the hospitals one gets the feeling, especially in relation to the legal representation issue, that simple justice is not being done: that it is totally inadequate to have a five-minute determination of a matter which is of crucial important to somebody. It is true that people go to these hospitals and they return to the community. It is true, as Dr Barclay said, that there is no great conspiracy in the mental hospitals seeking to draw people in, like some monstrous Dickensian institution which is making money out of the agonies of the oppressed classes. That is not true. The system does not work like that. The injustices

that exist in the mental health system are not intentional. They are the result of apathy on the part of people who are in the system and of the people who do not have access to the system. I do not think that legal representation is the answer to the problem. As I said in my comments, the problem of our neglect of old people (who constitute a large component of mental hospitals) represents a general social problem which can not be solved by having legal operatives in hospitals defending people against being admitted. The problem of alcoholism cannot be solved by having legal representation in hospitals! That is a problem of drug pushing and as a few parliamentary reports have recently pointed out (to their credit) it is not just a question of the young wicked people taking "pot": it is a question of older people drinking alcohol to excess and becoming a liability on the State.

Now in all these things I am sure that economic pressures are a major factor. I would like to see dramatic changes in society with which probably most of you would not agree but they are not going to happen tomorrow. Tomorrow I would like to see legal representation in mental hospitals because it would be one small step along the way to achieving social justice for this particularly oppressed and neglected group of people.

Paul Stein, Deputy Ombudsman

The title of this seminar is "Rights of the Mentally Ill", and because of the nature of the paper it has necessarily centered upon the possibility of legal representation of patients at magisterial hearings under the *Mental Health Act.* There is another means of review or appeal that is available against all public mental hospitals and their staff, from superintendent downwards and, I believe, including the magistrates who perform administrative tasks at these hearings, and that is the N.S.W. Ombudsman.

It seems to me that it is a very little known fact, because we have never received a complaint from a patient or an ex-patient of a State mental hospital. We do, from time to time, get a number of complaints from other public hospitals, from patients, ex-patients and from their relatives which we investigate. The point I want to make is that the Ombusman has quite sweeping powers of investigation. He has only persuasive powers of reversing a decision, but so far as the investigation is concerned we have virtually all the powers of a Royal Commission. It may be that in the future we will start to receive some complaints from patients or ex-patients about maladministration in State mental hospitals. You have only to look at the *Ombusman Act* to see the definition of wrong administrative conduct which covers matters such as unreasonable conduct, unjust conduct, conduct that is improperly discriminatory, conduct that arises from a mistake of fact or of law and, importantly for people incarcerated in mental hospitals, conduct for which reasons ought to have been given but have not.

Barbara Ovens, Chairman, Citizens Commission on Human Rights

I would like to thank Mr Stein, he will certainly be getting some submissions very shortly from patients.

We deal with those people who come out of mental institutions, disillusioned, upset, worried and not knowing where to turn. We are a group of individuals whose basic ideal is to fight for the media coverage and the uncoverage of any abuses. Especially in the field of psychiatric endeavour, and I stress psychiatric endeavour, because I feel we are losing sight of one very important fact – patients are taken into mental institutions and psychiatrists have the right to experiment upon them or at least treat them while they are still involuntary patients before they have been taken before a magistrate and made a ward of the State. A prisoner in a prison has more rights than a mental patient. Mental patients are, as Mr Woods said, the most depressed people in this world, especially in this State. They do not have the basic rights as set out in the United Nations documentation on freedom of human rights.

We lose sight of one thing; before a patient is taken before a magistrate he can be injected with drugs that are totally banned on the market. If a person was found with them on him, it would be a completely punishable offence by law. Often, I have documented case after case of people who have come out of mental institutions addicted to the drugs that they were given to take them off addictive drugs. This sort of thing can happen. When the Citizens Commission on Human Rights in Melbourne invited a number of psychiatrists to publicly have E.C.T. treatment since it was so "harmless" we did not hear anything further. E.C.T. is not harmless, unless of course you do not care if you lose some of your memory. To me my memory of my life is the most vital and important thing I have, and we are flippantly taking this away from mental patients because they are "mental patients", and yet we have not had a magistrate, we have not had a lawyer, or anyone prove that this person is a mental patient. I simply ask that mental patients have the same right as criminals, in that nothing happens to a criminal until he has been proven guilty and convicted. Even then he is not likely to be humiliated, abused, beaten or any of the other things that we have patients complaining to us about.

Give the mental patients the same rights at least as a convicted criminal. Do not call them *mental* patients. Maybe they are having problems in living. Have you ever had any problems in living?

Dr G. A. Edwards

I think many of the comments have diverged from what we were hoping to get some opinion about, i.e. the questions of patient representation, legal and otherwise, and its advantages and disadvantages. Some have been concerned with further changes to the statute. The Commission now has an extensive review of this legislation. We

recommended that this patient representation project be established in order to explore non-statutory ways of trying to safeguard and protect patients' rights in hospitals.

By focusing on the need to change and introduce more detail into the statute, one reverts to eventually creating the previous *Lunacy Act* which was full of an enormous range of details protecting all sort of rights and the requirements of officials; in many ways a traditional lawyer's delight, which certainly did no good for the mentally ill in this State during its years.

The current *Mental Health Act* went towards more medical treatment and more informal orientation, although much less than the current British *Mental Health Act* which does not even have magistrates. What there needs to be is to have as informal a system as is possible for people who do not object to treatment, but to provide the safeguards to ensure that only the seriously mentally ill who need to be cared for for their own protection or the protection of others are admitted.

I feel I must make some comment about medical ideologies and ideological perspectives. I have certainly heard a great deal of discussion about that during the committee over the last twelve months, but I see little point in exchanging a certain sort of medical or psychological psychiatric viewpoint for one, say that looks only at the narrow perspective of class struggle. There is scope for many different viewpoints in this matter and many can be complementary.

Patients' rights will only improve while staffing levels and finance levels for the services are adequate as well as some obviously proper statutory safeguards plus the exploration of other alternative approaches such as this patient representation project (which was not just a legal representation project). Making sure the patients have proper rights of legal due process is one aspect but other areas such as a proper information service are also important. During the project I realised how beneficial to the patients was the work of the non-legal advocates in ensuring that patients knew what the hearing was about, and what was involved as well as looking after many of their general arrangements for after care to complement the often limited and restricted resources of the hospital.

Thomas J. Kelly, Solicitor

Mrs Melville raised the issue of Govenor Pleasure Prisoners who are also mentally ill or have been. They are dealt with by the Parole Board which makes a recommendation. If one looks at the last reports of the Parole Board and divides the number of meetings of the Parole Board with the number of prisoners dealt with it will be seen that approximately 107 prisoners are dealt with at each afternoon meeting by the Parole Board. This makes the five minutes of the magistrates at the Mental Hospitals seem quite a long time indeed.

No one seems to have taken the point of District Court appeals into account. Except for small debts claims I think this is the only jurisdiction of the magistrates that is not subject to an appeal to a District Court judge. I realize that it is important that any such appeal be dealt with very quickly, but I would also point out that there is always a District Court judge hearing appeals and I would imagine it would not be too difficult to give these ones priority and fit them in.

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