# Involuntary Admission to Mental Hospitals: Justifications, Procedures and Limitations

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CONTENTS

ABSTRACT

The law relating to the involuntary admission to and detention in mental hospital of persons defined as "mentally ill" has been the subject of considerable controversy in New South Wales in the 1960s and 1970s.

It is pointed out in this study that criticism of involuntary admission procedures is of two types: first, criticism premised on the assumption that involuntary admission is fundamentally unjustifiable and ought to be abolished; second, criticism based on acceptance of the proposition that in some circumstances involuntary admission on the ground of mental illness is justifiable, but that it ought to be subject to certain procedural limitations or other conditions.

In Part 1 the major arguments commonly put forward in favour of the abolition of involuntary admission and detention are considered in turn. It is concluded that, although some of these are weighty, they do not overall and on balance prove the abolitionist case.

In Part 2 it is argued that, although excessive legalism in the involuntary admission process is to be avoided, certain basic requirements are necessary. In particular, the grounds for involuntary process should exclude mere behavioural eccentricity or religious or political behaviour. The sanction of involuntary procedures should not be used for mere social control.

It is argued that fairly tight restrictions should be placed on the grounds of "protection of self" and "protection of others" as bases for involuntary process.

It is suggested that the justifiability of involuntary procedures is strictly dependent upon the recognition of the entitlement of patients not to be subjected without full and informed consent - or other appropriate procedures - to the imposition of dangerous or hazardous treatments: in particular, electroconvulsive shock treatment or psychosurgery.

It is argued that legislative change by way of mere alteration of legal formulae will be inadequate to reform the involuntary admission and detention process unless there is also introduced a proper system for on-the-spot advocacy of patients' rights. Such an advocacy system might be by way of legal (or possibly lay) representation in judicial hearings and generally in and about the mental hospital.

## A NOTE ON BACKGROUND AND SOURCES

In his Lives of the English Poets, Dr Johnson said of Pope's "The Rape of the Lock" that in it "...new things are made familiar and familiar things are made new." (Bronson, 1958, 394)

In the field of mental illness and the law much has been written and much more said. This thesis inevitably traverses a great deal of material with which the reader will be familiar, and indeed it may be thought that the line of argument briefly indicated in the preceding Abstract is hardly revolutionary. Nonetheless it is hoped that at the very least the presentation and treatment is such that "...familiar things are made new."

It might have been possible on this subject to have developed an argument of startling originality by proposing, for example, that involuntary admission and detention should only be directed against red-headed men; or by arguing for compulsory sterilization of people who occasionally become depressed. Instead the writer has navigated what might be thought to be a fairly predictable course between the Scylla of medical licence and the Charybdis of "overjudicialisation."

Despite the fact that the conclusions reached are by no means extraordinary, the various strands of argument presented and indeed the totality of the research and writing involved in the thesis are the original and sole work of the candidate.

Three aspects of the background to this thesis must be mentioned:

Firstly, the writer is a practising barrister and, quite apart from university work on mental illness and the law, has appeared frequently as counsel in section 12 inquiries under the NSW Mental Health Act, 1958. These are inquiries held by a Stipendiary Magistrate for the purpose of determining whether a person said to be mentally ill should or should not be involuntarily detained. New South Wales is the only jurisdiction in Australia in which any such hearing is held automatically in respect of every patient whose involuntary admission is sought.

The opinions expressed in this thesis are inevitably to some extent based upon this experience, and on the writer's observations and impressions of involuntary hospitalisation gained during many visits to mental hospitals. The writer's experience of mental hospitals relates mainly to New South Wales institutions, but there have also been visits to hospitals in South Australia, Queensland, Victoria and England.

Secondly, the writer has drawn upon the standard professional legal and medical journals and books available up to 1st October, 1979, as well as upon a miscellany of materials from other disciplines. Although the legal system around which most of the argument and analysis is constructed is that of New South Wales, the bulk of relevant published

material in this area is in American law journals. (A great deal of this is somewhat repetitive.) What little Australian material has been published on the subject has been referred to, where relevant. Comparison is made at certain points with English law, practice and research material, and with statutory provisions relating to other Australian states.

Thirdly, the writer has been actively involved in the preparation of legislation to amend the NSW Mental Health Act, 1958. In 1972 the writer was appointed by the Health Commission of NSW as a member of the Mental Health Act Review Committee, chaired by Dr G.A. Edwards, then Superintendent of Parramatta Psychiatric Centre. The other members were Dr E.P. Houston, Medical Superintendent of Long Bay Prison Complex, Dr W.E. Lucas, Senior Lecturer in Forensic Psychiatry at Sydney University, and Mr S.S.W. Davis, Lecturer in Law, School of Health Administration, University of NSW.

The brief given to the Mental Health Act Review Committee was to make proposals for the reform of the personal (as distinct from the property) provisions of the Act.

This writer took a very active part in the deliberations of the Edwards Committee. An interim report was presented in 1975 and a final report (not significantly different) in 1976. The interim report was the subject of a seminar conducted by the Sydney University Institute of Criminology on 13th February, 1975, and is published in 1975 Proceedings of the Institute of Criminology, Number 22. (For the sake of convenience, this

document is referred to hereafter as the Edwards Report, or Edwards et al., 1975.)

Apart from taking an active part in the deliberations of the Committee concerning matters of policy, this writer alone performed the task of drafting the precise wording of the proposed amendments to the statute as for a Bill.

Because the Act deals mainly with involuntary admission, issues concerning that subject occupied a substantial part of the Committee's time. Understandably enough, no effort was wasted in considering whether or not it might be recommended to the Health Commission and the Government that involuntary admission be abolished. That was simply not a political option. The only argument could be as to the terms of what amendments might be suggested.

Quite independently of the activities of the Review Committee, this writer was stimulated to consider, from an academic viewpoint, the fundamental philosophical issue of whether involuntary admission and detention on the ground of mental illness is justifiable, or whether the arguments of radical abolitionists such as Dr Thomas Szasz really ought to carry the day. This thesis is the product of the writer's deliberations on this issue.

Inevitably, reference is made at a number of points to the Edwards Report, but it is emphasised that this writer's views and opinions herein expressed are separate and distinct

from any joint deliberations undertaken or recommendations proposed by the Edwards Committee. For example, this writer's views on enforced treatment vary markedly from those expressed by the Committee in 1975 and 1976. Further, the Report does not touch at all upon the matters dealt with in Part 1 of this thesis under the heading "Justifications". Conversely, the "Procedures and Limitations" dealt with in Part 2 of the thesis are limited to those matters which the writer regards as the fundamental and non-negotiable requirements of a system of involuntary admission. Many otherwise important matters (such as discharge, leave, community care and so on) which were mentioned in the Edwards Report are not dealt with here.

# CHAPTER 1
# INTRODUCTION

When citizens are incarcerated by process of law, more than merely technical legal issues are involved. The exercise of any legal power is in the broad sense a political matter and hence the involuntary admission of persons to mental hospitals, and their enforced detention and treatment there, demand from time to time fundamental policy debate.

The necessity for the widest possible perspective on this subject is emphasised because there is a tendency for it to be regarded as a purely medical issue, or a purely legal issue; or possibly (in the vein of compromise) as a medico-legal issue. Such analysis is too restrictive. Highly germane matters such as (for example) the politics of public housing, the role of old people in society and the concepts of "nuclear" and "extended" families, are scarcely dealt with at all in the purely medico-legal dialogue on involuntary admission.

In order to discuss sensibly the question of whether involuntary admission is justifiable, or whether it ought to be abolished, it is necessary to clarify certain assumptions about the kind of society in which the question can reasonably be asked.

Firstly, the question would be irrelevant in a society where, by virtue of there being a predominantly village culture, there were no mental hospitals as we know them.

Nuigini and Indonesia are important countries close to Australia where this would be true for most of the population.

Secondly, the question would be irrelevant in a society which was, although perhaps industrialised, based on a social system where family problems were dealt with entirely in the family; that is, an extended family system where problems of ageing, personal maladjustment or bizzare behaviour were coped with in some manner inside the family itself without reference to external authority.

Thirdly, the question would be irrelevant in a society which had no mental illness, or where whatever we understand to be mental illness were perceived as something else. This writer is not persuaded that there are or ever have been societies without any of the kinds of mental conditions or behaviours which we define as "mental illness". But certainly there have been and are - traditional Australian aboriginal society being one of them - cultures where the conditions we call mental illnesses were or are regarded as being something quite different. The deeply religious traditional Australian Aborigines, with their multiplicities of spirits, no doubt explained much of what we regard as mental illness as some manifestation of spirituality, just as mediaeval European Christians sometimes regarded schizophrenic episodes as "possession" by the devil.

In short, where "mental illness" is regarded as something other than the psychological disorder or disease we generally see it as, the whole perspective on the phenomenon is different. The appropriate response might be seen as being to attempt to placate the gods, or to venerate (or alternatively to destroy) the individual affected. Death at the stake would not these days in Australia be regarded as an appropriate prescription in pursuance of a diagnosis of mental illness: but it should not be forgotten that there have been times and cultures in which it was a common occurrence. (Jones, 1955, 3.)

The point is that the fundamental political, cultural, medical and religious forces in a given society will always profoundly effect - indeed determine - the manner in which mentally ill persons are treated. For this reason it is necessary to attempt to identify some of the relevant currents and forces in contemporary Australia which set a context for the issue under consideration to be addressed.

## Some History and Politics

In the nineteenth century there developed a fashion for the building of large, rurally or semi-rurally located institutions for the care and treatment of the mentally ill. Such asylums, as they became known, were closed and restrictive, even though their rustic placement was predicated on the theory that greenery or water views might sooth the fevered brows of inmates.

It is likely that this fashion originated partly as a response to the disordered conditions in cities caused by the helter-skelter industrialization of the nineteenth century. The swollen populations of cities such as Paris, Birmingham, London and New York were the result of immigration either from the country or from overseas. Old patterns of social control broke down. For the poorer classes, housing was cramped; for the children of the poor, the open street was the school. State run asylums - large in size for reasons of economy - were the social reformer's answer to the problem of mental illness just as large and publicly funded school systems were the answer to the problem of children on the streets.

In Australia, this fashion was followed. Between 1788 and 1838, mental invalids were treated very much in an ad hoc manner; many spent time in gaols. In 1811 Governor Macquarie established a small asylum at Castle Hill (about 25 miles from Sydney) but this was closed in 1825. In 1838 the Tarban Creek Asylum - a large institution still in existence as Gladesville Hospital - was opened (Edwards, 1978, 81). Procedures for admission into this asylum - and the others that were subsequently established - were easier than procedures for discharge. The resulting substantial length of stay in mental hospitals was a major characteristic of treatment of the mentally ill right through the nineteenth century and indeed up until after the Second World War.

As Krupinski and Stoller point out (Krupinski and Stoller, 1975), there was a dramatic reduction in the length of stay in

mental hospitals in Victoria between 1919 and 1962 (although an equally clear increase in readmissions in recent years). Undoubtedly the principal cause of these changes - which were nationwide - was the development of very effective tranquillising and anti-depressant drugs in the 1950s.

Gregory Zilboorg, a leading writer on the history of psychiatry, has identified the first "psychiatric revolution" as having occurred in the sixteenth century (Zilboorg, 1941). This "revolution" was the dawning of understanding that mental illness was something other than the possession of the individual by the devil, or forces of evil. Of course diabolism in relation to mental illness did not die out immediately, as witness the Salem witch-hunts portrayed dramatically by Arthur Miller in "The Crucible"; indeed even today certain of the less respectable clergy perform the rite of exorcism. Nonetheless, as Zilboorg says, the "first revolution" in psychiatry was of great historical moment.

Of no less historical moment to the victims of mental illness was the development and promulgation in the 1950s of highly effective and cheap drugs which in many instances cured, and in many more made manageable, the symptoms of schizophrenia and the affective psychoses. This indeed amounted to a "revolution" in the treatment of the mentally ill as significant as the abandonment of theories of diabolical possession.

The appalling conditions in asylums before the modern era have been illustrated by Sargent, describing his own experience at a London institution in the 1930s (Sargent, 1967, 34):

> "...either I would find the patients semi-poisoned and doped with bromides or else I might be immediately surrounded by a crowd of patients, dragging at my clothes and jealously hitting out at each other, the nurses doing their best to calm the pandemonium. At the end of the worst wards stretched a row of single cells. There was one whose occupant, a woman, had not, it was said, emerged voluntarily for seven years. She often stood waiting for my visit with a large chamber pot in her hand ready to empty it over me as soon as the door opened. Other cells contained patients whose temper was periodically so uncertain that the nurse would unlock the door, push in a tin of food and then quickly lock up again."

So far as patient care was concerned, Sargent said that (Sargent, 1967, 24):

> "Every few months at first, later every few years, we had to do examinations or sign certificates to the effect that a particular patient was still of unsound mind and must be detained. Many of these latter were written at the suggested dictation of the male or female ward nurse, because the doctor might know intimately so few of the patients. Four or five hundred were theoretically under his care, but he might not see the long-confined inmates from one year's end to another..."

These zoo-like conditions prevailed not only in England of the 1930s, but also across America and in Australia. This writer has spoken with a number of elderly nursing staff at, and retired from, Sydney mental hospitals, who confirm that the impression conveyed by Sargent might well have been drawn from a large Australian state asylum of the same era.

The medications which calmed the bedlam in asylums and transformed them during the 1950s and 1960s from places of noise and torment, were tranquillizers such as chlorpromazine and meprobamate, and anti-depressants such as imipramine and the monoamineoxidase inhibitors.

But have the possible theoretical benefits of the so-called "drug revolution" actually been used to the advantage of patients? Or to their disadvantage?

One of the most significant characteristics of Australian society as we enter the 1980s is intense social friction concerning the distribution of wealth, and in particular, argument as to the quantum of funds which ought to be available to governments for expenditure on public welfare. The decade 1970 to 1979 may be seen, historically, as neatly divided. Up to 1975, the energy and enthusiasm of the Labor Federal Government under Whitlam for substantial and increasing expenditure on public welfare provided an atmosphere - and indeed a financial environment - in which public and state supported hospitals could survive, and in some ways prosper.

After 1975, the enthusiasm of the Fraser conservative government for a reduced level of governmental spending on public welfare - including hospitals - reflected a changed political atmosphere of uncertainty precipitated by the Arab-Israeli War of 1973, consequential oil price rises and widespread simultaneous inflation and recession throughout the western world, including Australia.

It is not clear whether the 1980s will see in Australia a continuation of a generally conservative public attitude towards central governmental spending, or whether massively increased unemployment brought about by a combination of dislocation over energy resources and new technology and trade patterns will provoke a return to a centre-left emphasis on the necessity for planning and substantial governmental intervention and spending in the public interest.

So far as public mental hospitals are concerned, there is one blunt and undeniable reality: if they are not adequately funded, their physical and professional facilities can fall to a standard so appalling that their very existence is an affront to the civilised conscience.

This writer takes it to be absolutely axiomatic and fundamental that involuntary admission to and detention in a mental hospital cannot be justified if the basic standards of housing, food or medical care and management fall below an acceptable civilised minimum. If food is inadequate and patients starve or are malnourished; if rooms are overcrowded

and bedding filthy; if nursing staff are brutal and physically violent; if medical staff are ill-trained, chronically negligent or simply inadequate in numbers; then it must follow automatically that more sophisticated objections in principle to involuntary admission - e.g., inaccuracy in psychiatric diagnosis, and difficulties of predicting dangerousness - do not even arise for consideration. We might just as well, in such a situation, leave the mentally ill to fend for themselves in the parks and streets, in prisons, in Skid Rows, in doss-houses and in the hands of inadequate, uncaring or brutal relatives. There can be no sense or justification in the state substituting an enforced regime of neglect and inhumanity in place of a fate of neglect and inhumanity which may fall to the mentally ill in the general community.

Lest this first and fundamental principle be thought to be somewhat academic, it should be remembered that as recently as 1961 there was a Royal Commission of Inquiry into conditions at Callan Park Mental Hospital in Sydney, which revealed gross deficiencies in conditions. The Commissioner, Mr Justice J.H. McClemens, said of the hospital that (McClemens, 1961, 9, 10, 15):

> "Its most serious problem is overcrowding. This leads to unsatisfactory living conditions, unsatisfactory administration - doctor-nurse patient relationships, inadequacy of treatment standards..."

He also referred to

"...overcrowding...mass herding of patients, lack of privacy and unsatisfactory food service..."

He said that:

"There have been a number of acts of cruelty within the five years before the setting up of this Commission."

"Lack of finance over many years has led to gross overcrowding of Callan Park and, in turn, to deterioration of treatment standards, standards of comfort and to demoralisation..."

In 1868 Dr Norton Manning, a notable New South Wales medical administrator and psychiatrist of the nineteenth century, wrote in a report on asylums (in relation to the Parramatta Lunatic Asylum) that (Edwards, undated, 5(f).):

"I have not seen anything so unsatisfactory and so saddening as at Parramatta - except at Cairo...As to the general fitness of the Parramatta Asylum for the insane, I believe it to be as a whole, the worst in Christendom."

Such blunt condemnation might be understood and even possibly explained away in terms of the economic, social and medical problems of the nineteenth century. But what explanation can we proffer in answer to McClemen's equally

clear (albeit somewhat less florid) condemnation of a major Sydney public hospital almost a century later, in a time of peace and economic prosperity, under a state Labor government supposedly concerned to promote the public welfare, and at a time when the major new tranquillizing and anti-depressant drugs had become available?

The explanation is surely that, despite what economic, social and medical advances may have been made during the last century, the maintenance of high standards in public mental health institutions is not automatically a constant priority of governments. At the very least, a combination of public apathy about the mentally ill and governmental reluctance or inability adequately to fund mental hospitals may from time to time - or even chronically - depress the quality of accommodation and care below what this writer at least would describe as acceptable civilised standards.

This thesis in no way represents an attempt at a judgment, based on empirical observation, of the contemporary standards of care in NSW mental hospitals. The writer has in fact noted that standards of care do seem to be at or above "acceptable civilised" levels: but that is not an observation based on anything like a comprehensive analysis; and in any event it is not necessary to the argument.

The point is that it is always seriously <u>possible</u>, given the historical evidence, that standards of basic care might fall below acceptable levels. We might be in for a decade of

such fiscal conservatism and parsimony that all social welfare services bar those for the vociferous and well organised - a category into which the mentally ill in general most definitely do not fit - become appallingly defective and inadequate.

If such a state of affairs were to eventuate - and it is of course only one of various possibilities - then the use of legal (and physical) compulsion against the mentally ill could not be in any way justified. Those seeking to justify involuntary admission could not, as the Americans say, get to first base. It is morally and philosophically repugnant to argue for enforced care when that care will be at an unacceptably low standard.

The bulk of this thesis is based on the premise that the institutions to which the mentally ill may be involuntarily admitted are minimally clean, safe, spacious and comfortable; that there will be a sufficiency of appropriate and nutritious food; and that there will be caring and concerned nursing and medical staff, trained to at least minimally adequate levels of knowledge and efficiency.

Is it unrealistic to expect or demand such standards? Is it possible that to do so can produce a converse problem?

## The Politics of "Deinstitutionalization"

In recent times the political issue concerning standards of care for the mentally ill has manifested itself in debate over "deinstitutionalization". There is a school of thought to the effect that while modern methods of drug treatment have

permitted a dramatic improvement in the atmosphere inside mental hospitals, and a decrease in their inpatient populations, this latter trend has gone too far - modern policies have in effect amounted to abandonment of the mentally ill.

In 1967, the legislature of California passed the Lanterman-Petris-Short Act, severely restricting the scope for involuntary admission to mental hospitals. This Act (which came into effect in 1969) was indicative of a trend in the USA through the 1960s and 1970s towards a greater legislative recognition of the civil liberties of the mentally ill.

In a ferocious attack on the effects of the legislation, Barton has written (Barton, 1975, 216) that:

> "In California, a combination of pretension and propaganda conned gullible and superstitious legislators into closing down state hospitals so that some 30,000 patients were abandoned to a life of aimless destitution, wandering from derelict hotel to flophouse, from flophouse to park bench and from park bench to prison. Many of these ex-patients became half-starved (cat food was a luxury), sexually abused, brutalized, physically neglected and verminous; at the mercy of petty thieves and thugs, spending their time in the unsupervised company of winos, drug addicts and prostitutes; many died and some were murdered. All but the very worst conditions in the state mental hospitals were better than the neglect and misery that awaited them in the community."

Bitter and possibly exaggerated as it is, this statement contains more than a grain of truth. What appears to have happened in California is that the cause of protecting civil liberties has been used for the purpose of saving tax dollars. The point overlooked by ~~Robson~~ Barton and other critics of the Californian Act is that it would be perfectly possible both to provide adequate and proper facilities for the majority of the mentally ill - i.e., the voluntary or informal patients - and to protect the civil rights of the relatively small number of involuntary patients.

What appears possibly to have happened in California is a coincidence of two distinct trends; one, a materialistic and ungenerous sentiment among an uncaring majority of the population against spending money on public welfare, and in favour of spending it on themselves; and a trend, admirable in itself and based largely on the Bill of Rights in the American Constitution, of concern for legal freedoms and entitlements narrowly defined.

In this writer's view it is very important that these matters be kept separate and distinct. A generous concern for civil liberties does not of itself necessarily imply uncaring disregard for the actual day to day destinies of people with problems of mental illness, however much the recent coincidence in America of these things might make it appear that there is a causal connection.

On the contrary, it is submitted, a proper policy in relation to mental illness demands both that the state provide adequate and proper facilities for inpatient and community care, on a voluntary basis, for those who need it; and that it legislate, to protect the minority of those who need involuntary care, against abuse of their civil or legal rights.

The failure of American policy in this area in recent decades has been pointedly analyzed by Bassuk and Gerson (Bassuk and Gerson, 1978). They point out that between 1940 and 1975 the number of patient days spent in mental hospitals per 1000 of US population has decreased by 65%. At the same time, however, the rate of admissions has increased by 129% They say (p. 49):

> "That trend reflects a new philosophy of short term hospitalization. Moreover, a growing proportion of the admissions were readmissions (in 1972, 64 per cent of them); about half of the released inpatients are readmitted within a year of discharge. Those statistics must surely reflect the lack of a fully effective community based support system...between half and three fourths of the readmissions could have been avoided if comprehensive community facilities had existed. And generally they do not exist."

Bassuk and Gerson describe (p. 50) a pattern (which is sometimes referred to in Australia as the "revolving door" policy) in the following terms:

"Time and time again we see patients who were released from state hospitals after months or years of custodial care; who then survived precariously on welfare payments for a few months on the fringe of the community, perhaps attending a clinic to receive medication or intermittent counseling; who voluntarily returned to hospital or were recommitted...; who were maintained in the hospital on an antipsychotic medication and seemed to improve; who were released again to an isolated "community" life and who, having again become unbearably despondent, disorganized or violent, either present themselves at the emergency room or are brought to it by a police officer. The cycle begins anew."

They point out that the failure to establish proper community care facilities pushes former patients into "nonpsychiatrically oriented facilities", in particular, nursing homes. Precisely this phenomenon has occurred in New South Wales (Reynolds and Fleming, 1973; cited by Watson and Owen, 72):

"Nursing homes have been used for purposes of political and economic expediency by the NSW Government. Psychiatric patients have been moved en masse out of the state's psychiatric hospitals into nursing homes. There seems to have been little consideration given to the effect on the psychiatric patients themselves. Further, this policy has enabled a number of sub-standard nursing homes to remain in operation which would otherwise have been forced to close."

As Watson and Owen say (p. 72):

> "...the filling of nursing home beds with ex-psychiatric patients has the effect of once again decreasing the available accommodation for the frail aged in the community..."

So, indeed, the provision of services for the mentally ill is a highly complex matter, and each element of the whole interacts with and relates to others.

This writer would prefer to see established a health care system in which the element of private gain was completely eliminated. This could only occur, however, in a political system less materialistic than currently exists in either Australian or America. Bassuk and Gerson (1978,50) say that many discharged patients

> "drift to substandard inner-city housing that is overcrowded, unsafe, dirty and isolated. Often they come together to form a new kind of ghetto subpopulation, a captive market for unscrupulous landlords."

This phenomenon also has its equivalent in Australia; certainly in NSW.

For the purposes of this thesis it is not necessary to attempt to delineate a comprehensive plan for the solution of all of the problems of mental hospitals. But it needs to be recognized that modifications to the law for the purpose of

protecting the civil rights of the minority of involuntary patients will be in effect negated if the whole mental health care system is inadequately financed, or if a proper relationship is not maintained between central institutions, community care centres and institutions such as nursing homes.

The admirable aim of protecting the mentally ill from their own dangerous behaviour, or - in a few cases - protecting the community from dangerous behaviour by the mentally ill, can in part be fulfilled, this writer believes, by a properly limited system of involuntary detention and treatment. But if the mental health care system as a whole is characterised by neglect and confusion, if financing is inadequate and administration weak, then even the most elegantly drafted statutory protections will be irrelevant.

## The Legislative Context

Aspects of the history of legislation in New South Wales relating to the involuntary admission and detention of the mentally ill have been dealt with by McClemens and Bennett (McClemens and Bennett, 1962) and - from a medical viewpoint - by Edwards (Edwards, 1978).

It is sufficient for present purposes to say that the current NSW Mental Health Act of 1958 was the legislative manifestation of the drug treatment revolution which had occurred over approximately the previous decade.

The two most important features of the 1958 Act were, first, wider scope for voluntary admission; and second, provision for the initiation of involuntary admission procedures on the certificate of a single medical practitioner. These two changes profoundly altered the character of the mental hospital system.

Like the English and Victorian Mental Health Acts of 1959, the NSW statute represented a turning away from rigid legal controls towards reliance on medical discretion. Certainly the NSW Lunacy Act of 1898, which the 1958 statute supplanted, was heavily legalistic. Referring to the English Lucacy Act of 1890 (which was the source of most subsequent Australian legislation), Jones wrote (Jones, 1960, 40, 93):

> "The very length of this Act singles it out from all previous attempts at lunacy legislation, and it bears the heavy impress of the legal mind. Every safeguard which could possibly be devised against illegal confinement is there...Asylums could only take certified patients; and patients could not be certified unless the illness reached a stage where it was obvious to a lay authority - the justice of the peace."

In this latter regard the NSW statute of 1958 retained one element of legalism which the Victorians and the English forewent in 1959: it is still necessary in NSW that the admission of the involuntary patient be ratified by a Justice of the Peace - albeit in the guise of an itinerant stipendiary magistrate who visits each admission centre once per week to

fulfil his statutory duties under Section 12.

Nonetheless the thrust of the changes in NSW in 1958 were (as in England and Victoria in the next year) substantially towards a medical model for involuntary admission and detention. The changes did not find favour in all quarters. A Justice of the Supreme Court of NSW wrote a strong attack on the failure of the new Act to protect the rights of the individual, as the old 1898 Lunacy Act had done. (Myers, 1961.)

In any event, the current legislation permitting involuntary admission is, throughout Australia, based principally on a medical model.

The New South Wales provision "defining" mental illness for the purpose of involuntary admission is typical of those in the other Australian jurisdictions. According to Section 4 of the New South Wales Mental Health Act (1958),

> "'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."

Under Section 12 of the Act, a mentally ill person may be admitted to an admission centre without his consent upon the certificate of one medical practioner in terms of Schedule 2. This is the standard procedure for involuntary admission, although in some cases involuntary admissions may be initiated by police or other persons.

In Victoria, Section 3 of the Mental Health Act (1959) defines "mentally ill" as:

> "...suffering from a psychiatric or other illness which substantially impairs mental health."

Under Section 42, a person may be admitted to and detained in a psychiatric hospital on the medical recommendation of one doctor. The patient must then be seen by the superintendent, who may initially authorize twenty one days observation, and then, after another examination, authorize six months detention and treatment.

In Western Australia, Section 28 of the Mental Health Act (1962) provides that:

> "(1) A person may be received into, and admitted to, an approved hospital upon the production of a referral, in the prescribed form, by a medical practitioner...
>
> "(2) Every person referred under this section may be received into an approved hospital for observation, for a period not exceeding seventy-two hours; and during that period he shall be examined by the superintendent or another psychiatrist."

According to Sections 38 and 39, the patient so admitted is said to be detained. The period of operation of this compulsory power is six months, but may be extended by the superintendent, on the opinion of another psychiatrist, for another twelve months and possibly thereafter. (Sections 39

and 45.) Under Section 46, a patient aggrieved by a Section 45 extension may apply to a magistrate for an inquiry about the matter. The holding of such an inquiry is not automatic. (Certainly there is no automatic magisterial or judicial inquiry into the appropriateness of the detention at or shortly after the initial point of admission, NSW being the only state with such a procedure.)

The Tasmanian Mental Health Act of 1963 is closely modelled on the English Act of 1959, and is thus strongly based on a medical model. Applications for admission (either for observation or treatment) must generally be founded on the recommendations of two medical practitioners (section 14), but in a case of "urgent necessity" (section 19) on one medical recommendation.

As in the English Act, "mental disorder" is the central concept and it is taken to mean

> "mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind..."

"Mental illness" itself is not defined. The main additional requirement is (as set out in Section 18 in the case of admission for observation):

> "that he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons"

and (as set out in Section 20, in the case of admission for treatment):

> "that it is necessary in the interests of the patient's health or safety or for the protection of other persons that he should be so detained."

A General Pattern

Legislation in the other Australian jurisdictions (i.e. Queensland, South Australia, the ACT and the Northern Territory) is in broad not significantly different from the laws briefly outlined above. Indeed there is a general pattern to the legislation in all jurisdictions in certain key aspects, notably:

(1) All jurisdictions permit involuntary admission to mental hospital on the ground of mental illness;

(2) All jurisdictions are heavily inclined towards reliance on medical discretion;

(3) No jurisdiction requires a full judicial hearing as a prerequisite to involuntary admission;

(4) No jurisdiction defines "mental illness", although all make some gesture towards limiting the grounds for admission by requiring that it be in "the patient's own interest" or "for his protection", or "in the interests" or "for the protection" of others. In none of the statutes are such formulae spelt out;

(5) In all jurisdictions the involuntary admission may be, and often is, initiated by one doctor (except in the Australian Capital Territory where under section 4 of the Mental Health Ordinance, 1962, two medical certificates are required in all cases);

(6) No jurisdiction (except NSW) requires automatically that there be judicial or magisterial review of involuntary admission once it has occurred;

(7) No statute spells out with any great degree of clarity the extent to which treatment may be imposed without consent on involuntarily detained patients.

The Abolitionist Arguments

In considering the justification for such involuntary admission procedures as they currently exist in all Australian jurisdictions, one must contend with the radical argument that not only ought there be reform of involuntary admission procedures, in fact there ought to be no such procedures sanctioned by law at all. There are diverse groups and persons who take this view, but one can refer to the general phenomenon of an "anti-psychiatry movement." In recent years Professor Robin Winkler, a psychologist at the University of Western Australia, has been a prominent spokesman for this movement. Winkler has been involved in so-called "pseudo patient" studies, and reports of such experiments give rise to a number of criticisms of mental hospitals and admission procedures. (Winkler, 1974; Owen and Winkler, 1974.) Various other individuals and groups from time to time express similar criticisms, but it is important to distinguish between criticisms aimed at modifying present systems, on the one hand,

and, on the other hand, the radical abolitionist viewpoint.

The most unequivocal exposition of the views of the anti-psychiatry movement is to be found in the writings of the American psychiatrist Thomas Szasz. The arguments which Szasz puts forward have, of course, no direct bearing on the legal position in New South Wales or Australia; nonetheless he bases his views upon reasoning which might very well be as applicable in this country or in this state as it could be said to be in the USA. There, his influence upon attitudes towards involuntary commitment has been very considerable. The existence in the USA of the Association for the Abolition of Involuntary Mental Hospitalization can be traced to the arguments put forward by Szasz. Although there are many others both within and outside America who advance the radical abolitionist viewpoint, Szasz is its most articulate and prolific proponent.

If one seeks to justify the present arrangements in New South Wales and the other Australian jurisdictions concerning involuntary admission of mentally ill persons, it is necessary to take serious account of the arguments put forward by the anti-psychiatry movement. The most important of these arguments are as follow:

* <u>The Existence of Mental Illness</u>

  Since there is in reality no such thing as mental illness, involuntary admission and detention on the ground of mental illness are by definition unjustifiable.

* The "Social Control" Argument

Involuntary admission and detention of the mentally ill is not genuine therapy, but in fact a form of social control in which the medical profession plays the role of policeman or gaoler.

* Inaccuracy of Diagnosis

The diagnosis of mental illness is highly inaccurate, with the result that involuntary admission and detention is arbitrary and unfair.

* The Overprediction Argument

It is not in fact possible accurately to predict dangerousness to self or to others, these being important grounds upon which mental health statutes allow involuntary admission and detention; the error which psychiatrists tend to make is the error of overprediction of dangerousness rather than underprediction, and this poses a grave threat to civil liberties.

* The Argument as to Discrimination

Even if it is possible accurately to predict violence, there are various categories of persons more dangerous than the mentally ill as a group (e.g., young males) who are not subject to arbitrary incarceration. It is discriminatory that the mentally ill should be so subject.

These various arguments are considered in turn in chapters 2 to 6.

Some Limitations Of This Thesis

It should be noted at the outset that the discussion is limited in some specific ways:

(i) Attention is directed at involuntary admission and detention particularly in relation to mental illness as distinct from its use in relation to drunkeness, drug-taking, mental retardation per se, or senility per se, although obviously persons who fall into these categories may also be mentally ill. Mental illness, without attempting a comprehensive definition, is taken to refer to the major psychiatric illnesses such as the schizophrenias and the affective illnesses, particularly psychotic depression.

(ii) Discussion is concentrated on five main arguments for the abolition of involuntary admission and detention on the ground of mental illness, but there is no attempt made to deal with the important issue of physical conditions in hospitals, either in New South Wales or in any other jurisdiction.

(iii) There are a number of important collateral issues dealt with in mental health legislation which are not fully dealt with: in particular, property provisions, provisions for discharge and transfer, offender-patients, etc.

(iv) Part 2 of the thesis sets out what this writer proposes as the very minimum of restrictions upon involuntary admissions consistent with regarding the procedure as justifiable. By no means should these be seen as a comprehensive set of proposals; they are merely the basic minimum of restrictions adequate - it is submitted - to nullify some of the quite telling arguments for abolition considered in Part 1.

# CHAPTER 2

## THE EXISTENCE OF 'MENTAL ILLNESS'

In his famous book "The Myth of Mental Illness" (Szasz, 1961)- and in a series of somewhat repetitive writings since then - Szasz argues against the view that mental illness is directly comparable with physical illness and (correspondingly) against the view that the proper handling of psychiatric disorders requires the medical training of the psychiatrist. While he is willing to acknowledge the existence and effect of physical brain disorders such as tumours, he argues that other kinds of mental illness are in fact not mental illnesses at all but rather merely ethical or social problems: "problems in living". For the purposes of furthering this argument Szasz considers hysteria as a paradigm case. He suggests that what Charcot, Freud and others who have written on the subject of hysteria describe as a mental illness is in effect simply a technique of communicating some kind of difficulty in adjusting to the world and other people.

Yet Szasz goes beyond merely pointing out the vagueness of hysteria as a clinical condition. In a broad generalization he argues that there is no such thing as mental illness at all. In the later book "The Manufacture of Madness" (Szasz, 1970), he confirms his belief in this proposition. He says there (at. p. 106) that mental illness can be regarded as

> "a stigmatized status imposed on citizens by their oppressors instead of a condition or disease exhibited by or contained in suffering patients."

In informal talks and commentaries, including a radio program broadcast by the Australian Broadcasting Commission in 1975, in which this writer participated, Szasz has specifically argued that "mad" people only pretend to be mad; that the hallucinations and delusions of the schizophrenic are simply fabricated.

The present writer would agree with Dr A.A. Stone who has written (Stone, 1973, 36) that:

> "When Dr Szasz reaches this level in his analysis of the myth of mental illness, he obscures reality as I understand and comprehend reality. Psychiatry and psychiatrists cannot take the credit nor the blame for creating those painful states of mental anguish which characterise what we call mental illness."

If one examines the statistics relating to the admisstion or involuntary admission of persons to mental hospitals in Australia or elsewhere one observes that the diagnosis of hysteria is not commonly applied to patients. The most common serious mental illnesses are schizophrenia, (or the schizophrenias) and depression (the most common of the so called "affective" illnesses). This writer is not a psychiatrist but has observed many cases of schizophrenia and depression. In acute phases hallucinations and delusions of the most bizarre kind can be manifested. As a matter of commonsense practical judgment arising from observation, it is very difficult to accept Dr Szasz' arguments about the nature

of hysteria as conclusive proof that there is no such thing as mental illness as it is manifested in schizophrenia and severe depression. The proposition that all reported delusions and hallucinations are merely pretence on the part of the patient (as Szasz quite definitely argues) seems to be almost sensational bombast on his part, a kind of exaggeration of his argument intended to outrage. And outrage it does. Most psychiatrists flatly reject it, pointing out that hysteria is not psychosis. While majority opinion is in itself no evidence of truth, the generally held view that most psychotics actually believe their delusions and actually experience their reported hallucinations seems to accord with the behaviour of mentally ill patients.

A distinction must be drawn between saying, on the one hand, that there is no such thing as mental illness, and saying, on the other hand, that mental illness is difficult to diagnose and to define and involves quite different considerations in a number of regards from those involved in dealing with ordinary physical illness. These are two quite distinct positions. The latter view is argued convincingly by Seymour Halleck (Halleck, 1971). He says (at pp. 104 and 248) that:

> "Psychiatrists must immediately stop all propaganda designed to convince the public that mental illness is a disease <u>just like any other disease</u>. Instead, they should publicly acknowledge that <u>some behaviour disorders resemble physical illness and others do not</u>." (Emphasis added.)

It is noteworthy indeed that Halleck, who adopts a generally radical position on the nature of mental illness and the role of psychiatrists, does not deny absolutely or flatly the existence of mental illness.

A similarly important distinction is between saying that mental illness is the product of social and environmental factors, and saying that mental illness does not exist at all. In the writings of members of the 'anti-psychiatry' school to which Dr Szasz belongs (and particularly in his writings) these matters become confused. To say that psychiatrists should place less emphasis on the pathology of the individual and look rather towards the nature of the society which produces mental illness is not to deny the existence of the phenomenon of mental illness. For example, Halleck says at p. 13:

> "...psychiatric treatment that focuses upon internal conflict encourages the patient and those who influence him to believe that his social environment is not contributing to his misery and that the environment is therefore adequate."

This is clearly not a denial of the existence of mental illness; it is a statement that mental illness can be the product of a defective environment rather than the product of pathology in the individual. This point can be further illustrated by reference to an experience of this writer.

In 1973 the writer visited Broadmoor Hospital in England where approximately 750 mentally ill persons were detained (Butler Report, 1975, 17), most of them having come into serious conflict with the criminal law. Upon noting among the patients a number of male West Indians and Pakistanis quite disproportionate to their numbers in the English population at large, it was explained to the writer that of the two major groups of diagnoses present in the hospital (i.e. paranoid schizophrenia and depression) most of the blacks and coloureds were suffering from paranoia. In contrast, white patients were more evenly distributed between the two broad categories of diagnosis. This fact might be explicable by reference to the prevailing racial situation in England rather than by any constitutional pathology inhering in the individuals affected. Many British working class whites despise and resent Pakistani and West Indian migrants. No doubt the migrants are sensible of this dislike, with the result that in many cases a realistic feeling of being unwanted may be exaggerated into a delusion of persecution. The writer has noted a situation similar to this in relation to Australian Aboriginals in Morisset Mental Hospital in New South Wales, a hospital at which many of the 'criminally insane' in this state are detained. But without arguing the accuracy or merits of this kind of hypothesis, it will be appreciated that one is proposing an environmental or social basis for or influence upon the illness: to suggest this is not to propose that the mental illnesses in question are somehow unreal or mythological.

A final point to make about the question of the existence of mental illness is that if one rejects Szasz's denial of it, one does not necessarily thereby reject his other criticisms of mental hospitals. Again to quote Stone (Stone, 1973, 24):

> "...in certain respects Dr Szasz is correct, and the psychiatric establishment is guilty as charged. The epidemic of lobotomies which occurred during the 1950s seems in retrospect to reflect the zealot's frenzy rather than the scientist's cautious objectivity; so, too, the exaggerated claims for psychotherapy, the unproven value of 'preventive psychiatry' the sloganism of Community Psychiatry. An on other matters Dr Szasz presents powerful arguments. His comments on the role of value judgements in psychiatric assessment need very careful consideration. Certainly it is wrong when it occurs that value judgements should masquerade as objective clinical assessment, but for the purposes of this discussion in isolation these matters are irrelevant."

Even if one agrees with most or all of this, it does not prove Szasz's basic point.

So far as the argument goes that mental illness is a myth and that therefore involuntary admission on the ground of mental illness cannot be justified, it is appropriate to quote the philosopher Antony Flew who wrote in Crime or Disease

(Flew, 1973, 61):

> "As the title of his book suggests Szasz undertakes to show, not just, as I would agree to be both true and important, that the concept of mental illness has been dangerously abused and absurdly over-extended, but rather, what is surely false and extravagant, that it has not proper application at all - that there simply is, and perhaps can be, no such thing as a mental disease."

Flew's comment is sound. As he implies, the first of the arguments mentioned above cannot be sustained. Denials of the existence of mental illness are not to be classed with denials of the existence of God: God is easy to define but hard to find; mental illness is difficult to define but easy to observe. The writer's own experiences lead him to believe that it is a grotesque misuse of language to describe certain mental states as mere "problems in living". It is useful to adopt the acute perceptions of Peter Kocan, a distinguished poet and former mental patient who spent 1966 to 1976 detained for an attempt on the life of Arthur Calwell, then Federal Parliamentary Leader of the Australian Labor Party. Kocan wrote, in a poem entitled "The Leopard" of a certain "criminally insane" patient (Kocan, 1975, 3):

> "See him - the psychopath, giver of death
> To several men - his grin, hovering
> In a corner, encompasses the room
> And a sour chuckle hangs from his teeth.
> He wears his air of menace like a skin.

"His dignity disarms. You long to poke him
And shout "boo!" and see him react;
But that would be vulgar, self-demeaning.
He is so like a leopard that watches,
Calmly noting your offhand timidity.

His iron claw, which flashed under the moon,
Has been taken away. It is primeval
Guilt upon his head and the rank, jungle smell
Of his savagery that chills your blood.
You know that your guilt too rests with him."

Of course it is extreme to use such an instance as a denial of Szasz's argument, but since that is an extreme argument, Kocan's poetic perception can legitimately serve as a rebuttal of it.

# CHAPTER 3

## THE "SOCIAL CONTROL" ARGUMENT

The anti-psychiatry movement views involuntary admission and detention not as true medical therapy, but rather as part of the broader system of social control by which elite groups maintain power. The doctor is thus equated with the policeman and the gaoler. The contention is that psychiatrists should not perceive the decisions they make as being taken in isolation; they should see themselves, so it is argued, as part of an overall pattern of social and political control.

The publication in 1959 by the existential psychiatrist R.D. Laing of The Divided Self (Laing, 1959) was a notable event in the study of schizophrenia. This work popularised the view of schizophrenia as the product of social milieux, and particularly of the family milieu. This was of course by no means an original argument since researchers such as Wynn and Singer, Lidz and Bateson had years earlier written on the particular influence of the family situation in producing schizophrenia.

Nonetheless Laing's exposition of the theory was taken up with great popular enthusiasm, mainly because of his peculiar skill in communicating an understanding of the schizophrenic mind. Theodore Lidz has acknowledged this (Lidz, 1972, 151), saying of Laing that

> "...his most important contribution is his own particular insight, his sense of what's going on in a schizophrenic patient - his sense of the whole thing

> is extraordinary and has helped us to comprehend more clearly what we were dealing with. And it has been helpful that he has examined and emphasised the interfamilial problems that are so much a part of the schizophrenic's situation."

In The Politics of Experience and The Bird of Paradise (Laing, 1967), Laing went considerably further in his existential explanation of the causes and significances of schizophrenia; indeed, so empathetic was he in The Politics of Experience with the position of the schizophrenic that he went so far as to advance the view that the course of a schizophrenic episode may be no bad thing in itself, but in fact positively useful and helpful. Thus one could infer that interference with the course of a schizophrenic episode by way of attempted treatment (let alone by the imposition of treatment) would be unhelpful.

The view that the schizophrenic experience is somehow fulfilling or ennobling is rejected by most psychiatrists. For those who perhaps lack Laing's peculiar but undoubted insights into the schizophrenic mind, it appears that an episode of madness is usually an experience filled with pain and fear, and that on balance it may be preferable to attempt to alleviate this pain and fear rather than to rely on the nebulous possibility that some ennoblement or self-fulfilment will be visited on the person who proceeds through an episode unsupported and untreated. To say this is not to reject out

of hand those theories which suggest that in an obscure way mental illness might act as a "defence mechanism" in certain cases; i.e. that in particular circumstances a person might become psychotic as an unconscious method of avoiding some worse consequence. Farberow and Schneidman, for example, have argued that schizophrenia is adopted in order to avoid or overcome strongly felt impulses to commit suicide. This kind of theory is pure speculation, and is empirically unverifiable, but it has a certain minimal plausibility. Laing, on the other hand, would have it that madness is a thrilling experience, desirable in itself, and that we would all probably be better and stronger people for having undergone it at some stage. This is not very far removed from the primitive view of the madman as inspired, and a proper object for adulation. It is a view which this writer, at least, would reject as romantic but misleading.

But leaving aside this aspect of Laing, what follows if Bateson, Lidz et al. are correct in their theories as to the nature of schizophrenia? So far as causation is concerned, it does not necessarily follow from any 'environmental' theory of schizophrenia that involuntary admission to mental hospitals is unjustified. It is clear in medical research and in the social sciences generally that the discovery of the cause or the causes of a particular phenomenon is not necessarily a prerequisite for developing a proper policy. (For example, it is not clearly understood why the major tranquillising drugs work - but they do.)

In the view of this writer, whether it is socially, genetically or otherwise caused, schizophrenia in its severe manifestations is a mental illness which calls at least for concern if not for treatment; in some circumstances, it will be suggested here, it may call for the exercise of involuntary powers.

A second aspect of the "social control" argument is the assertion that involuntary admission and detention is in fact the equivalent of imprisonment, or arguably (to the extent that it may be indeterminate) even worse than imprisonment.

Certainly, it is true that a name given to an institution is not necessarily an accurate indication of the function which it performs. For example, the New South Wales Department of Corrective Services uses the term "administrative segregation" (Prisons Act, Section 22) to describe what is more commonly known as "solitary confinement", but the name does not change the nature of the practice. The experience of incarceration is a subjective one. Whether persons on the outside give it a different name ('detention', 'internment', 'quarantine', 'remand', 'commitment', 'training', etc.) is beside the point.

But how valid is the claim that mental hospitals are, so far as involuntary patients are concerned, like prisons? In attempting to answer this question, it is useful to list the similarities and differences between the position of the

convicted prisoner held in the prison and the involuntarily admitted mental patient detained in a mental hospital.

The most significant point of similarity is that both the prisoner and the detained patient are subject to legal and actual deprivation of liberty; neither is allowed at will physically to leave the institution in which he is placed. As a corollary of this deprivation, both are subject to some degree of institutionalisation, and to stigmatisation, both while in the institution and following release from it. Both are subject to certain losses of civil rights, particularly the power to vote. (South Australia is the only jurisdiction in Australia where all prisoners have a right to vote.) Both lose effective control, at least for the time being, of most money or property which they might own. Both lose control of physical integrity, and may, if deemed to have behaved in an intolerable manner, be confined under close restriction and perhaps subjected to pacifying injections.

It is noteworthy also that the numbers of persons detained involuntarily in mental hospitals can be very substantial. Proportions of course vary according to time and place, but in New South Wales on 30th June in 1976, those detained involuntarily in mental hospitals numbered 3717 while those confined full time in prisons by the Department of Corrective Services numbered in total 3616. (Sources: NSW Health Commission Research Division; NSW Department of Corrective Services Annual Report, 1976-1977.)

This writer has not been able to obtain later comparable figures. It is likely that since 1976, the 30th June census figure for involuntarily detained patients has slightly diminished. The corresponding census figure for prisoners in New South Wales prisons (including unsentenced prisoners) as at 30th June 1979 was 4094. (Source: NSW Department of Corrective Services Research Division.) In any event it is clear that the system of involuntary detention in mental hospitals is approximately of the same size as the prison system, although relativities may fluctuate.

No direct comparison can be made of lengths of stay, but again there appears to be similarity between the two systems. The best estimate of the average length of stay of involuntary patients in NSW mental hospitals as at 30th June 1978 is 7.3 months (as against approximately seven weeks for voluntary and informal patients.) (Source: NSW Health Commission Research Division.) As for prisoners, the Annual Report of the NSW Department of Corrective Services for 1976-1977 showed that 90.6% of the sentenced prisoners released during the year had served less than twelve months.

A major difference between the two systems, however, is in relation to security. Prisons place heavy reliance on security. On the contrary, security is generally only a minor issue in mental hospitals. There are now

(leaving aside wards for the so-called 'criminally insane') very few closed wards in Australian mental hospitals. Certainly there are very few in New South Wales. Walls and fences around mental hospitals have in many cases literally been pulled down (e.g. Rydalmere). Little distinction is drawn between voluntary and involuntary patients in treatment and movement within and about the hospital. The orthodox medical view (doubtless correct) is that such discrimination would generally be inimical to treatment. Few windows are barred and virtually any patient who seriously wished to could escape. Some, of course, do so, but such departures are generally not the cause of great alarm.

Leaving aside the question of loss of liberty, some critics of involuntary detention in hospitals are inclined to nominate stigma as the most significant similarity between hospitals and prisons. A paper delivered by Professor K.O. Shatwell in 1973 (Shatwell, 1971) includes a passage which makes this point with some force:

> "An assumption which has gained some currency amongst well meaning persons, particularly in the context of drug-addicted persons, is that a criminal conviction carries with it a social stigma whereas a civil commitment does not. Any defamation lawyer would agree that the latter allegation is at least as injurious to the reputation as an allegation of conviction for a drug offence. Further, compulsory hospitalization carries with it some other serious legal disabilities. A person so

> hospitalized may be interdicted from the management of his property; or he might find the hospital records subpoenaed to provide his wife with immediate grounds for divorce, or used as a bar to future employment in either the Commonwealth or State public services, or again, it may bar him from entry either as a visitor or as a resident from some other country.

It follows that on the question of the comparability of involuntary admission and imprisonment one must not shrink from acknowledging the basic fact of deprivation of liberty in both situations. It is true that mental hospitals are not walled and barred, as in the past, and that treatment is usually kindly intended (although perhaps not always kind in effect); nonetheless hospitals detain certain people. If involuntary admission is to be justified, the coercive nature of it must be squarely faced. It is the view of this writer that in certain limited cases and situations, involuntary admission can be justified, but it is in large part recognition of the coercive aspect which compels the imposition of limitations and restrictions on the procedure.

Another aspect of the 'social control' argument relates to the financing of mental hospitals. Simply, state mental hospitals are generally for the poor, while the wealthy gravitate to private facilities. For example, a person who is a high executive in a major oil company and who in the course of a sudden episode of mental illness injures or threatens to

injure himself or a member of his family or a neighbour, would be unlikely to go through normal involuntary admission process and end up in a state mental hospital; he would probably be looked after by persons who were concerned about his reputation, the family's reputation and his company's reputation. He would probably be cared for in a private nursing home or similar establishment. On the other hand, if the same type of illness and the same general kind of behaviour pattern were to be manifested in an unemployed middle aged bachelor who lived alone in a boarding house, the likely consequences would be the initiation of involuntary admission procedures according to the relevant statute, and subsequent care in a state mental hospital. That this kind of distinction exists in all Australian jurisdictions (as it does in all American jurisdictions) is well established and known. In the absence of a fully comprehensive national health scheme, free enterprise psychiatric medicine tends to concentrate its attention upon those persons who are most capable of paying for the service. The practice of psychiatry is generally time consuming and involves expensive sessions of conversation between doctor and patient.

The movement in America towards a so-called legal 'right to treatment' in mental hospitals is generally acknowledged to derive from a paper by Birnbaum (Birnbaum, 1960). Writing on the subject of American state mental hospitals in which persons might be incarcerated for long periods of time without

receiving adequate psychiatric care and attention, Birnbaum argued that such hospitals should be required to provide for their patients services of an approximately similar standard to those provided in private mental hospitals for the wealthy. He referred to certain guidelines laid down by the American Psychiatric Association for the provision of psychiatric facilities (APA Standards for Psychiatric Facilities).

The "right-to-treatment" approach to the improvement of state mental hospitals was endorsed by an American court in the famous case of Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971).

In a major paper on the subject of the so-called 'right to treatment' and generally on the subject of the relationship between law and psychiatry in contemporary America, Robitscher has detailed the evasiveness of the private sector of American psychiatry in confronting the kind of argument put by Birnbaum and others (Robitscher, 1974, 150):

> "In February 1967 the Council of the APA approved a reactionary position statement on the right to treatment. ...it said 'Clearly, in the perspective of the over-all mental health manpower shortage in our country, one must settle for something less until personnel shortages can be overcome.' The formula which the APA went on to specifically endorse, an old formula dating back to the Model Draft Act of 1952, was that patients are to be

entitled to treatment only 'to the extent that facilities and personnel are available.' ...by adopting this position statement the APA was saying that organised psychiatry felt no responsibility for the improvement of the public mental hospitals system. It was inviting the kind of response from the courts that has since been expressed in Wyatt v. Stickney.

"In 1969 the APA dealt the Birnbaum concept a second blow by discontinuing its formulation of minimal patient-staff ratio for private mental hospitals."

Robitscher also points out that:

"APA standards for Psychiatric Facilities (1969) omit any recommended objective personnel ratio. The 1958 addition of these standards had required a ratio of 1.30 for admission and intensive treatment services; 1.150 for continued treatment and geriatric services and 1.50 for mental hospital medical and surgical services, with ratios also established for clinical psychologists, registered nurses, occupational therapists, psychiatric social workers and others."

Robitscher is no psychiatric radical. He is not to be classed with Szasz, Laing and Cooper in his attacks on what might be called the 'psychiatric establishment'; nor, though he is qualified both as a lawyer and as a psychiatrist, is he a vigorous supporter of those civil liberties lawyers who during the 1960s and 1970s have utilized the "due process" and "equal protection" provisions of the American Constitution

to gain for the law a significantly greater role in the US mental health care system than it previously had. He is a moderate, arguing against excessive reliance on community treatment and arguing against the over-use of the law as a weapon for improving mental health care services. Nonetheless the case which he makes out against those persons who control the provision of psychiatric services in the United States is, whatever use he wishes to make of it, highly damning. He lays the major blame for the inadequacies of the state mental health care system directly at the feet of private psychiatry. He says at pp. 173, 174:

> "...much of the present ill-will that exists between law and psychiatry, much of the present harassment of psychiatrists by lawyers, could have been prevented. Private psychiatry could have recognised its obligation to public as well as to private patients. Training programs could have sensitized psychiatric residents to the civil rights issues which they ignored in pursuit of more 'scientific' knowledge. ...the vacuum which the law has rushed to fill should have not been allowed to develop."

and at p. 176:

> "The subjects which we are concerned with today - 'right to treatment', competency to stand trial, commitment, the procedural rights of patients - lose out in the market place because they do not have a dollars-and-cents value."

The funding of psychiatric hospitals in Australia does not depend to any significant extent at all on local government; it is based on state and federal finance. Nonetheless the structures providing for psychiatric services in the United States and in Australia are broadly equivalent. Here as in the USA, psychiatrists tend to make more money in private practice catering to the problems of the middle class and financially well-off rather than in the public service catering to the needs of the chronically mentally ill and the chronically poor.

One particular aspect of the provision of psychiatric services in New South Wales is fodder indeed for those members of the 'anti-psychiatry' school who wish to believe in theories of social conspiracy. It is that not only are voluntary or informal psychiatric patients excluded from the operation of the hospital insurance systems; persons who are <u>involuntarily</u> admitted into New South Wales mental hospitals and there detained for some period of time are, even though held against their will, required to pay the normal fees for hospitalization. Admittedly the superintendents of the state mental hospitals do make efforts to have persons in this situation exempted from some or all payment. Nevertheless whatever humane bureaucratic manoeuvres are carried out in order to provide relief in many individual cases, the general rule still persists. It is astounding that a crude distinction should be drawn between the availability of hospital insurance benefits for physically ill persons and for those mentally ill. It is even

more astounding, indeed quite bizarre, that ordinary payment requirements should apply to persons detained involuntarily. If state mental hospitalization rather than treatment in private clinics were to be the fate of the middle class or well-to-do mentally ill person, one might reasonably doubt that such oppressive rules would be tolerated for very long.

A further aspect of the 'social control' argument is Szasz's contention (omn.op., passim) that psychiatrists are more concerned with healing people - or as he would put it, with manipulating people - than with civil rights. Accordingly, he suggests, it is inevitable in the mental hospital situation that therapy will generally be put before freedom. Certainly there is considerable truth in this view; the only real argument is whether one accepts the conclusions which Szasz suggests flow from acceptance of it. The wards of the general hospital in which doctors are trained during their undergraduate careers are places where the doctor's writ runs very effectively. Persons in hospital for appendicitis or pneumonia are normally not disposed to quibble with the doctor about what therapy is prescribed, nor to quibble about the most appropriate time for discharge. In the mental hospital, however, things are considerably different. Certainly in so far as the involuntary patient is concerned, it cannot be blandly assumed that what the doctor prescribes as therapy for the patient will be automatically accepted by him as right and appropriate. Indeed in many cases the reverse is true; the patient positively wishes to leave and positively does not wish

to be treated. He is detained not simply because he is mentally ill, but also because for some social reason (generally, danger to himself or others) it is thought necessary by several doctors and perhaps by a legal tribunal that he should be detained. Szasz suggests that the medical doctor trained in the treatment of physical illness finds it impossible to come to terms with the different situation of the mental hospital and involuntary detention, and that he can in these circumstances virtually never be anything other than basically authoritarian. According to Szasz, if there is a conflict in the mind of the doctor between therapy and freedom for the patient, there is no contest at all. Freedom will lose out.

Szasz's conclusion from this (that all psychiatrists ought simply to refuse to become involved with involuntary mental hospitalization) is, this writer would suggest, unacceptable. Nonetheless the proposition that the "mental set" of the traditionally trained doctor requires considerable modification in the mental hospital situation must be constantly remembered by those concerned with the provision of psychiatric services. The recognition of the social purpose (as distinct from the medical element) in involuntary hospitalization is vital.

The central meaning of what has been referred to above as the 'social control' argument against involuntary hospitalization is expressed in the antithesis of 'change' and 'adjustment' as aims of the psychiatrist. According to Claude Steiner in a 'Radical Psychiatry Manifesto' (quoted in de Chenne, 1974, 70):

> "Extended individual psychotherapy is an elitist, outmoded, as well as nonproductive, form of psychiatric help. It concentrates the talents of a few on a few. It silently colludes with the notion that people's difficulties have their source within them while implying that everything is well with the world."

The argument is that the psychiatrist firstly seeks pathology in the individual and aims to adjust the individual to suit his surrounding environment; while accepting that the external status quo cannot or should not be changed, the psychiatrist attempts to modify the attitudes and behaviour of the patient so that the patient will be able to get along with those around him and the outside society at large. On the contrary, it is suggested, what the psychiatrist ought to do is to attempt to change the external environment, if it is that which is at fault, or to change the attitudes or the behaviour of the patient for the patient's own ultimate benefit, even though this may bring him or her into conflict with the external world.

This notion involves an acceptance of an essentially political function for psychiatry. As Edgar Z. Friedenberg has written of Laing (Friedenberg, 1973, 44):

> "The crux of Laing's opposition to psychiatric diagnosis and much psychiatric practice (i.e. traditional psychiatry) has been that it is repressive, coercive, political rather than psychological in that it is really a means of controlling people and putting those who make nuisances of

themselves out of the way or destroying their capacity to be their own obnoxious selves. Psychiatrists use insights derived from personality theory and data about the subject's psyche in order to do a more devastating job, but they are basically unconcerned with his being and quite willing to sacrifice his selfhood for political ends."

It is important to understand that general expressions such as 'anti-psychiatry' and 'radical therapy' conceal considerable differences among the views of persons grouped under such terms. Again to quote Friedenberg's perceptive (if ill-written) essay on Laing, at p. 51:

"The confusion...of those who lump together as left-political quasi-revolutionary compeers persons who criticize society primarily because it alienates people from themselves and their capacities for growth, and critics who complain primarily of society's gross inequities, has caused a great deal of difficulty in the past few years."

and at p. 52:

"...those who try to follow the Tao...are surely more radical in their rejection of contemporary Western societies...than the most ardent revolutionaries bent on structural reorganisation and the seizure of power in the name of greater justice and equality of opportunity, who nevertheless leave the basic values of the society intact."

This kind of distinction needs to be borne in mind when one evaluates the validity of arguments of the kind referred to above. Maoist and Buddhist critics of involuntary mental hospitalization cannot reasonably be equated; Szasz himself, while saying many of the kinds of things which Laing says, appears to follow a political philosophy of classical right-wing libertarianism.

While conceding the validity of various aspects of the 'social control' argument, this writer is inclined to agree with Dietz who says (Dietz, 1974, 206-7):

> "The family, peer groups, schools, religion, occupational organisations and so on are all agencies of social control. Thus to say that mental health systems are agencies of social control is not to say that they are repressive, totalitarian or otherwise illegitimately coercive but merely to point out that, like other institutions, they can be.
>
> "...some of us who were first developing our ideas about psychiatry during the era of Szasz, R.D. Laing...and the student revolution developed a stance which we called 'radical psychiatry'.
>
> "...I still believe this perspective to be logically and phenomenologically sound. <u>The difficulty arises when one tries to apply it to the everyday crises of psychiatric practice. Faced with a violent patient or a suicide attempter, even the radical psychiatrist reverts to</u>

traditional tactics of control. Is this merely because he fears bodily harm or loss of his job? Or do these extreme situations serve to uncover the more general principle that social control is indeed necessary? I have come to believe that, if not necessary, it is at any rate inevitable; and we would do better, therefore, to devote our efforts not to the abolition of social control but to the improvement of the control agencies which already operate in our society." (Emphasis added.)

The significance of Dietz's observations on this point was brought home to the writer of this article in a striking way in early 1975. Having for several years been involved with the committee dealing with reform of the New South Wales Mental Health Act, the writer chanced to meet a friend who had earlier indicated strong opposition to the idea of involuntary admission and detention on the ground of mental illness. This tied in with her general political views which might be described as anarchistic. Expecting to be chastised, the writer mentioned that the committee had not, in its report, recommended the abolition of involuntary admission. No chastisement was forthcoming, and the writer inquired as to the apparent change of heart. The explanation was that a friend of hers had become psychotic, and the libertarian abolitionist arranged to have the afflicted friend live at her house to calm her down and so avoid the evils of hospitalization. After about six days and sleepless nights during which furniture and other things were smashed, people assaulted and

abused and the frenzy of the psychotic friend remained unabated, eventually resort was had to the involuntary admission procedures in the Mental Health Act.

# CHAPTER 4

## INACCURACY OF DIAGNOSIS

A third major argument against involuntary admission is that the assessment or diagnosis of mental illness by psychiatrists is highly inaccurate.

This argument has been illuminated in various so-called 'pseudo-patient' studies which have been done during the past few years. Rosenhan (Rosenhan, 1973) arranged for eight persons who were not mentally ill to have themselves admitted to various psychiatric hospitals (twelve in number) by pretending mental illness. The pretence which was made by the pseudo-patients was that they 'heard voices' saying 'empty', 'hollow' and 'thud'. Despite the fact that the fabricated case histories given were not "seriously pathological in any way", (p. 25), all but one of the pseudo-patients were diagnosed as suffering from schizophrenia and stayed in the hospital subsequently for varying periods of time ranging from seven to fifty-two days, with an average stay of nineteen days.

As a further part of his study Rosenhan gave notice to a particular hospital (not involved in the original study) that a number of pseudo-patients would be seeking admission at that hospital within the next three months. Actually it was not intended that any pseudo-patients should in fact seek admission to this hospital and none did. By way of testing the ability of the admitting psychiatrists at this hospital to distinguish pseudo-patients from real patients, psychiatrists were asked to indicate if they thought that any of 193 patients admitted during that period was a pseudo-patient. Forty one of the 193 were said to be pseudo-patients by one or more staff members (including attendants and nurses ) and 23 were

considered suspect by at least one psychiatrist (p. 252).

Rosenhan draws the conclusion from this that psychiatrists working in psychiatric hospitals are not in fact able "without massive errors" (p. 252) to distinguish between mental illness and sanity. Accordingly, the argument runs, involuntary admission on the ground of mental illness is unjustifiable since psychiatrists cannot accurately diagnose the phenomenon; admission is random and arbitrary. (It should be noted that Rosenhan did not himself advocate abolition of involuntary admission. Others have drawn this conclusion from his work but it does not appear to be his stated position).

The Rosenhan study has been replicated in New South Wales (with some variations) by Winkler (Winkler, 1974). This work tends to suggest the same kind of conclusions in relation to New South Wales mental hospitals and New South Wales psychiatrists as were drawn by Rosenhan in his American study.

One must ask, accepting the facts of Rosenhan's study as being substantially true and accurate, whether it is really valid to say that the inherent inaccuracy of diagnostic assessment of mental illness is proven. The obvious objection which has been made by many people is that the psychiatrist in the mental hospital is not normally expected to distinguish between sanity and the pretence of insanity. Wolitzky (Wolitzky, 1973, 472) says:

> "...one cannot draw any definitive conclusions concerning the diagnostic ability of the psychiatrists in Rosenhan's study to distinguish insane from sane - one can only question their ability to distinguish 'insane' from 'feigned insane', quite a different matter."

Consider the following situation: a person who has been involved in a minor car accident reports pain in his lower back. He goes along to a doctor complaining of this and indicates to the doctor in the course of examination that he is in the process of suing the driver of the vehicle which caused the accident producing the injury. In these circumstances a doctor conducting an examination would consider the possibility that the patient had some motive for pretending to be suffering from an injury that was not real, or to be suffering from an injury of greater seriousness than was truly the case. The doctor may possibly be able to conduct certain tests which will tell him whether there is any organic injury which might be related to pain. But if these tests are negative he still cannot rule out the possibility that the injury is genuine. He may suspect pretence but he cannot assume it. But where the psychiatrist is considering a question of mental illness there is normally no reason for the doctor to suspect that the patient is feigning.

Szasz notwithstanding, people do not in the normal course of events pretend to be intensely or suicidally depressed. It may be that in many cases the patient unconsciously wishes to

attract attention to himself, but nonetheless the depression itself is usually genuine. And in the case of schizophrenia, it is almost impossible to imagine circumstances (except artificial ones such as constructed by Rosenhan or a war situation such as in Joseph Heller's "Catch 22") in which a person would wish to pretend to be suffering from hallucinations or delusions.

The fact that clinical assessment of psychiatric states is difficult, variable from country to country, and susceptible to fashions in psychiatric thought is well established; (Beck, et al., 1962; Cooper et al., 1972; Wing et al., 1967; Fleiss, et al., 1973).

As Bartholomew and Milte point out (Bartholomew and Milte, 1976, 451):

> "There are a number of more recent studies available which set out data indicating a lack of reliability in diagnoses by psychiatrists, and clearly if there is no reliability then there is no validity, although the opposite does not hold. Katz describes a piece of research where a number of psychiatrists 'were asked to indicate the presence or absence of psychopathology on behavioural items during the presentation of a videotape of an interview. They were also asked to make a diagnosis. Of the group of 35 participants, 21 labelled the patient psychotic and 14 labelled him neurotic.' Later, Katz and others using

> a filmed interview 'found that approximately one-third of the American psychiatric audience diagnosed the patient as having some form of schizophrenia, one-third as being neurotic, and the remaining third as having a personality disorder. When the same film was shown to a British audience at the Maudsley Hospital, London, no diagnosis of schizophrenia was made, but 59 per cent of the British psychiatrists made a diagnosis of personality disorder, a further 22 per cent diagnosed psychoneurosis, 16 per cent suggested other diagnoses, and 3 per cent (one psychiatrist) made a diagnosis of manic-depressive psychosis." (Footnotes deleted.)

Yet if one accepts the proposition that it is difficult to diagnose some mental illnesses and that there will in many cases be disagreement as to diagnosis, it does not necessarily follow that some system of involuntary admission cannot be justified. It is necessary, however, that any such system should involve safeguards and protections against the improper detention of a person who is not in fact mentally ill. Firstly, it is necessary that involuntary admission should clearly apply only to persons who are very seriously mentally ill; not to the large borderline group of persons about whose condition there might be some doubt, into which category Rosenhan's pseudo-patients would fall. Secondly, it is necessary that detention be not merely based on the opinion of one doctor.

In New South Wales at the present time, before involuntary detention will be ratified, it is required that a diagnosis of mental illness should have been made by three doctors, separately and independently of the evaluation by the others; and further that a magistrate should acquiesce in these judgments. Of course it would be possible to argue about precisely how many doctors ought to be involved in the judgment process, and about precisely what form the legal component of admission should take (i.e. whether by jury as in many American jurisdictions, or by a magistrate in New South Wales, by the Sheriff as in Scotland or by a Mental Health Tribunal) but clearly the uncertainty and difficulty of diagnosis and assessment of mental illness does require something more than the single assessment of one medical practitioner. A multiplicity of medical and legal judgments can (provided that each judgment is genuinely independent of the others) constitute a sound protection against erroneous and improper diagnosis.

Furthermore, the pseudo-patient studies appear to have involved <u>voluntary</u> rather than involuntary admissions. Voluntary admission is usually on the basis of mental illness alone; involuntary admission is based usually on a diagnosis of mental illness <u>and additionally</u> the establishment of some social element such as danger to self, or danger to others. These are (or ought to be) requirements additional to the requirement of a diagnosis of mental illness. The fact that Rosenhan and his colleagues apparently had themselves admitted on a voluntary basis is important because where

admission is voluntary, an admitting medical officer is generally not so concerned about the prospect of an incorrect or improper diagnosis of mental illness as he is in the case of an involuntary admission. Leaving aside the possible consequences of inappropriate treatment, the social harm or injustice visited upon the person who willingly seeks admission and is (let us say) wrongly diagnosed as mentally ill is clearly not so great as the harm or injustice imposed upon a person who is brought to the hospital under protest and (again let us say) misdiagnosed as mentally ill. So far as the question of involuntary admission is concerned, a more meaningful study would have resulted had Rosenhan carried out a more elaborate pretence and arranged to have his pseudo-patients presented at a hospital 'under duress' following 'certification' by a medical practitioner. Whether in those circumstances involuntary detention would have followed is highly doubtful, assuming that the only symptoms of mental illness were voices saying 'empty', 'hollow', or 'thud'. Certainly, under any system of legislation covering involuntary admission which was drafted with concern to include only cases where mental illness and danger to self or others was clearly established, and to exclude those cases falling within the 'grey' area of diagnosis, the hospital would not have accepted or detained the patients.

An amusing (if somewhat frightening) experiment by Braginsky and Braginsky (Braginsky and Braginsky, 1974) illustrates the subjectivity in diagnosis of mental illness. It is summarised as follows by Steingarten (Steingarten, 1976, (602-3):

"The researchers videotaped two staged psychiatric interviews, using the same college seniors to play the patient in each. The first section of both tapes was the same: the 'patient' complained of sleeplessness, irritability, poor appetite, fatigue. After that the tapes diverged. When the patient was asked about his political beliefs, in the first tape he expressed a middle-of-the-road philosophy and decried radical tactics. In the second tape, he expressed a New Left philosophy. At the end of each interview, the patient was asked for his views on the mental health profession. The middle-of-the-road patient criticized the profession for destroying traditional values; the radical criticized it as the handmaiden of a repressive society.

"Each tape was played to a different audience of mental health professionals. After each section, the audiences were asked to rate the degree of pathology they observed in the patient. As you'd imagine, the first part of each tape (where the symptoms were the same) produced the same average rating - mild pathology. But as the interviewer delved into politics, the middle-of the-road patient remained stable while the radical was seen as increasingly disturbed. Then as both patients began to criticize the mental health profession, their mental health took a grave turn for the worse. To test these extraordinary findings, the Braginskys revised the last section of the radical's tape, now having him praise the

profession. The new tape was shown to a new audience. Up until the end, the pattern established in the first experiment was duplicated - the radical was judged as increasingly disturbed as he expressed his New Left beliefs. But then, when he praised the mental health profession, the raters astonishingly promoted him to normality."

# CHAPTER 5

## THE PREDICTION OF DANGEROUSNESS

This argument is that whether or not it is possible to diagnose serious mental illness, psychiatrists cannot with an acceptable degree of precision predict those cases where a person is likely to be dangerous to self or to others and those where he is not. And since dangerousness is the main factor which (coupled with the fact of mental illness) is said to justify involuntary admission, then what is argued to be a justification actually fails to be such.

It is not satisfactory simply to generalize about 'dangerousness' in the abstract. The ability of the psychiatrist or anybody else to predict dangerousness depends on what kind of danger is postulated. Firstly, one must distinguish between danger to self and danger to others. Secondly, under the heading of danger to self one must at least distinguish between danger of suicide, danger of serious bodily injury to self, danger of causing oneself financial or social embarrassment, and danger of neglect of one's person or affairs. Thirdly, under the heading of danger to others one must at least distinguish danger of homicidal attack, danger of serious assault, danger of minor assault, danger of causing family and social disruption, and danger of causing public nuisance.

"Dangerousness" should be recognised as a pejorative term. To say that there is a serious danger of X happening is to say (1) that there is a high or substantial risk of X happening, and (2) that X is bad or undesirable. The necessity to

recognise the value loaded nature of the term stems from the habit of some psychiatrists of talking in the abstract about a particular person as dangerous on the assumption that the doctor's own values as to the undesirability of certain behaviour are universal. For example, psychiatrist 'A' might consider that the intention of an eighteen year old patient with schizoid personality to leave home and join a 'hippie' commune poses a serious danger to him, justifying involuntary admission. Dr 'A' might be particularly concerned about possible loose living and drug abuse on a 'hippie' commune. Psychiatrist 'B', on the other hand, may see this intention not as posing a danger but as a hopeful sign of improvement. He might feel that the young person's problems have been caused by the family situation and that leaving home for a less restrictive atmosphere would be likely to be beneficial to his mental health. Thus what represents a 'danger' to one psychiatrist represents to another the opposite. When use is made of the terms 'danger', 'dangerous' and 'dangerousness' it is to be noted that there is (i) a probability aspect, and (ii) a value-judgment aspect. It would be inconvenient to eschew the term 'dangerousness' entirely but it is confusing to use it simplistically.

(a) Prediction as to "danger to others"

The argument from prediction against involuntary admission applies with considerable force to the prediction of the likelihood of homicidal or aggressive behaviour. The essential

problem is the rarity of such behaviour, since the prediction of rare or unusual events can be statistically difficult. The normal civil situation is not to be compared with the condition of a nation at war. Where armies confront each other in the field, and a soldier sees a person wearing the uniform of the enemy, it is reasonable to assume that the person so clothed will, if allowed to do so, engage in aggressive or homicidal behaviour. Preventive measures are obviously indicated. But in the normal civil situation of peace there are no unequivocal indicia of hostile intent. The homicidal, suicidal and assaultive among us do not wear uniforms with flashes stating "BEWARE".

It is certainly not true that mental illness is in itself the equivalent of a uniform of insignia indicating dangerousness. The attitude towards mental illness throughout the nineteenth and earlier centuries which produced the walled, locked and barred madhouse has disappeared. The mental health revolution of the 1950s and 1960s has been well and truly won. Only the ignorant would assert today that mental illness is in itself and generally an index of dangerousness. Aggression is rare amongst patients in mental hospitals. The overwhelming majority spend only a short time in the hospital and are then returned to the community. As for chronic long stay patients, it requires only the briefest observation to persuade one that the main difficulty with such persons is apathy and introversion rather than danger to other persons. Nor is this simply the product of the institution. Chronic schizophrenics

living in the community are generally a burden to relatives and to themselves rather than a danger in any physical sense of the word. Even the paranoid person with beliefs of persecution is only rarely violent or dangerously aggressive.

Various studies of the dangerousness of ex-mental patients have been done, but lend little support to the view that mental patients are in general or identifiably more likely to be assaultive or homicidal than members of the community at large. One unpublished study referred to in an article by Laves and Cohen (Laves and Cohen, 1973, 51) says that:

> "...former inmates of mental institutions are less dangerous than persons without such a history. In a 5½ year study of 5000 former patients it was found that those without prior arrest records have a surprisingly low rate of arrest following release from the hospital."

A footnote refers to the article as being by Brill and Malzberg, and as entitled "Statistical Report Based on the Arrest Record of 5354 Male Ex-patients Released from New York State Mental Hospitals During the Period 1946-1948". (This study is also referred to by Fottrell, Bewley and Squizzoni (Fottrell, Bewley and Squizzoni, 1978) but has not been available to the writer.)

The contrary is suggested in a study by Rappeport and Lassen (Rappeport and Lassen, 1965). This study dealt with male adult patients over sixteen discharged from Maryland

state mental hospitals as two separate populations in 1947 and 1957. The numbers involved were 708 and 2152 respectively, and the procedure adopted by the researchers was to compare arrest rates (presumably an approximate measure of dangerousness) against arrest rates for the general population as shown in the FBI Uniform Crime Reports. The offences considered for the 1957 group were homicides, rape, robbery and aggravated assault. The conclusion reached (p. 780) was for both groups that:

> "...for some serious offences the psychiatric population has a higher arrest rate than the general population."

Specifically it appeared that for robbery and rape offences, the patient population had a higher arrest rate than did the population at large. Strangely, one might have thought, the rates for aggravated assault were approximately the same.

There is a major methodological weakness in this study which renders it of dubious worth. Obviously it is not valid to compare a sample of persons discharged from an American state mental hospital of the 1950s with the contemporary population at large. It is clear that at that time, as subsequently, working or lower class persons would be more likely than middle class persons to become patients in a state hospital, and that in order to avoid stigma and to obtain better treatment, the middle class mentally ill person would be more likely to seek the anonymity of a private hospital.

Thus the persons leaving a state hospital in a given year would properly be comparable with a sample of the general community equivalent to them in a social class background, not with the general population at large. The arrest rate of the whole general population would be lower than that of the section of the general population with class characteristics the same as those of the population of ex-patients studies. One must be particularly suspicious that this would be so if blacks tended to go to the state mental hospitals while whites tended to go to private hospitals where possible. For this reason it would appear that what Rappeport and Lassen show is not that mentally ill persons have a higher arrest rate than the general population, but only that poor persons have a higher arrest rate than the general population. This proves nothing. In order to make the point which they sought to make, the authors ought to have at least attempted to allow for social class as a variable factor.

The same methodological error was perpetrated by Zitrin et al. (Zitrin, Hardesty, Burdock and Drossman, 1976) in another American study which "found" that the arrest rate for psychiatric patients was higher than for the general population, and by Giovannoni and Gurel (Giavannoni and Gurel, 1967) who looked at functionally psychotic (mostly schizophrenic) war veterans. Without proper study of the class variable, such studies are useless - indeed, positively misleading.

They have led Mesnikoff and Lauterbach (Mesnikoff and Lauterbach, 1975) to conclude - by reference in particular to Brill and Malzberg - that before 1960 there was a research consensus that (p. 422)

> "...ex-patients showed no greater, or even smaller rates of violent criminal behaviour than the general population. In contrast, most recent studies reinvestigating such comparative crime rates, have reported that psychiatric patients released to the community display as much violent crime as the general population and in certain categories appear to have higher rates."

This is not only ill-expressed; it ignores the vital question, "Which part of the general population?"

The proposition that former mental patients are probably not significantly more violent than people in the general population is indirectly supported by a study of Fottrell, Bewley and Squizzoni (Fottrell, Bewley and Squizzoni, 1978) of aggressive and violent behaviour among a group of psychiatric in-patients at Tooting Bec mental hospital in London. This is a hospital which draws general psychiatric admissions from a population of about 270,000.

It was found that most aggressive and violent behaviour was of a minor nature and was perpetrated by a minority of patients who repeatedly behaved in this fashion. This was so even though the wards studied had only acute or sub-acute cases.

They say at p. 66 that:

> "The four wards had a total population of 104 patients and this number remained approximately constant throughout the study."

Unfortunately, the authors do not indicate how many people were admitted to and left the wards during the nine month period: i.e. it is not clear what the patient turnover was. This is a significant defect of the study. But in any event, they say at p. 67 that:

> "During the nine month period there were 175 incidents of aggression or violence and 76 patients were involved. All incidents were of a minor nature and no one received major physical injury. One hundred and six of the incidents (61 per cent) consisted of abusive, threatening, demanding or disruptive language. On 52 occasions (29 per cent of all incidents) there was physical violence against the person. This was directed against the self on 29 occasions (16 per cent) and against others on 23 occasions (13 per cent)...
>
> "A minority of patients were involved in a majority of the incidents - 14 patients accounted for 88 incidents."

The general picture painted by Fottrell et al. of a typical psychiatric hospital certainly accords with this writer's impression obtained from some limited experience in and observation of mental hospitals. By and large they are

not particularly violent places, and the patients in them are usually not particularly aggressive or violent. No doubt things were different a few decades ago before the advent of the major tranquillizing drugs, and no doubt there is more potential for aggressive acting out in special hospitals such as Morrisett and Broadmoor than in general hospitals, but in general mentally ill persons are not - at least by virtue of their mental illness - identifiably or particularly dangerous.

Yet easily the most significant fact about the supposed "dangerousness" of mental patients is that even if it were shown clearly and without technical error that mental patients or ex-mental patients have an arrest rate for serious offences which is twice, even three or more times that of the population at large with which proper comparison can be made, there is no practical policy consequence which flows from this. The actual figures quoted by Rappeport and Lassen demonstrate this clearly. For example, they suggest that the arrest rate for the subject group for rape offences was much higher than for the population at large. In 1957, three of the group of 2152 releasees were arrested for rape, a rate of 139.4 per 100,000 of the population. The arrest rate for members of the general public was 20.9 per 100,000. In 1960, one of the releasees was arrested giving a rate of 46.4 per 100,000, as against 20.1 per 100,000 for the population at large. So far as applying a practical test is concerned, the predictive usefulness of this difference is virtually nil. Even amongst mental patients or ex-patients, we are faced with the fact

that the overwhelming majority are not dangerous, if we are talking in terms of serious crime. One might draw an analogy with the situation of a strong swimmer and a moderately good swimmer cast adrift in the Pacific Ocean in a storm, hundreds of miles from land and far from the shipping lanes. The strong swimmer has a better chance of surviving than does the other, but in both cases the chances are very remote. The overwhelming probability is that neither will be rescued.

So it is with the likelihood that a given individual in a general population will commit a serious and dangerous crime. In the absence of more specific considerations indicating dangerousness (the most important of which is the fact of having committed assaultive or dangerous acts on a recent occasion) the fact that a person is or has been mentally ill will not allow one to predict future dangerousness. Mental illness is certainly not, as in the analogy mentioned earlier, the equivalent in civilian life of a uniform or insignia indicating a probability that the wearer of it will take hostile action against one. Unless those in authority are prepared to say that it is justifiable to lock up (say) 98 or 99 non-dangerous mentally ill persons in order to prevent the injury which might be caused by the one or two who are truly dangerous, any comparison between the arrest rates or the dangerousness of the population at large and the population of the mentally ill is bound to be irrelevant. In short the position is this: it has not been demonstrated that the mentally ill are in general more dangerous than the population at large.

But even if this were to be demonstrated to the degree which Rappeport and Lassen and Zitrin et al. purport to show (but do not), such a demonstration would not of itself justify involuntary admission to a mental hospital on the ground of mental illness.

In a leading paper on dangerousness, (Livermore, Malmquist and Meehl , 1968) it is said at p. 85 that:

> "On the armchair assumption that paranoids are dangerous, we have tended to play safe and incarcerate them all. Assume that the incidence of killing among paranoids is five times as great as among the normal population. If we use paranoia as a basis for incarceration, we would commit 199 non-killers in order to protect ourselves from one killer. It is simply impossible to justify any commitment scheme so premised."

The phenomenon of the overprediction of dangerousness is referred to in another leading paper published in the same year (Dershowitz, 1968) in which the literature is reviewed:

> "Psychiatrists are rather inaccurate predictors; inaccurate in an absolute sense, and even less accurate when compared with other professionals, such as psychologists, social workers and correctional officials; and when compared to actuarial devices, such as predictive or experience tables. Even more significant for legal purposes, it seems that psychiatrists are particularly prone to one type of error - overprediction.

In other words, they tend to predict anti-social conduct in many instances where it would not, in fact, occur. Indeed, our research suggests that for every correct psychiatric prediction of violence, there are numerous erroneous predictions. That is, among every group of inmates presently confined on the basis of psychiatric predictions of violence, there are only a few who would, and many more who would not, actually engage in such conduct if released.

"One reason for this overprediction is that a psychiatrist almost never learns about his erroneous predictions of violence- for predicted assailants are generally incarcerated and have little opportunity to prove or disprove the prediction; but he always learns about his erroneous predictions of non-violence - often from newspaper headlines announcing the crime. This higher visibility of erroneous predictions of non-violence inclines him, whether consciously or unconsciously, to overpredict rather than underpredict violent behaviour."

One important difficulty pointed out by Wenk et al. (Wenk, Robison and Smith, 1972, 402) is that:

"The classification of events on the basis of the magnitude of their consequences may not be a true indicator of an individual's violence-proneness. The severity of injury resulting from a given interaction is only partly determined by the assailant's intent or

factors within his control, and innumerable factors may make the difference between no injury and death, or between minor and major injury."

For example, as Newton and Zimring (Newton and Zimring, 1970) have shown, whether the victim of an assault lives or dies may depend entirely on whether the assailant has to hand a lethal weapon, or can use only his fists, or a less than lethal weapon. This is an important factor, since many violent incidents occur in the heat of the moment and without premeditation. Again, the extent of the injury may depend on chance factors such as the kind of clothing which the victim was wearing at the particular time or on the proximity or efficiency of an ambulance service.

This problem interacts with the problem of the relative rareness of violent acts in general as a major difficulty facing the person who seeks to predict violence in any population, whether amongst the mentally ill, those convicted of crimes, those in certain age or racial groups, or otherwise.

One of the best papers on the general subject of predicting dangerousness is by the late Professor P.D. Scott, a distinguished psychiatrist with great practical experience (Scott, 1977).

Scott analyzes various factors which are sometimes said to be linked with or indicative of dangerousness, and points out very persuasively the ease with which potentially violent individuals may escape notice. He says (at 133) that:

"Some of the most devastating violence is produced by quiet, inoffensive persons with no previous criminal record, who have been under great stress for a long time and finally explode into a single brief but perhaps very dangerous act".

As to the usefulness of psychometric tests in the assessment of dangerousness, he is pessimistic (Scott, 1977, 135):

"No doubt the contribution of new forms of standardized test is potentially great, but to date they are not clinically very helpful in this field."

Scott's preeminence as a forensic psychiatrist permits him to make numerous acute observations about the unavoidable task of attempting to distinguish the dangerous from the non-dangerous. For example he says (at 138),

"A single interview near the time of release by a stranger is not a good basis, on its own, for assessing dangerousness. As already stated most help is to be got from plodding through records, nurses' notes and trial transcripts, and talking to the staff who are in daily contact with the patient."

But even the individual perceptiveness of a P. D. Scott provides no complete solution to the inherent difficulty of predicting dangerousness.

A dramatic illustration of this difficulty is the American Supreme Court decision in Baxtrom v. Herold (1966) 383 US 107, and its consequences. In this case a prisoner had been convicted of assault. During the period of his imprisonment he had been transferred to a security hospital for the criminally insane which stood under the jurisdiction of the New York Department of Correction. A petition was brought requesting that he should upon the expiration of his sentence

be either released or, if it were thought that he continued to be insane, transferred to a civilian mental hospital under the jurisdiction of the Department of Mental Hygiene. Since New York state law at the time guaranteed that any civilian person admitted initially to a mental hospital on an involuntary basis should have a right to a jury hearing, it was argued that to allow Baxtrom's continued incarceration following the expiration of his sentence to be based on a hearing without a jury would be in breach of the equal protection clause of the Fourteenth Amendment to the Constitution. The Supreme Court accepted this argument saying at p. 111:

> "It follows that the State, having made this substantial review proceeding generally available on this issue, may not, consistent with the Equal Protection Clause of the Fourteenth Amendment, arbitrarily withhold it from some."

The result of this decision was that a large number of persons (967) who had been detained in institutions for the criminally insane and who were considered to be dangerous were required to be transferred to low security civilian mental hospitals. By the end of the first year after this had happened, only seven of the transferees had been retransferred to the maximum security institutions. Eight years later only 26 of the 967 had been returned. Many had been released to the community. As Steadman and his colleagues have shown in a

series of writings about the Baxtrom patients, the psychiatrists and lawyers involved in the assessment of the dangerousness of these persons erred grossly in the way of predicting far too many "false positives": i.e., they overpredicted the danger. (Steadman and Keveles, 1972; Steadman, 1973; Steadman and Cocozza, 1974; Cocozza and Steadman, 1974; Cocozza and Steadman, 1976; Steadman and Cocozza, 1978.) As was made clear in the 1973 paper, (p. 317) there was nothing about the 26 returnees which distinguished them from the other patients released in any way which could have usefully served as a predictive device:

> "We were able to find only two factors differentiating the Baxtrom returnees from the other Baxtrom patients. The returnees were much younger than the other Baxtroms: the average age of returnees at the time of transfer was 33, while the average of the other Baxtrom patients was 47 at the time of the transfer."

The second differentiating factor was the scores on an objective test of dangerousness based on previous criminal history (id.):

> "This difference does not mean, however, that the return could have been predicted from the scores. Over 90 per cent of the Baxtrom patients with a high score on the objective test did <u>not</u> return to Matteawan or Dannemora. It does mean that the younger patients with more serious criminal histories were the group most likely to return,

but the vast majority even of this highest risk group did not return." (Emphasis added.)

Steadman's work on Baxtrom has been criticised in considerable detail by Gordon (Gordon, 1977) who strongly attacks a number of the statistical assumptions and supposed misconceptions underlying it. In particular he argues (at p. 252) that

> "If the percentage of noxious deviants in the larger community is small...even severe side effects will appear miniscule when averaged over the entire population, and any cavalier policy favouring release can be defended successfully. For this reason, it is usually more appropriate to consider effects on the local micro-community immediately surrounding a released person when that person is simply mentally ill...There is no justification for imposing burdens on the micro-community that one would not tolerate oneself or would not recommend for the entire community."

Crudely put, Gordon is really saying "Don't let them out if you wouldn't be prepared to live with them yourself", an argument which might have some force on the hustings but is really no answer to the fact - clearly demonstrated in the Baxtrom saga - of overprediction.

The more effective point made by Gordon is that the overprediction of dangerousness might arguably be justified on simple policy grounds. While Steadman and company proclaim

that most of the Baxtrom releasees were in fact able to live peacably either in ordinary civil hospitals or in the community at large without committing offences and being returned to the high security hospital for the criminally insane, nonetheless some did commit assaults and other violent offences. These would not have happened had the Supreme Court decision not occurred.

Gordon argues that since most people who end up in institutions for the dangerous criminally insane usually do so only after serious offences which are repeated, then to some extent they forfeit certain rights. For the protection of the community they must tolerate being detained as "false positives" - i.e., persons who would not commit further offences if released - in order to avoid that amount of harm overall which would result from a general release. He argues that some 30 to 40 per cent of releasees under Baxtrom in fact were dangerous, an interpretation of the material at variance with that advanced by Steadman and others.

Gordon's criticisms must be read in the light of his special interest - he was an Advisory Board member of the Patuxent Institute in Maryland which for many years operated as a centre for the detention of the criminally insane. In 1977 the state legislature of Maryland, under influence of the Baxtrom studies, abolished indeterminate detention. Gordon's critique is largely an apology for and justification of the old policies. Under the camouflage of much detailed

statistical analysis, he is really saying that if even only one of three or five lunatic criminals is going to commit a serious offence if they are all released, they should all be detained indefinitely. This is no doubt an arguable position to adopt, but his reinterpretation of the Baxtrom material is not at all persuasive. If Steadman's figures are correct, it is not one in three or five of the Baxtrom patients who committed further serious crimes; it is one in thirty or forty.

In the view of this writer the Baxtrom materials do show a clear tendency to an unacceptably high level of overprediction of dangerousness with respect to continued detention.

How does this relate to involuntary admission and detention of the mentally ill in civilian mental hospitals?

Firstly it demonstrates that so far as <u>detention</u> is concerned, our predictive capacities are so weak that we cannot justify prolonged detention on the ground of danger to others. But what of involuntary <u>admission</u>?

It is notable that most of the studies critical of the capacity of psychiatrists (and others) to predict dangerousness are concerned with the <u>long term</u> possibility of dangerous behaviour. It is quite a different matter, for example, where a doctor is called to a house and observes a patient whom he knows to be mentally ill physically attacking his wife and children and smashing things. As far as the next ten minutes are concerned, the predictive ability of the doctor (or, indeed, of a fireman or bricklayer who happened to be present) would no doubt be very high. There is nothing in

the literature of dangerousness which demonstrates that a doctor is not able to see the nose on his face, even though he cannot be certain that it will be in place next week or next year.

The paragraph above was written for a draft of this thesis in 1976. Since that time Monahan (Monahan, 1977 and Monahan, 1978) has made the same point. He wrote in 1977 (pp. 363, 364):

> "There is a growing literature purporting to demonstrate that mental health professionals are grossly inaccurate in predicting violent behaviour...A careful reading of this research, however, reveals that it is derived exclusively from situations in which the subjects were institutionalised for a lengthy period of time - several months to several decades - before the predictions were tested in the open community. There is reason to believe that these situations are qualitatively unlike those which obtain in the case of the short-term predictions of violence, such as occur in the emergency civil commitment of persons believed to be imminently dangerous to others..."

In a recantation in 1978 (Monahan, 1978, 199) Monahan said that:

> "Rather than demonstrating that all forms of violence prediction are "doomed" (as I have previously stated)... a more discerning reading of the existing research suggests that it demonstrates the invalidity only of predictions made in one context that an individual will be violent in another, very different context."

He further says (p. 200):

> "I know of no data substantively relevant to the question of predictive accuracy in emergency commitment situations. The empirical question, therefore, is an open one."

This writer would respectfully agree with this analysis. We know that people cannot predict violence accurately in the long term, but common sense suggests that the prediction of violence in the immediate short term is probably reasonably possible. We shall no doubt see about this from further studies. At the present this writer takes the view that the act of predicting violence is indeed inherently difficult and liable to error, but that if we are dealing only with the immediate short term forecast necessary for the purposes of admission, the possibility of overprediction and "false positives" does not of itself constitute an insurmountable objection. It is vital, however, that such involuntary admission should be severely restricted in duration and subject to various other limitations as will be indicated.

(b) Prediction argument as to danger to self

The immediately foregoing arguments have been directed to the question of the predictability of behaviour dangerous to persons other than the mentally ill person. The same kinds of problems arise in relation to the prediction of behaviour dangerous to self. Rosen (Rosen, 1954) points out the difficulty of predicting isolated incidents of which suicidal behaviour is a kind. This difficulty is the greater where the basis for the

assessment of dangerousness is merely a threat of suicide. One can postulate a scale of grounds which might be required for involuntary admission on the basis of danger to self; first, a suspicion on the part of the psychiatrist (or other relevant person involved in the decision) that the individual in question might suicide or attempt suicide; second, a belief to this effect based on statements or threats by the individual; third, a belief to this effect based on observation or reliable report of an actual suicide attempt or gesture; fourth, a belief to this effect based on knowledge of consistent and repeated serious attempts at suicide, including a recent attempt, and knowledge of expressed determination to carry out a further attempt if provided with the opportunity.

One might easily extend this list to allow for further refinements, but the point is made. Clearly the efficiency of the prediction will depend upon the point along the above-mentioned scale which is chosen as the place at which to make the prediction.

Prediction of suicidal behaviour is clearly more difficult if based on an intuitive feeling or sixth sense than if based on the objective observation that the person has already made a number of determined attempts to kill himself or herself.

Stoller, a leading Australian authority on suicide, has expressed himself on this subject in terms which are no doubt applicable elsewhere: he says (Stoller and Krupinski, 1972, 335) that the group most at risk of suicide are:

> "depressed middle-aged and elderly persons, especially those who are psychotic, have had previous episodes, have made determined attempts before and have become depressed without adequate environmental cause."

However, he goes on to make the point that although one might say that persons falling within this category are at risk,

> "even after such groups are delineated, the relative rarity of such cases in a time-and-space continuum makes it extremely difficult to mount a special programme to isolate and treat them before the final act of suicide." (Id.)

To isolate them, that is, from the many other persons having similar characteristics who are <u>not</u> in the immediate future going to commit suicide.

Stengel points out (Stengel, 1967, 39) that the main difficulty in predicting suicide stems from the complexity of the motivations of persons who engage in self destructive behaviour:

> "Human behaviour usually has multiple motivations, not all of them obvious and some antagonistic to each other. People, according to some psychiatrists, either want to die or to live. That most people who commit suicidal acts want to do both at the same time, and that these suicidal acts may also serve as punishment for others, seems difficult to grasp. Yet there is ample evidence

that this commonly happens. To divide people who commit suicidal acts into those who want to kill themselves and those who do not, with a sprinkling of those who do not know, is as justified as to divide married people into those who love and those who hate each other, or parents into those who love and those who hate their children. In fact, the main reason why human relations, and psychiatry, are so complicated and confusing, is that most people love and hate, want to die and to live, and to kill and preserve life at the same time. Why should we expect those people who commit suicidal acts to behave as if they knew exactly what they wanted and to act accordingly? Only rarely is human behaviour governed by one tendency only."

For a long time the persons who committed suicide and those who attempted it were regarded as belonging to one homogeneous class. Although this view continues to be expressed even relatively recently, it is Stengel's main contribution to the study of suicide that he has caused such simplisticism to be reconsidered and indeed widely rejected. (Stengel, E., 1952; Stengel and Cook, 1958; Stengel, 1964.) Although, as international comparisons show, there are some variations between cultures in rates of suicide and attempts, and in methods used (World Health Organisation, 1974) it is nowadays accepted that certain important differences between those who merely attempt and those who complete suicide are discernible. In the report of a study of suicides

and attempts in Victoria in 1963 (Krupinski, Polke and Stoller, 1965, 775) it is said that:

> "There are significant differences in age between the attempted and completed suicide groups. In both sexes a higher proportion of younger people attempted suicide and a higher proportion of older people completed suicide."

And Stoller has written (Stoller, 1969, 2) that:

> "As elsewhere, females predominate in attempted suicide (2-3/1), whilst more males than females complete suicide (2/1)."

In a careful study of suicides and attempts in Los Angeles County in 1957, it was found (Shneidman and Farberow, 1961, 28, 29) that:

> "The committed suicides and attempted suicides showed marked variation in age distribution. Both male and female commits show a modal age of 42, whereas among the attempted suicides the peak occurs at age 32 for males and 27 for females. For both sexes, attempts in the sixties and above are relatively rare compared with commits (6 versus 27 per cent). There are more attempts among both sexes in their twenties and thirties than there are commits (56 versus 29 per cent). Indeed, more than three times as many females in their twenties attempt suicide rather than commit it (29 versus 9 per cent). In general, the older the person, the more likely that suicidal behaviour will have lethal consequences. (It is

well known that suicide rate, especially in males, goes up with each decade after age fifty.)"

Stengel (Stengel, 1967, 36) says British studies showed that:

"The peak of the attempted suicides was in middle age and females were in the majority, which is at variance with the suicides which have a later peak and a male majority."

In Australia it appears that the pattern of suicidal behaviour and attempts approximates to these descriptions. (Krupinski, Polke and Stoller, 1965, 774; Hetzel, 1971, 160). The general picture of there being certain distinguishing characteristics for the two groups is clear. However, there is substantial disagreement, in Australia and elsewhere, as to whether it can be said that attempters and completers are two entirely separate and unrelated groups.

According to the World Health Organization (WHO, 1974, 95, 96):

"Those with theories about suicidal behaviour can be split into groups according to their theories. For example, unitarians see each type of suicidal behaviour as an expression of one intention, which is to die. Thoughts or threats of suicide, attempted suicide and committed suicide are seen as quantitative expressions of the wish to die. Counter measures are centred on

preventing death. Binarians, of whom Stengel is given as an example, see two different groups - suicides, who die by their action, and attempted suicides whose intention is to damage themselves but not to die... Pluralists see various intentions among those who attempt suicide. Some may be described as making a suicidal pause in their lives; they want to make a break with the past and then to go on. They will deny any intention to kill themselves, saying instead that they wanted a long sleep. Others who fail to complete suicide have made an appeal; they know they have taken a risk and want to see if it will work out in their favour. Lastly come the individualists, who think each case of suicide or attempted suicide is unique and they leave it to the treating psychiatrist to decide whether the desire to die was real or not."

This is a relatively simplified analysis of the various theories about the nature of suicidal behaviour (for a more detailed review, see Beall, 1969) but it serves to indicate the main divisions of opinion. The only one of these approaches which is consistent with a firm belief in the possibility of accurately predicting in advance that a particular person will attempt (or further attempt) suicide is the first mentioned unitarian theory, and this is the view which is at least consistent with the known facts about suicide and attempts. Apart from the characteristics of age and sex which have already been mentioned as relevant factors, there is the matter of the

ratio between suicide and attempts. The best available estimates are that attempts outnumber actual suicides by something in the proportion of 7:1 or 8:1.

It is easy to appreciate why this was a question about which little was known for a very long time. The population of committed suicides in any jurisdiction can, given accurate reporting procedures, be fairly clearly established, at least within certain limits.

The population of attempted suicides in a given place during a given year, however, is subject to no complete central analysis or recording procedure, nor could it be. There are a certain number of persons who take overdoses of drugs and are admitted to the casualty sections of large hospitals, and this group can be measured with reasonable accuracy. But in addition there are persons whose attempts result (for reasons of family discretion, perhaps) in them going to or being taken to a private hospital, or in cases where the wound inflicted was not very serious, to a general practitioner. And there is probably another group of cases where the nature of the suicide attempt is such that, intervention having occurred, it is not necessary to seek medical help (e.g. "Russian Roulette" where the firing pin of the gun does not strike a bullet). Because of the difficulties of estimating these populations, most studies of suicide and attempted suicide have tended to define the sample of attempts in terms of those admitted to public hospitals for emergency treatment.

However, in the study by Schneidman and Farberow mentioned above, a careful effort was made to contact all medical practitioners in the area studied. The co-operation of the American Medical Association was obtained and there was a remarkably high response rate of over 70% to the questionnaires. The total number of attempts in Los Angeles county in 1957 was reported to be 5906, made up of 3887 noted by doctors and 2019 obtained from the records of hospitals. This gave a ratio of just under eight attempts to each suicide, a figure which roughly tallies with that reported by Stengel. (Stengel, 1967, p. 36: "It has been estimated that the number of attempted suicides is about 6 to 7 times as high as that of the suicides".)

From this ratio it is clear that most attempters do not go on to commit suicide subsequently. Stengel and Cook (1958) showed that only 1 to 5 per cent of suicide attempters subsequently went on to commit suicide within the following 5 to 10 years.

There has been no Australian study establishing with precision the ratio of attempters to those who subsequently go on to suicide, but the best opinion is that it would also be high (i.e. many attempting and few succeeding). Krupinski et al., (Krupinski et al., 1965, 777) say

> "Our Victorian figures also differ from Ringel's (1961) statement that one third of suicide attempts have a fatal outcome. From our own figures coupled with those of Buckle et alii (1965), our impression is that the ratio

of suicidal attempt to completed suicides in Victoria is much higher than that noted by other authors. However, an absolute answer can be given only through a study covering admissions to all types of hospitals and clinics, as well as those cases dealt with by private medical practitioners."

Edwards and Whitlock tried to obtain a wide coverage in the Brisbane study of attempts and suicides (Edwards and Whitlock, 1968) but although they obtained information from large hospitals and from private psychiatrists, they were reluctant to ask general practioners to disclose details of behaviour which was defined in that state as a criminal offence. Further there was no statement in the report of just what proportion of private psychiatrists replied to the circular. One assumes that the proportion was low, as they were given details of only seven patients seen in private practice. Clearly their figures do not accurately reflect the total volume of attempts. The number of suicides they report in Brisbane in 1965 was 163, and the number of attempts 680, a ratio of about 1:4. One imagines that if the coverage for attempts had been as extensive as in the work by Stengel and by Shneidman and Farberow, the ratio would have been a good deal higher (i.e., many attempting and few succeeding).

Assuming then, a large number of attempters and a small number of those who actually complete the act, what conclusions can we draw as the predictability of suicide?

One thing appears clear: that it is not possible to predict suicide with a very great degree of probability merely from verbal threats. The studies discussed so far apparently involve cases where ther has been some actual physical suicidal gesture, however slight, and even in these cases the difficulties of prediction are large. These difficulties are greater if we have regard to the number of persons who merely threaten suicide verbally. Clearly such a study could never in fact be done, but a survey which involved the asking of the question "Have you threatened to kill yourself during the last year?" would, if honestly answered (which it would not be), probably result in a figure not five or ten times higher than the actual suicide figure, but perhaps 20 or 50 times higher. The implication of this is unavoidable; the involuntary admission to mental hospitals of persons who merely threaten to commit suicide is only justifiable if it be frankly understood that it involves the prediction of many "false positives".

Is the involuntary admission of those who have actually made an attempt open to the same objection? In answering this question three matters need to be considered; first the numbers of those attempting and completing suicide who are mentally ill; second, the proportion of suicides who have not previously made an attempt; and third, the proportion of attempters who subsequently suicide.

As to the first matter, Krupinski et al. (Krupinski, Polke and Stoller, 1965, 774) point out that:

> "Of the 302 males who died in Victoria as the result of a proven or suspected suicide, 64 (or 21.2%) had been previously under the care of the Mental Health Department. The corresponding figure for females was 32 of 147 (or 21.8%)...In other words, one in every five persons who committed suicide in Victoria in 1963 had been previously under the care of the Mental Health Department. These are of course minimal figures, as they are concerned with persons with recorded previous Departmental psychiatric history, and do not cover those treated by private psychiatrists and general practitioners and those who had not received any medical care at all."

Clearly then there are a substantial number of persons who commit suicide when they are <u>not</u> mentally ill in the normally accepted sense. There is one school of thought which holds that any person who commits suicide must, by definition, be mentally ill; but his is consistent only with an unacceptably wide definition of mental illness. If we narrowly confine mental illness to the schizophrenias, affective illnesses and organic disorders of a kind resulting in delusions, hallucinations or some other manifestation of loss of contact with reality, there appear to remain at least some people who commit suicide while not mentally ill. Even if we generously (and unrealistically) multiply the approximate 20% referred to by Krupinski et al. by four, to take account of suicides who might have been mentally ill without coming in contact with the Department, we still find at least 20% of suicides

to be sane at the time of the act. But of course this would be an overestimation of the correlation between mental illness and suicide.

Stengel puts the matter quite definitely (Stengel, 1973, 59):

> "It has been found that on the average one third of the people who commit suicide have been suffering from a neurosis or psychosis or a severe personality disorder... At any rate, the majority of people who commit suicide have not been under psychiatric treatment. This is true for the United Kingdom and probably for other western communities."

The study by Edwards and Whitlock of suicide and attempted suicide in the Brisbane metropolitan area confirms this for that area. (Edwards and Whitlock, 1968.)

The second matter is the proportion of persons who commit suicide without having made an earlier attempt. It is clear on the available evidence that this group is either a majority or a large minority of those who succeed in committing suicide. Stengel (Stengel, 1967, 36) says that:

> "...only a minority of those who commit suicide have attempted suicide before."

Krupinski et al. (Krupinski, Polke and Stoller, 1965, 778) say:

"Almost half of the middle-aged persons who completed suicide had been previously in the care of the Department - in contrast to elderly suicides, for whom this was true on only a small proportion of cases." (Emphasis added.)

The third and most important matter is the proportion of those who make a suicidal attempt who subsequently go on to commit suicide.

Stengel (Stengel, 1973, 98) says that although

"People who have attempted suicide present a highly vulnerable group with an excessive suicidal risk",

nonetheless

"the large majority of people who make suicidal attempts are likely to survive..."

"Follow up studies carried out elsewhere and covering longer periods than the London investigations also show that only a small minority of people who make suicide attempts kill themselves later."

In a valuable article reviewing 15 follow up studies (Dorpat and Ripley, 1967), it is suggested that the best estimate which can be made is that the rate of subsequent suicide among attempters is somewhere between 10 and 20 per cent.

Tuckman and Youngman followed up 3800 consecutive attempts by persons aged 18 years of age and older who came to the attention of the Philadelphia Police Department. (Tuckman and Youngman, 1968.) A one to

six year follow up study showed 48 deaths from suicide in the sample. The researchers constructed a prediction scale from their materials, in the formulation of which they utilised various separate factors, namely:

Age, sex, race, marital status, living arrangements, employment status, physical health, mental condition, medical care within six months, method, season, time of day, where attempt made, time interval between attempt and discovery, suicide note, previous attempt or threat to kill. Allocating one point or zero for the presence of each presumably predictive factor, the cases were categorised in four groups of ascending risk, 0-1 points, 2-5 points, 6-9 points and 10-12 points. It was found that for the highest risk group (19-12 points) there was a 6% chance of completed suicide within the follow up period subsequent to the attempt (60.61 per 1000 among attempted suicides). Those in the second highest risk group were assessed as having a 1.9% chance of suicide.

One cannot dismiss this study on the ground that the prediction scale was based on unweighted factors. Tuckman and Youngman also developed two weighted predictive systems out of the same materials, but the simple one-point unweighted scale produced the same results.

Generally the evidence suggests, as Dorpat and Ripley say (Dorpat and Ripley, 1967, 76) that:

"...the majority of those who attempt suicide do not later commit suicide, and that a majority of those who have committed suicide have not made prior suicidal attempts."

Further, it seems clear that if we consider a particular suicide attempt, even one in a high risk category, the probability is that that person will not subsequently commit suicide. That is, in short, we cannot predict suicide very accurately, and it is certain that if we incarcerate mentally ill people on the ground of danger to self, we will incarcerate at least one person (but more likely five or ten more) who would not have committed suicide anyway for every one who would have done.

This writer asks why, in this face of the clear statistical evidence about prediction, should one shrink from concluding that involuntary admission of the mentally ill on the ground of danger to self absolutely cannot be justified?

One important factor lies in the human capacity to ignore distress which is distant and unrelated, whereas distress in those closer generates sometimes intolerable concern and anxiety. Where that distress manifests itself in self destructive behaviour which is direct and unequivocal, we are unable to rationalise it as anything else. So we tolerate fast driving, parachuting and other dangerous behaviour. These activities generally take place out of the house, away from us, and they appear to have some purpose other than self-destruction. We generally do not feel anxious and guilty if

they result in death. We may feel sad, but we recognise that it is impossible and unacceptable to proscribe such activities, and we do not feel directly responsible. Unequivocally self-destructive behaviour, however, which is carried out in one's physical presence, particularly by a person in respect of whom one feels some family or other obligation, is difficult to let pass or to rationalize.

One might be tempted to suggest that the impact of a million deaths in India equals a hundred deaths in Europe equals ten people killed in a bus crash in Queensland equals the impact of one death in one's street or an illness of medium seriousness in one's own family. Morally justifiable or not, this semi-facetious equation accurately reflects the way most people graduate their feelings of responsibility towards others and it represents one very real reason why involuntary admission to mental hospitals on the ground of danger to self continues to be part of the law.

Suicidal behaviour, whether successful or not, is often more or less consciously calculated to cause distress and worry to close relations or friends. And whether or not so calculated, it commonly has this result. The persons affected by the suicidal behaviour commonly feel guilty at real or imagined failure in coping with or helping the actor.

This reaction is almost inevitable in a community which at least pays lip service to the values of social responsibility, care and concern for others - particularly close relatives.

Viewed in this context involuntary admission on the ground of danger to self may still be justifiable (or at least understandable) notwithstanding the problem of overprediction, provided that the following conditions are satisfied:..

(i) that detention be for a short period only;

(ii) that detention be subject to stringent medical and legal review;

(iii) that proper attempts to treat the patient should be undertaken;

(iv) that the restriction on liberty should not be in the circumstances excessive; and

(v) that the physical conditons of the enforced detention and treatment should be of a standard which is socially acceptable.

While acknowledging that the evidence mentioned before in relation to the overprediction of suicide is sufficient to endow the abolitionist position with at least a minimum quantum of intellectual respectability, this writer takes the view that it is not compelling, and that on balance, and subject at least to the restrictions enumerated above, the retention of a system of involuntary admission on the ground of danger to self is justifiable. A further important matter to be mentioned in relation to this conclusion is the argument that such a system does not by any means entirely abrogate the

"right to suicide" (if there be one) since a person who determinedly wishes to kill himself will probably do so anyway.

For many persons, this is clearly true, and statistical patterns of suicidal behaviour indicate that older sick males (in particular) often suicide successfully with great determination and no warning. But what about those who are physically incapable of securing the means for suicide? Is such a rule not unfair to these persons? Perhaps it is. But on the other hand emphasis on the provision of short terms only of involuntary detention would tend to overcome this; i.e. if continuous detention of the periodically suicidal is not allowed. If the person is so ill as not to need any physical restraint, this issue merges into the problem of euthanasia.

A third reason why we might shrink from the strictly logical consequences of the prediction argument (i.e., the abolition of attempted suicide as a ground for involuntary admission) is that most suicide attempters "come out the other side" of the experience willing to go on living, at least. Some display gratitude that they were helped, albeit involuntarily, through a time of crisis and thank medical and nursing staff for the care and concern shown them. Witness the very common case of attempted suicide during post-puerperal depression. This transitory illness, no doubt commonly based on physiological causes rather than on an extended intellectual consideration of the justification for continued existence, provokes feelings of profound despair. Usually it lifts after

a short time and the woman regains, if not happiness, at least a belief that it is worthwhile to continue living. In cases such as these, where a depression is known to be likely to lift in a short time, where family and children are distressed, where the future of a small baby is involved, it seems, to this writer at least, foolish and cruel to deny the legitimacy of involuntary admission, provided that it does not involve enforced treatments such as ECT.

Against this, it might be said that the involuntary admission procedure still involves, on the statistics referred to above, the admission of many 'false positives'. This is no doubt true, but it is a value judgment whether one is prepared to accept some depressed mothers being inaccurately diagnosed as likely to commit suicide and thereby being hospitalised, for the sake of the occasional one whose life would thereby be saved. Assuming good to reasonable conditions in mental hospitals, proper treatment and facilities, and proper legal protection and representation, this overprediction seems to be justifiable.

The transitory nature of post-puerperal depression has been emphasised in this example. What if the suicide attempter has been suffering from an illness which is long-standing and chronic? In this case the prediction argument is more powerful and involuntary admission the more difficult to justify. The problem is that in such a case it may be thought necessary to detain the patient for a long time, perhaps for a number of years, and the sheer arithmetic of overprediction of

false positives means that many people will be locked up for a long time when in fact they would not have committed suicide anyway. The value judgment of this writer is that the involuntary detention of the chronically depressed for long periods of time, or so repeatedly as to make the detention almost continuous, cannot be justified. Short term detention of the chronically depressed can be justified on the following kind of argument: if a person really wishes seriously to kill himself, and that wish is the result of a long standing belief (whether rational or not), he can usually find the means to give effect to his wish. He can take himself somewhere where he will not be discovered and he can shoot himself, or poison himself or whatever. In present circumstances, it is not likely that mental health laws will be able to prevent him from taking this action. De facto, involuntary admission procedures cannot completely cancel out this 'right'. Therefore, provided that he has gone far enough in his actions to say that he has 'attempted' suicide, as distinct from merely making a threat of it, the conclusion can reasonably be drawn that he is to some degree equivocal about his intentions. If he is still alive, this fact indicates that he lacks the single minded dedication to suicide found in that group who commit the act by violent and effective means. He may, of course, be incapacitated in some way which prevents his effective suicide, but the majority of persons do not fall into this category; in fact, a considerable proportion of those who actually do suicide suffer from some serious illness

or incapacitation which does not, ultimately, prevent the achievement of their purpose. Short term detention (i.e. months rather than years) of those chronically depressed can be justified on the basis that no unequivocal intention to die has in fact been shown; that treatment may prompt recovery; and that a limited period of detention justifies the inevitable overprediction of 'false positives'. Even so, a reasonable person might take the view that while involuntary admission of the transitorily mentally ill is justified on the basis of danger to self, it is not, because of the over-prediction problem, justified in the case of the chronic or long term depressive.

Another argument which bears consideration is that, despite the statistics on overprediction, involuntary admission on the ground of danger to self can be justified on the basis that suicide is often closely associated with, and indeed is the converse of, danger to others. This kind of idea stems from the Freudian theory of the close co-existence in most humans of a death instinct and an aggressive instinct tending to self-preservation (Starke, 1973, 39-40). The many cases which occur of murder followed by suicide are evidence that there may be some connection between aggression against others and aggression against oneself; similarly, there is a not so common but still well known kind of murder where a person's upbringing has been restrictive, where high or unattainable standards of behaviour have been imposed on him so that he suffers from chronic feelings of guilt throughout his life, and ultimately he 'breaks out' and kills someone in circumstances which are

most surprising to those who know him. In such cases psychiatrists writing court reports may speak in terms suggesting that the guilt and aggression which has for a long time been directed inward has been suddenly directed outwards to another person.

Although this kind of argument may have a certain initial appeal, in fact all it does is to suggest a double danger. There is no evidence that either danger to self or to others is more predictable simply because one may discern some relationship in the nature of two things. Thus the arguments as to prediction and overprediction still stand and must be countered by those who would justify involuntary admission on either basis.

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*From the general line of argument advanced in this chapter to the effect that doctors tend to overpredict dangerousness it does not follow that doctors are thereby to be blamed. Doctors usually tend to seek to avoid harm - that is a natural result of their training. Another factor might be the fear - largely unjustified - of malpractice suits.

Australian doctors (perhaps in contrast with their American counterparts) need have little fear that the underprediction of dangerousness will lead to litigation. There is no equivalent in this country of cases where a doctor who does not initiate involuntary admission proceedings is sued by a person subsequently injured by a patient. Provided a doctor acts in good faith, even his errors will not necessarily constitute negligence, as the English Court of Appeal pointed out in Whitehouse v Jordan (1980) 1 All E.R. 650. So far as release from custody is concerned, the same principal would undoubtedly apply. Neither the common law of torts nor the statutory law in any Australian jurisdiction puts doctors at serious risk of legal action in respect of decisions, bona fida, to release. Certainly if a legal tribunal, such as the Mental Health Tribunal under the 1958 N.S.W. Act, decides to discharge a patient (section 6) any medical practitioner who has participated in the decision is saved from any suit against him. This writer would not propose any other rule.

# CHAPTER 6

## THE ARGUMENT AS TO DISCRIMINATION

### As To Danger To Others

In attempting to justify involuntary admission it is not only the absolute difficulty of predicting violence or dangerousness in particular cases which is important; of equal significance is the fact that mentally ill persons may be said to be as a class discriminated against. (Livermore, Malmquist and Meehl, 1968.)

It is certainly possible to specify classes of persons who are more likely to be dangerous in the sense of being assaultive or homicidal than are mentally ill persons in group. For example, young male persons aged fifteen to twenty five are, in group, relatively likely to be dangerous; youth and maleness are two clear characteristics of assaultive criminal behaviour. And, if one wished to nominate another category of persons more dangerous than mentally ill persons as a class, those released from prison after serving sentences for serious assault other than homicide would surely qualify. Previous criminal history is generally, almost universally, recognized as the most powerful predictor of future criminal behaviour. This is not to say that a history of convictions is a guarantee of future criminal behaviour; it is, as the Baxtrom and other evidence shows, nothing of the sort. But it is a better predictor than any other factor: certainly better than mental illness *per se*. (Payne, McCabe and Walker, 1974).

Yet in most common law jurisdictions there is no provision allowing retention in prison of a person who, having served a full sentence for assault, is still, on the threshold of release, considered by prison authorities to be dangerous. And upon completion of his sentence, in most jurisdictions in the common law world, there is no procedure for the former convict's arbitrary return to prison. There are some exceptions to this principle. In New South Wales, for example, there are provisions in the Crimes Act (1900) for a person to be sentenced as an habitual criminal to a longer period than he would otherwise have received on the usual retributive basis. But in the rare instances where this happens, the added sentence is given at the time of trial, not years later. Why not, in the case of any person who has in the past served a sentence for assault, allow subsequent imprisonment simply on the certificate of a policeman or a probation officer? Merely to propose any such scheme is to reveal its unacceptability, yet it is precisely this kind of scheme which in many common law jurisdictions, and in all of the Australian states and territories, is provided in relation to mental illness. This is the most powerful argument against involuntary admission or detention of the mentally ill on the ground of mental illness alone.

Yet one can accept this argument as generally valid without necessarily adopting the abolitionist view. Provided that the procedures for involuntary admission are not directed against mental illness per se, but against persons

who are mentally ill and in addition are dangerous to a degree which would broadly be regarded as justifying incarceration in other areas of the law (particularly the criminal law) where appropriate procedures for protection of individual rights are set down, one can argue that involuntary admission of the mentally ill would be justified. One might contend that even if the protections accorded civil liberties under the criminal law are admirable, it is nonetheless inappropriate in many cases to deal with the matter through the police and the courts; that if a person is mentally ill he needs treatment, or at least fairly careful handling, and that the best place for that to be provided is in the setting of the mental hospital. While the arguments as to the uncertainty of diagnosis of mental illness and as to the unpredictability of dangerousness are powerful and perhaps overwhelming objections to the provision of procedures allowing involuntary admission on the basis of mental illness alone, they fail to prove that involuntary admission should not be allowed in some limited circumstances, subject to proper legal procedures and protections. As was pointed out in chapter 5, prediction of distant dangerousness is considerably more difficult that the prediction of immediate dangerousness. Provided that there be established a system which requires of the doctor immediate rather than "long distance" observation, the possibility of error will probably be significantly reduced.

As for the argument about discrimination, the same conclusion can be drawn. If one confines a system of involuntary admission on the ground of danger to others to emergency situations where there is a probability of immediate injury of a serious physical kind, it is likely that the person will have qualified for being dealt with under the criminal law anyway. Thus it could not be said that the mentally ill person was being subjected to a penalty, while a mentally well person in the same situation and having behaved in the same manner would have escaped the notice of the law. In the emergency situation it is not a question of whether the law will be invoked, but of the form in which it will be invoked.

The Discrimination Argument As To Danger To Self

Why should the mentally ill person who threatens suicide be subject to detention while the equivalent "sane" person is not? Does this not represent unfair discrimination against the mentally ill? Why should we regard the suicide threat of the "sane" person as acceptable, rational and not appropriate for intervention, but the suicide threat of a person suffering from depression as a ground for involuntary detention? Why, if we lock up the mentally ill suicide threatener, do we not lock up (for example) the stunt man who announces his intention to fight a shark in a cage knowing that he will probably be killed in the encounter? In the former case, it will be noted, there is an actual direct

intent to suicide, while in the latter, death may be foreseen but it is not ostensibly a conscious purpose.

The most important reason why we draw a distinction between the mentally ill and the sane in these cases is because we believe that mental illness distorts perception to a degree which invalidates judgment. Is this realistic? It can surely be argued that the judgment and perception of an adventurer or stunt man might be strongly influenced by the desire for fame, publicity and riches to a degree equivalent to the distortions caused by mental illness. A proposal was bruited in 1975 for a "fight" to be held in a cage between a shark and a man, although ultimately it never occurred. Let us hypothesise such a case where the promoters offer one million dollars to the man who comes forward, and let us say that there is only a 30% chance of the man surviving the encounter. The "fight" will be filmed and televised around the world, and there is great interest in it. Can we truly say in such a case that the shark fighter has made a more rational decision than the depressed person who wants to end his life?

Is the man who has a fight with his wife and, in a rage, gets into his car and goes for a drive, making a rational decision? Deaths commonly occur in such cases. Is the nurse who is rejected by her married lover and then goes to Northern Australia to work in a leper colony, with its known risks, making a rational decision?

Two important distinctions can be drawn between the decisions made here by "sane" persons to enter upon some more or less dangerous activity as in the case of the shark fight, and the suicide threats or attempts of the mentally ill:

(1) The performance of the act decided upon by the "sane" person is not explicitly or objectively suicidal.

It involves, or appears to involve, some other purpose than merely bringing about the cessation of life. Presumably the shark fighter will attempt to kill the shark and not simply allow himself to be eaten; the nurse will attempt to avoid leprosy; the enraged husband will attempt to avoid other cars even though driving in a furious manner. Despite possible unconscious (or even conscious) wishes to die, these kinds of activities are distinguishable from the act of the depressed suicide attempter who swallows a bottle of sleeping pills or puts a shotgun in his mouth.

Whatever the <u>motives</u> be, the <u>purposes</u> appear different. An objective observer would clearly interpret pill-taking or head-shooting or cliff-jumping behaviour as suicidal, whereas he would say in the other kind of case, "He is fighting a shark"; "he is letting off steam after a fight with his wife"; "she is nursing lepers". As was pointed out above, most people find it easier to tolerate equivocally suicidal behaviour at some distance than unequivocally suicidal behaviour close to them.

Unequivocally suicidal behaviour (unexplained by some factor such as imminent death due to incurable cancer) is very threatening in most social contexts. People tend to ask themselves: "If he cannot find life worthwhile, what have I got to live for? Our conditions are similar." As a means of protecting one's own conception of the value of living, it is more attractive to postulate causes for other people's suicidal depression in curable factors than in some immanent, immutable and malign characteristic of the world or human nature.

Perhaps strictly in terms of civil liberties this process of logic, or rather this sentiment, is irrelevant or is not justifiable, but the writer would assert that it is in practice one of the most important reasons why involuntary detention of the mentally ill, would-be suicide, remains legally and practically possible. Apart from cases (such as the cancer example) where the sane suicide threatener or attempter is responding to a comprehensible problem, and the intention to suicide is manifest and unequivocal, sane actions which involve even very considerable danger to self are only equivocally suicidal. Observers can write off such actions by saying some such thing as "he died because he was not clever enough at fighting sharks." They are not compelled to reach the self-threatening conclusion that the death occurred because life is not worth living.

(2) A second distinction between the sane and the insane who threaten suicidal behaviour is that there is no treatment to be given (in a psychiatric hospital,

for example) to the person dying of incurable cancer who intends to kill himself, or to the adventurer who wishes to fight a shark.

There is no miracle drug to overcome stupidity, nor is psychotherapy a cure for cancer. But if the suicidal behaviour stems from mental illness, there is reason to hope that treatment in a psychiatric hospital or clinic may make the person better. This is, admittedly, merely a hope in some cases. It is foolish to suggest that all mental illnesses can be cured by treatment. Nonetheless, even adopting the pessimistic view that it is time alone which can cure, and that treatment is only incidental to this process, experience shows that the lapse of a few weeks or months may well see the disappearance of suicidal impulses. Time will not cure incurable cancer, nor will it (unless the person is detained indefinitely) prevent the reckless or the venturesome from engaging in shark fights, mountain climbing or hang-gliding.

For these reasons at least, a legitimate distinction between the sane and the insane suicide threatener can be maintained. Probably, using the word in a commonplace way, decisions made by the sane are more rational, on the whole, than decisions made by persons who are mentally ill. Yet one does not need to argue that the decisions of the shark fighter, the angry husband or the jilted nurse are particularly

rational or admirable. Perhaps they are not. But (1) they do not unduly worry other people and (2) there is nothing we can do by way of treatment to prevent them from occurring.

This analysis may be satisfactory to account to the case of the reckless adventurer, but what of the cancer victim facing certain agonizing death who threatens to suicide? Is his decision to suicide, made while sane, really distinguishable from that made by a person sunk in the depths of depression? Why should the latter only be subject to involuntary admission and detention? Is it not discriminatory and unfair to deny him what he sees as the blessed relief of death, if what he sees as the future appears as bleak to him as the agony facing the cancer victim?

It is simple to choose the cancer victim as an example and, at the opposite extreme, to postulate a case of transitory melancholia such as the post-puerperal depression. This writer, at least, finds it easy to say that in the cancer case involuntary admission and detention is not justifiable, but that it clearly is justifiable in the case of the depressed mother. But what if the distance between these two extremes is not so great? Consider the following case: a man aged 65 years has a broken hip which has been causing him trouble for a number of years. He has had three operations performed on it, none of which has been really successful and he remains in considerable pain. His family are all dead and he has no friends. He is very depressed and the doctors diagnose him as

being mentally ill. He attempts suicide. Is his case in fact any different from the case of the sane person facing incurable cancer? If we do not detain the cancer victim, why should we detain the man with the broken hip who faces a hopeless future?

A position which this writer find attractive and has foreshadowed is recognition of what might be described as a 'limited right to die' reflected in the laws relating to involuntary detention of the mentally ill. It is that while it is justifiable to detain and treat involuntarily the person who becomes extremely depressed and who is diagnosed as mentally ill, it is justifiable only under certain conditions; first, that only a relatively short period of detention be contemplated; second, that the nature of the illness be such that an improvement of the condition of the patient can be reasonably expected to occur in due course; and third, as a corollary of these propositions, that the involuntary detention should not in effect amount to a 'life sentence' condemning the patient to an indefinitely hopeless future in which he is actively and repeatedly prevented from taking his life.

Obviously it is very difficult to draw a line between the case of the transitory illness where involuntary detention would be justified, and cases of long term depression where there is persistent frustration of the suicidal wishes of the patient, in the face of the proven failure of either time or treatment to effect any improvement in the patient's condition.

This writer would be prepared to err on the side of caution, to allow detention and to accept that strenuous efforts ought to be made to prevent suicide by the mentally ill; but nonetheless would press the view that at some point in time a line must be drawn. There is good reason for this apart from the simple feeling that such detention would be cruel and pointless. The statistics on prediction of suicide make it clear that to release from detention a person whom it is thought might commit suicide does not guarantee that he will. On the contrary, as we have seen, the possibility of suicide is generally overpredicted by psychiatrists considering release.

The conclusion of this writer is that a distinction can properly be drawn between the cancer victim facing certain death who threatens suicide, and the depressed person defined as mentally ill who threatens suicide. Subject to the limitations and qualifications suggested in the preceeding paragraph, involuntary detention can be justified in the latter type of case. There will always be an area of judgment where the decision of a doctor or tribunal charged with determining the issue of detention or release will be open to criticism on the ground that, despite mental illness, the wish of the particular patient to die is reasonable and should not be frustrated. It may be pointed out in such cases that treatment has over a long period failed; that doctors cannot prescribe (for example) new accommodation and lodgings in a situation of a general housing shortage; that doctors cannot

prescribe new friends; that the individual's bleak view of his future prospects is, despite being influenced by mental illness, concomitant with the level of rationality or irrationality with which 'normal' people determine their affairs.

Those who take a conservative view of the role of the psychiatrist and the state's power in relation to mental illness might object that to release a patient in such circumstances and for such reasons would be to 'give up' in breach of a moral obligation to continue, for as long as possible and as vigorously as possible, the effort to save life. This view overlooks the factor of absence of consent to detention, and also overlooks the likelihood, emphasised in the preceeding argument, that suicide is generally over rather than underpredicted.

There will always be hard cases where the doctor or tribunal will find it difficult to weigh these competing arguments, and certainly this writer is not disposed to accept a system which allows detention without proper justification and safeguards; subject to this, the conclusion is reached that involuntary admission and detention can be justified not only in cases of transitory depression such as that following childbirth, but even possibly in cases such as that of the example of the man with the broken hip who is old, mentally ill and faces a barren future. In the latter kind of case, however, the decision to detain should be made reluctantly and carefully.

If it is accepted that the above analysis might be a sufficient justification for discriminating between the sane and the insane suicide threatener or attempter, what happens about the case where a person is both mentally ill and suffering from an incurable cancer which the reasonable person might think of as grounds for suicide? Although this is a highly hypothetical question, it does stand to test the logic of the position set out above.

Let us assume that we do not have to decide whether or not to administer euthanasia in these circumstances, or to assist ('aid, abet, encourage, counsel or procure...') the person to commit suicide, but only to decide whether or not to admit and detain involuntarily. Further, let us assume that we are confident that the person will kill himself if not prevented, and that that is what a sane and rational person might do in the circumstances.

To admit and detain in this situation would be difficult to justify except on the basis that once a person becomes mentally ill he is incapable of making a rational judgment about any aspect of his life. This is clearly not true. Many mentally ill people suffer from delusions which are quite self contained, and which do not prevent them from making competent and reasonable judgments about things unrelated to the subject of the delusion. Perhaps this is applicable particularly in relation to the schizophrenias, but it is also relevant to the affective illnesses including depression.

Leaving aside the issue of the legality of suicide, surely it would be unreasonable to admit and detain in a situation where, objectively, suicide was a sensible and humane way of avoiding a pain-wracked and humiliating death.

How then do we distinguish between this case (the mentally ill person who also suffers from incurable cancer), and the case mentioned above of the mentally ill person aged 65 years who has a broken hip, for whom treatment (both physical and psychiatric) has failed, and who faces a very bleak and friendless future? In the latter case we either (1) say (a) that we will substitute our judgment for his and say that objectively his future is not as bleak as he thinks it is (or (b) objectively that it is); or (2) say that we should not substitute our judgment for his, either (a) because his mental illness does not prevent him from making a rational decision about his future, and that he should be allowed to make the decision whether or not we agree with it, or (b) because we respect his right to decide irrationally.

Which of these approaches to take should depend, it has been suggested, on factors such as the likely length of detention, the prospects for improvement by treatment or effluxion of time, and a judgment as to the degree of rationality exhibited by the person. This assumes that only the first three alternatives ((1)(a) and (b) and (2)(a)) mentioned in the above analysis are acceptable. If the course is adopted ((2)(b)) of assiduously respecting the

right of the mentally ill to make what an objective observer would regard as an irrational decision, involuntary admission and detention clearly is not justified. Such an approach is certainly arguable and respectable, based on the proposition that since there is a very large grey area between the manifestly 'rational' decisions of sane persons and the manifestly 'irrational' decisions of the mentally ill, injustices must necessarily occur, and therefore no attempt to draw a line should be made.

The present writer acknowledges some force in the view, but on balance rejects it; provided that a cautious and conservative approach is taken to involuntary admission, and that other conditions previously mentioned are satisfied, detention is justifiable in this hypothesised situation. A distinction is therefore drawn - at least in theory - between the mentally ill person suffering from incurable cancer who attempts suicide (who should <u>not</u> be involuntarily admitted) and the mentally ill and friendless 65 year old man with the broken hip (<u>perhaps</u> to be involuntarily admitted and detained) on the basis of an objective determination of the rationality of the act of suicide. In order to draw this distinction it is necessary to make clear and acknowledge that in the latter case the judgment of the doctor or tribunal is being substituted for the judgment of the individual concerned.

For these reasons and with the qualifications suggested, it is argued that involuntary admission and detention on the basis of danger to self is justifiable despite the "discrimination" argument.

# PART 2

## PROCEDURES AND LIMITATIONS

# CHAPTER 7

## A LIMITING DEFINITION

The traditional medical view is that the "overjudicialisation" of involuntary admission procedures is "clumsy and self-defeating" (Rock, Jacobsen and Janopaul, cited in Gupta, 1970-71, 405). Many lawyers, uncertain about the nature of mental illness and in any event by training inclined to categorize and 'pigeonhole' things, take the view that the law and lawyers should not interfere in what is traditionally regarded as a 'medical' area.

Although it is reasonable to be sceptical and questioning about the beneficial effects of the intrusion of lawyers into certain areas of human activity, it should by now be accepted that legal process has a significant role to play in relation to the involuntary admission of the mentally ill. The "hard-line" approach of intransigent adherence to a purely medical model cannot be sustained in the face of a careful analysis of how and why involuntary admission occurs. The evidence about uncertainty of diagnosis, overprediction of dangerousness, and the problem of discrimination surely compels rejection of the notion of the doctor as policeman, judge and gaoler. It may not be true that mental illness is a myth, or that the mental hospitals are a conspiracy against innocent deviance; nonetheless involuntary admission is a drastic infringement of civil liberty which cannot be left to the unfettered and absolute discretion of the medically qualified. Indeed, it has been argued in Part 1 that the philosophical foundations of involuntary admission are so much open to argument that it in fact cannot be justified at all

unless there are proper legal restrictions on the process. It is appropriate at this point to attempt to support this proposition in more detail.

The first step in so doing is to squash the notion of "self-regulation" which is inevitably raised by industries or professions at bay in the public arena. If it be accepted, as has been argued, that psychiatrists tend to overpredict dangerousness and that it is necessary to distinguish between minor danger to others and major danger to others, and that there are a host of philosophical complications attendant upon the idea of "danger to self", it becomes obvious that a code of practice must be devised and utilized. Codes of professional practice are, of course, drawn up and followed in many areas. Nobody would suggest that it was necessary to legislate about whether procedure X or procedure Y should be followed by medical practitioners in the surgical removal of appendices. But doctors are the only people who remove appendices. They are the only persons in the community who can do so with proper skill and care. They operate upon their patients with their consent. The considerations involved in decisionmaking about such surgery are entirely technical - no questions of public policy are involved.

On all of these points the removal of an appendix is quite different from the process of involuntary admission of the mentally ill. In the latter case, there are other persons who can make judgments about mental illness. The patients do not,

by definition, consent. The considerations involved are as much philosophical as technical. Major questions of public policy are inevitably involved. It follows that such codes of practice as are devised and followed should be drawn up by the Parliament, as the legitimate and authorized vehicle for the expression of the public will. Statutory laws, once promulgated and subjected to interpretation by the courts from time to time, provide a consistency which is frequently absent from less formal modes of regulation. (Of course it is true that in NSW there has been a dearth of litigation on the subject of mental health generally; but since it will be proposed that there ought to be greater involvement by lawyers in the admission process itself and in the hospitals in general, this will not be a barrier to the development of consistency in rules).

In this chapter it is proposed to consider the question of a definition of mental illness; and in particular, the problem of limiting the notion so as to exclude from it conditions and behaviours which, for the purpose of protecting the freedom of individuals, ought to be excluded.

## Defining "Mental Illness"

The NSW Mental Health Act (1958) defines "mentally ill person" in a circular fashion. Section 4 says that a "mentally ill person" is one 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..."

No attempt is made to define what constitutes "mental illness". In the view of this writer, the failure of the Act to attempt to define "mental illness" in a comprehensive fashion is both practical and philosophically justifiable. The legislature might just as well have embarked on the exercise of attempting to define in statutory language the taste of an avocado in season or the sexual attractiveness of the female fruitfly. To use a human analogy, the attempt might as well have been made to define "happiness". The impossibility of such as exercise requires no abstruse explanation.

Rather the legislature has sought to give utility to the expression 'mental illness' by subtracting from its global totality certain situations which will not qualify for the legal purposes in question. In other words, the person must <u>firstly</u> be mentally ill (whatever that may mean) and <u>in addition</u> he must require care, treatment or control for his own good or in the public interest. It is a further requirement still that he must be for the time being incapable of managing himself or his affairs.

These additional requirements are unsatisfactory and inadequate. Further such requirements will in due course be proposed and specified by the writer. But it must be acknowledged initially in our analysis of the grounds for involuntary admission that the approach of the NSW statute is fundamentally sound. The only sensible way to define mental illness for the purpose of involuntary admission is to start with the global concept, however broad and ambiguous it be, and pare it down by appropriate and workable qualifications.

It might be immediately objected, of course, that such a process is bound to fail because the initial figure from which a series of deductions is made is unknown; all subsequent calculations must then conclude at an unknown point. No doubt this objection is logically and mathematically well founded, but nonetheless, it will be argued, such a process is practical and workable in terms of a legal definition.

Lest this seems at first sight a somewhat unconvincing argument, it needs to be stressed that the attempt to define mental illness in precise and comprehensive terms would involve a hideously protracted and difficult task. The relationship between mind and body has been one of the central problems of western philosophy for millenia. It has kept many clever people occupied for entire lifetimes. It involves questions arising in the expanding areas of physiology, chemistry, psychology and so on. It involves, as we have seen in relation to the "deviancy" argument, difficult problems about social definitions of "normality", and further associated problems about the acceptability of eccentricity.

It is this writer's firm conclusion that the process of developing and drafting clear, humane and workable laws about mental disorder and its problems does not depend, <u>in limine</u>, on the comprehensive elucidation of the "true meaning" of the phenomenon. Just as we can do practical and important things in our everyday lives without knowing all the "causes" of what enables action to occur, laws can be successfully made and operated utilizing terms some of which are less certain than others.

If we cannot obtain clear professional agreement about the meaning of "mental illness" (and nothing is more certain than that we cannot) we can at least confine and restrict it. In short, if we cannot stop the beast from eating people, we can build a cage to keep him in. It will then be possible still for philosophers, observers and practitioners to walk around the cage pointing out peculiarities, differences from other varieties, taking notes and puzzling deeply about what they do or do not observe. They may write learned papers on the subject. But the legal definition will consist in the bars and wires which make up the cage.

Against what dangers will a cage of words around the concept of "mental illness" protect us?

Fortunately these are fairly clear. There is a history of the misuse of legal powers to control the mentally ill from the Middle Ages to the present day. Elastic definitions allow these in authority to restrict, imprison or even kill persons whose religious, political, sexual or personal characteristics are regarded as unsatisfactory. In recent experience, the well documented abuse of mental hospitals under Russian state capitalism are well documented. (For example, Medvedev, R. and Medvedev, Z., 1971.)

Apart from positive oppression, a limiting definition will ensure the exclusion of categories of persons whose mental condition may be akin to mental illness, but whose treatment is better managed without formal involuntary admission; notably, the senile and the mentally retarded.

An Excluding Provision

This writer proposed, and the NSW Mental Health Act Review Committee included in its report, a provision the purpose of which would be to prevent the involuntary admission of citizens for reasons which are, in effect, political. The recommendation was (Edwards et al., 1975, 15, 16) 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."

The writer regards this proposal as more effective than section 4(5) of the English Mental Health Act (1959) which merely says that:

> "Nothing in this section shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder...by reason only of promiscuity or other immoral conduct."

Briscoe has pointed out that many medical practitioners in New South Wales initiate involuntary admissions to mental hospitals for inadequate or improper reasons (Briscoe, 1968).

Although this would normally be done in good faith, it is highly dangerous. This writer would argue that legislation should spell out in the clearest terms that involuntary admission ought not to be regarded as a tool for social control of behaviour regarded as socially offensive. That ought to be a function of the criminal law, if of any branch.

It is not only "promiscuity or other immoral conduct" (in itself, incidentally, a form of words implying a doubtful value judgment) which may be the basis for an improper admission. Medical practitioners educated in a cloistered or conservative atmosphere in many cases hold very conservative views about people's behaviour. The Briscoe study shows clearly that there may be a tendency to lock up people under the mental health laws for a wide variety of inappropriate reasons. Hence the breadth of the limiting provision which this writer proposed and would still endorse.

It is not necessary to resort to examples from the Soviet Union to demonstrate the misuse of psychiatry for political purposes. This century there have been in New South Wales a number of notable such cases. Most recently (1976) a troublesome but highly intelligent prisoner called Brett Collins was made the subject of an inquiry by the NSW Corrective Services Department. Because of some disciplinary problem, the prisoner was referred to a consultant psychiatrist, Dr W.E. Lucas, for psychiatric assessment. Dr Lucas refused to examine Collins psychiatrically, although he did interview him. He said in his report that:

> "This articulate and intelligent man manifests no signs of psychiatric illness and no information has been given to me supporting the suggestion that he might be suffering from a psychiatric disorder."

The Royal Commissioner on Prisons (Nagle, 1977, 277) said he agreed

> "...with Dr Lucas' impression that 'psychiatric referral (was) being used for reasons other than concern about (the prisoner's) mental health and general well-being'."

The integrity shown by the psychiatrist in this case indicates that medical vigilance can be a major protection against abuse of mental health laws.

A similar result occurred in 1971 when a Sergeant of Police, a Mr P. Arantz, was referred to a psychiatrist after he had "leaked" to the press certain crime statistics which were embarrassing to the then Police Commissioner, Mr Norman Allan, and to the State Government.

Mr Arantz's "whistle-blowing" was regarded by the psychiatrist he was sent to as no evidence at all of mental illness. He was not involuntarily admitted to a mental hospital, and the doctors acted as guardians of his rights. Nonetheless he was gravely damaged in his personal reputation by the suggestion that he was mentally ill.

One of the most bizarre episodes in NSW lunacy history is the famous case of William Chidley. Hornage has related

the sorry history of a harmless mentally ill person who was repeatedly locked up merely for publishing in pamphlet form his peculiar notions about sexuality (Hornage, 1971).

Chidley's central theory (no doubt delusional but surely no more absurd than some of the whimsical notions which are central tenets of belief for lawyers, economists, educators etc.) was that the problems of the world could be solved if sexual intercourse were to occur with the male penis limp, rather than erect. For promulgating this theory of sexuality, Chidley attracted condemnation from church leaders and many respectable citizens. He was at various times detained at Darlinghurst, Callan Park and Kenmore mental hospitals. There was never any evidence that he was violent or suicidal - merely a minor social nuisance. Ex parte Chidley (1916) 33 WN (NSW) 63.

Under the proposed limiting provision mentioned above, the contemporary Chidleys of this state - of whom there are many - would be protected.

Edwards (1978, 127) details a number of other famous cases of improper use of mental health laws in NSW. He refers to the Tichbourne cases of 1897 and 1902, the Neilson case of 1902, the case of Sister Ligouri in 1920, the Farr case of 1921, the case of Beatrice Miles in 1923 and the case of Captain de Groot in 1932.

Of these, the de Groot incident is the most notorious. On 19th March, 1932,a ceremony for the opening of the Harbour Bridge occurred. As a political protest against J.T. Lang, the

NSW Premier, Captain de Groot pre-empted the opening by slashing the ribbon with his sword and declaring it open on behalf of the "decent and loyal" citizens of NSW. Police arrested de Groot and took him to Darlinghurst Reception House as "a person deemed to be insane".

De Groot was released after a magisterial inquiry the following Monday, when it was held that he was not insane.

This episode is similar in one regard to the Arantz case of 1971, when the action in question was offensive to another strong Premier - in that case, R.W. Askin, who was Minister for Police as well as Premier.

These cases are famous and well publicised. No doubt others may occur which are never brought to light. This writer regards the promulgation of a limiting provision, as suggested above, as vital for the purpose of preventing abuse of the medico-legal process.

The value of the proposed limiting provision has been commented upon by Dodd (Proceedings, 1975, 123) in the following terms:

> "My first reaction was to condemn it outright as a purely cosmetic operation and legally redundant in any event... On reflection and especially on remembering Briscoe's article I realised that there are still in the world today a large number of psychiatrists and other people who are of the opinion, for instance, that homosexuals

are ipso facto mentally ill. There are some people who still believe that persons convicted of criminal offences are ipso facto mentally ill. On reflection I think that that amendment is worthwhile."

Dodd expresses a qualm that doctors may, just by the very mention in the statute of things such as promiscuity (etc.), mistakenly regard them as ground for admission.

Watson (Proceedings, 1975, 145) makes the following comment:

"...I wish to reinforce Mr Dodd's point in his reservation about the rewording of clause 4 which appears on p. 14 of the Report. My reservation is clear. It is the word 'alone' in the part: '...that provided no person shall be considered to be mentally ill for the purposes of this Act by reason alone of the political nature or by reason alone of sexual deviance'. It is not merely otiose; it is, to my mind, regressive. It says, as I see it, that one's political views or one's sexual behaviour can be considered relevant but not sufficient grounds for being committed. As far as I am concerned my homosexuality or somebody else's membership of a political party is completely irrelevant, and should be specifically excluded from that particular provision."

It is submitted that the answer to Dodd's qualm and Watson's positive objection is surely that it is inevitably necessary to ensure, if and when such a legislative provision

is introduced, that doctors are soundly educated about the proper meaning of it. This writer finds it frankly difficult to understand how the provision, specifically aimed at reducing or eliminating discrimination, could reasonably be described as "regressive". The provision does not say that "...one's political views or one's sexual behaviour can be considered as relevant but not sufficient grounds for being committed."

Watson regards it as a "whimsical notion" that "many homosexuals may in fact suffer mental disease". He says (p. 145):

> "I do not see that there are any grounds, given the present state of sociological theory, for the persistence in the use of the term 'sexual deviance' in a law to describe homosexual behaviour, or that the word 'promiscuity' should have any relevance in an Act such as this. Unfortunately the Committee, despite relatively enlightened views, subscribes on the following pages to some rather whimsical notions, saying that many homosexuals may in fact suffer mental diseases. As far as I know there is no good evidence for that claim. I consider that particular proposed amendment to my mind needs serious rewording."

This is misleading. The Mental Health Act Review Committee never said, nor would this writer say, that there are proportionately more homosexuals than heterosexuals who are mentally ill. Watson implies that no homosexuals at all are

mentally ill. That is ludicrous. If the proportion of homosexuals in the population is (say) 5%, there is no reason at all for supposing that that particular group of persons is in some way immune to or exempt from the affliction of mental illness. To delete the word "alone" from the proposed provision would mean that persons who were "sexually deviant" or "drug takers" (or whatever) could never be involuntarily admitted. This would give such persons, quite without warrant, an exemption from the law applicable to the general population. The words "by reason alone" are necessary to preserve the balanced operation of the provision.

Let us assume, for example, that William Chidley, as well as promulgating the idea of limp-penis sexual intercourse, assaulted people who disagreed with his views. Should he have been exempt from involuntary admission just because his views on sexuality might reasonably be regarded as "deviant"? Surely not. Or assume that a paranoid Fascist believes that all left-wing demonstrators deserve to be beaten up. He takes the view that Hitler would have endorsed such an approach. He is undoubtedly mentally ill. Should he, having committed assaults, be exempt from involuntary admission merely because his views are "political"? Certainly not.

What the proposed limiting provision prevents is the misuse of the law <u>purely</u> for the penalization of the kinds of behaviour or conditions there enunciated.

However, on the face of the proposed provision it might conceivably be argued that, although none of the listed conditions, circumstances or behaviours "alone" may be considered grounds for involuntary admission, some in combination might be (Proceedings, 1975, 147-148). In the view of this writer, such an interpretation would be somewhat eccentric, but for more abundant caution it might be preferable if there were added some limiting words such as "...or by reason of any of these things in combination."

The reference to "drug taking" in the proposed provision is sufficiently broad to cover the ingestion of all kinds of drugs, prescribed medically or voluntarily taken. Briscoe pointed out that mere drunkenness was frequently (and mistakenly) considered by medical practitioners to be a sufficient basis for the writing of a Schedule 2 Certificate under the 1958 NSW Act (Briscoe, 1968).

The problem is, of course, that the symptoms of drug use can easily be mistaken for the symptoms of mental illness. The disorder of mood which characterises the affective psychoses may be mimicked in the effects of a wide variety of drugs. The hallucinations of schizophrenia may be mimicked in the hallucinations of L.S.D. ingestion.

What the proposed provision is aimed at is an assurance that:

(a) the Mental Health Act is not used as a weapon for locking up and detaining otherwise normal people in the community who use (or even misuse) drugs;

(b) but at the same time (provided other requirements are satisfied), persons who as a result of the effects of drug taking present as or show the symptoms of mental illness may be at least initially treated as such for the purposes of assessment.

It will be noted that just as a person may be promiscuous and at the same time either mentally ill or not mentally ill, a person may be a drug taker and at the same time either mentally ill or not mentally ill.

Whether or not there should be a system of legal control for the physical sequestration of drug takers is another issue. At present the tendency in Australia is to lock up various drug misusers in gaol, following the application of criminal laws (notably the NSW Poisons Act (1956) and its equivalents in other jurisdictions and the Commonwealth Customs Act (1901)).

Civil commitment of drug users merely on account of drug use is a separate matter entirely. It is not the place here to state arguments for or against any such system, and this writer expressly indicates no view on the subject. Suffice it to say that if a person is to be incarcerated because he is or has been taking drugs, that is distinct and separate from the question of whether a person is to be detained on the ground of

mental illness. Mental illness and drug use sometimes overlap but there is no necessary connection between the two.

Arguably the precise form of words used in the proposed limiting provision is not exactly what is needed to give effect to the policy aim which this writer has outlined here. Possibly further refinements of drafting may improve the stated aim. But the policy itself is clear. The mental health laws should not be a vehicle for the punishment or control of political, sexual, or social deviance.

# CHAPTER 8

## DANGER TO SELF

It is central to this writer's view that mental illness alone does not justify involuntary admission.

It was argued to and accepted by the Mental Health Act Review Committee that the central definition should be that:

> "'Mentally ill person' means a person who owing to mental illness requires care, treatment or control for his own protection or the protection of others."

The writer drafted a further section in the following terms spelling out the meaning of "for his own protection".

"Section 4A:

(1) For the purposes of the definition of 'mentally ill person' set out in section four of this Act, the words 'for his own protection' will be considered to be satisfied only where either:

(a) the person whose mental health is in question has recently attempted to kill himself or to cause serious bodily harm to himself; or

(b) there are reasonable grounds for belief in the likelihood that the said person will, by act or neglect, cause death or serious bodily harm to himself."

It has been argued before in this thesis that suicidal or self destructive behaviour can in some circumstances constitute a sufficient basis for involuntary admission.

It is not proposed now to canvass this whole issue once again.

The formula of words referred to above indicates that the self destructive behaviour of the mentally ill which will be sufficient as a basis for involuntary admission should be confined to cases where there is at minimum a risk of serious bodily harm.

If the formula were confined only to the circumstances indicated in sub-paragraph (a) above, it would only be an actual recent attempt to kill oneself or to cause serious bodily harm to oneself which would be sufficient. It is, of course, arguable that this ought to be the full breadth of any appropriate provision. It is clear that even those who attempt to kill themselves, generally do not go on to complete the act. Even if we confine ourselves to the category of actual attempters, the involuntary admission of such persons who are mentally ill will result in the admission of a number of "false positives" - i.e. those who would not ultimately have killed themselves regardless of whether or not they were preventively incarcerated for a certain period. Without question, the introduction, as a basis for involuntary admission, of a mere <u>threat</u> (as distinct from an <u>attempt</u>) to kill or injure oneself, greatly increases the number of false positives who will be locked up for a certain period of time.

It might be argued therefore that a mere threat of suicide should not be regarded as a circumstance attracting the operation of the involuntary admission process.

Nonetheless, this is not a view to which this writer adheres. The insertion of sub-paragraph (b) in the proposed provision is precisely for the purpose of including various forms of the threat situation.

This writer takes the view that where a threat is sufficiently serious or repeated that in the view of competent psychiatric examiners there is a likelihood of death or serious bodily harm, involuntary admission is justified. It is accepted that this will inevitably mean the involuntary admission and detention for a certain period of an indeterminate number of persons who would not otherwise have gone on to kill themselves in any event.

In justification of this writer's view, it needs to be pointed out that if a person is very deeply depressed, it is common that he or she will not really care where he or she is, or what he or she is doing. A short period of hospitalisation in such circumstances, provided conditions are decent and civilised, is not so great an imposition. Although there will be a number of "false positives" who are detained to no beneficial effect, in terms of what they would or would not have done anyway in the long run, there will be a small indeterminable proportion of people whose lives will be saved by intervention. People who repeatedly and plausibly say that they are going to kill themselves, sometimes in fact do. The problem of psychiatric over-prediction is a serious one, but recognition of this should not obscure the fact that some apparently suicidal people may in fact mean just what they say.

The causing of "death or serious bodily harm" may well be as a result of neglect rather than as a result of some positive action. The Mental Health Act Review Committee gave several examples of the circumstances in which this might or might not occur (Proceedings, 1975, 18):

> "Case 1. A seventy year old lady lives alone and suffers from senile dementia. She has had a broken hip six weeks previously and her mobility is substantially impaired. She does not want to leave her house, and a "Meals-on-Wheels" service brings her dinner every day. She is not starving but her poor mobility coupled with her dementia and her solitude make it likely that she will have an accident and further injure herself in the house. In these circumstances, it might well be concluded that 'there are reasonable grounds for belief in the likelihood that the person will (...by neglect) cause death or serious bodily harm to (herself).' If this were so, involuntary admission and detention would be justified.
>
> Case 2. A seventy year old woman suffering from senile dementia lives with her son and daughters. She has some money and property including land about which she will do nothing. She refuses to pay council rates on land or any other bills, this results in the possibility of the land being sold up to pay the rates and this poses a threat to the family business. Persuasion to accept psychiatric treatment failing, and the woman presenting no physical threat to herself or others, it would be

quite unjust in this case to force involuntary admission and detention. The appropriate step in an application under section 39 of the Act to have the woman's affairs looked after by the Master in the Protective Jurisdiction, since she appears to fall into the category of being 'through mental infirmity arising from disease or age, incapable of managing (her) affairs'. (Section 39)."

A key aspect of the proposed formula "for his own protection" is that the word "likelihood" is used.

It has been pointed out by various critics of involuntary admission laws that it should not be regarded as sufficient that a mentally ill person might conduct himself or herself in such a way that he or she might be injured. That is, the mere off-chance of injury should not be regarded as a sufficient basis for involuntary detention. In Australian law, the word "likelihood" has usually been interpreted as meaning a probability of more that 50% (Pemble v. The Queen, (1971) 124 C.L.R. 107; La Fontaine v. The Queen (1976) 11 A.L.R. 507). "Likelihood" therefore means a situation in which it is more likely than not that a certain consequence will ensue.

By contrast it might be said that the behaviour of a certain mentally ill person is somewhat erratic, and that such person will "possibly" jump out in front of traffic, or jump over a cliff, or whatever. The trouble is that the possibility of this kind of behaviour arises in the case of just about

every person who could properly be described as suffering from a mental illness. A statutory formula such as this would mean that there would be virtually no limit on involuntary admission of the mentally ill. It would be possible to detain those who just may or might get themselves into physical trouble by virtue of their mental disorder. It is, in this writer's view, a necessary limitation on the proposed power that the mentally ill should not be involuntarily admitted or detained unless there is a serious risk that they will cause death or serious physical harm to themselves. It is submitted that the best way of expressing this limitation is by the use of the term "likelihood". Any higher requirement, such as "great likelihood", "overwhelming probability" or "near certainty", would be unreasonably tight. It would be a condition almost impossible to satisfy.

If we consider the case of the example cited and discussed in the Mental Health Act Review Committee Report, we see that it would very much depend on the circumstances whether or not a reasonable person would conclude that there was a "likelihood" that the lady in question would case death or serious bodily harm to herself. It may well be that an appropriate view in the circumstances of that case would be that because of the lady's impaired mobility it was highly likely that she would not be able to move about with sufficient freedom to enable herself to be properly fed. There is no reason why starvation should not constitute "serious bodily harm", and in the circumstances of that case it might well be felt that there was sufficient ground for involuntary admission.

On the other hand, the involuntary admission of the aged and mentally disturbed is a matter of some difficulty, in that many old people who have houses in which they have lived for many years, do not wish to leave them. Obviously they should not be forced to leave these places where they have spent most of their lives and have many happy memories, except for very sound reasons. It might be argued indeed that a person in those circumstances might prefer to die in a happy place than to live in one which is alien and full of strangers. This writer takes the view that it might be proper to permit the latter course of action if the person in question can be properly described as mentally capable, but if his or her senility or other mental disorder has reached such a point that he or she is incapable of making proper judgments, the exercise of involuntary powers may be justified. The proposed formula of words seeks to make it clear that involuntary admission should not be forced on any elderly person, albeit senile or mentally ill, on the mere offchance that he or she might not be able to look after himself or herself. The social worker or doctor involved should state: "Well, I am doubtful about this old man - I am not sure that he can look after himself - but on the other hand, I can't say that it is likely that he will cause serious bodily harm to himself, therefore I must leave him alone."

That may well be a process of reasoning which would be common under a law which followed the proposals referred to above. It will be seen that again we are confronted with the

problem of balancing the right of individuals to live as they please as against the desire of the community, expressed through its medical, legal and social work agents, to care for or control the mentally ill. The decisions which have to be made will frequently be very difficult both to make and to justify. But the fact that hard decisions may have to be made does not mean that we are excused from the obligation to formulate appropriate laws.

The other major limiting aspect of the proposed provision is that it excludes from the formula of "for his own protection" any idea that the individual person must be protected against making himself the butt of social ridicule or other harm. The Mental Health Act Review Committee said (Proceedings, 1975, 17):

> "It does not extend to other kinds of harm to which a person may come while suffering from a mental illness. Such a person may suffer, for example, social harm in the nature of embarrassment or ridicule; harm in the nature of lost employment prospects; or harm of a financial nature for himself or family. Provided the person presents no threat to his own life or physical wellbeing, we do not consider that these kinds of threatened harm ought to be a basis for involuntary commitment. No doubt it would be appropriate in many such cases for attempts to be made to persuade the person to accept voluntary treatment, but possible harm of a social, moral or financial nature should not justify detention without consent."

This is a very important division, narrowing of grounds, and this writer agrees strongly with the logic of the Committee in this regard. One particular difficulty of this approach has been pointed out forcefully by Ellard (Proceedings, 1975,130):-

> "I think the Committee has fallen into error...they have devoted great attention to the question of what action should permit a person to be scheduled, and have confined themselves to the act of physical violence or the apprehension of physical violence. An example may make my objection clear. Imagine that some eminent member of this seminar should have his first manic episode tonight after we have all departed. Tomorrow morning he wakes up refreshed and empowered by the notion he is a chosen person with a message to impart, and to impart the message the better he decides to walk down George Street with no clothes on handing out $50 bills. He is doing violence to no one, he is not going to do any violence to himself, and I am called. Here is this person with a pile of $50 bills in front of him which he has withdrawn from the bank and he informs me what he is about to do. I can write a Schedule 2 and deal with the matter, but if the Act were to be amended as suggested I would have no power at all. There is nothing I could do. There would be little point in going to the Supreme Court and trying to have the person's finances controlled, as the person could still go out the door and would later be confronted with photographs of himself in the evening newspaper.

> The consequence of that is personal catastrophe, and a man who has been respected and eminent can be reduced in a moment to an object of derision. This may ruin his life, or when he recovers and looks back at what he has done he may become depressed and kill himself. I would ask the Committee to consider the proposition that violence may not be the only thing which might justify involuntary admission."

There is a certain logic in what Dr Ellard says. However in the view of this writer it would be impossible to formulate a provision which permitted involuntary detention in these circumstances, without at the same time excessively broadening the whole range of circumstances in which involuntary admission might be permitted. If a person in a manic phase wishes to run down the street and give away $50 notes, that is of course most unfortunate. But how do we distinguish between that person and the person who in the course of a long and very distinguished career, for example, develops a paranoid hatred of some person at the place where he works and makes false accusations? The harm by way of economic loss and destruction of a career which can come about as the result of one brief period of insanity is surely no different in the one case from the other. A life is virtually in ruins as a result of each particular aberration. But to allow involuntary admission on such grounds as these is far too broad. Are we really to say that "for his own protection" means protection against any possible kind of foolishness at all?

The sane and the insane alike are occasionally guilty of financial stupidity, of behaviour which is offensive to other people, and may be the subject of embarrassment and indeed ridicule.

Foreshadowing the kind of criticism made by Dr Ellard, the Committee said (Proceedings, 1975, 18):

> "In such cases where there is no threat of physical harm to self or others, but there is a threat of (say) gross financial mismanagement, an application can be made under Section 39 of the Act to have the person's affairs managed by the Master in the Protective Jurisdiction; an order under this Section can be made without the person being forced to go into hospital and be detained there."

It is notable that under the present Section 12 of the 1958 Act, once a person is involuntarily admitted to and detained in a mental hospital, his financial affairs then automatically become subject to the Master in the Protective Jurisdiction. That is, the decision by the magistrate formally to admit the patient automatically means that his financial affairs then become subject to the control of the Protective Division of the Supreme Court of New South Wales.

In the view of this writer, this result should not automatically follow. As Ulrick says (Proceedings, 1975, 128):

> "...there should also be a means of providing for the detention of the patient without providing necessarily for the management of his estate...the magistrate could

make separate findings. In other words he could find that the patient required detention for medical reasons, and then he could make a finding that he was incapable of managing his estate."

Now it is already the position that under Section 39 of the 1958 Act an application can be made to the Supreme Court that in respect of a person who is incapable of managing his affairs, a manager of his property can be appointed. So far as the example given by Dr Ellard is concerned, it would be possible for the relatives to have an order made that his estate be managed by a specific manager, with the result that his bank account and other sources of funds could be frozen and his possible maldisposition of them thereby thwarted. The result of this would be that it would not be necessary for the person to be involuntarily admitted to and detained in a mental hospital in order that the protection which Dr Ellard regards as being appropriate could be provided. Of course, the doctor might say that the person needed psychiatric treatment and that such treatment might be provided by involuntary detention and possibly by no other means. This writer at least would regard such an argument as being of some weight, yet not of sufficient weight to justify involuntary detention of the person. The example is a convenient one for Dr Ellard because manic depression is a type of mental illness which can certainly be fairly effectively treated by means of the lithium treatment developed by Dr Cade. Nonetheless, despite the possibility of treatment being effective in such

a case, this writer takes the view that that alone does not justify involuntary admission. This is of course a blunt value judgment.

The Section 39 application in such a case would possibly be one means of providing a solution acceptable to all sides. However, Ulrick has pointed out that from a practical viewpoint the Section 39 application may be inappropriate. He says (Proceedings, 1975, 127):

> "Section 39 requires a full Supreme Court application based on a summons and affidavit and possibly oral evidence. It would normally involve instructing a solicitor and briefing counsel, with legal costs probably at least $700. Section 39 serves very well when the estate is large and where relatives desire to manage the estate under the supervision of the court. There were 10 of these cases in 1974 so it can be seen that they are not very popular and they are not very practical."

Ulrick argues that a simpler and less expensive means of bringing the patient's estate under the control of a court should be provided than the full Supreme Court application as referred to above. This could possibly be achieved, he suggests, by an application before a magistrate.

The Mental Health Act Review Committee took the view that there are serious dangers in permitting a very simple application to be made to a court in order to isolate an

individual from the control of his financial assets. Those who have had any experience with the bitterness and wrangling involved in the average family company which proceeds for one or more generations, will be aware that control of money within a family can be the subject of intense disputation. People can be grossly unreasonable and indeed covetous to the point of fraud. The problem with providing a very simple means of isolating an individual from his financial assets is that while it may be convenient for those concerned with the administration of the estates of mentally ill persons, there would arise the temptation for the misuse of any such procedure to the advantage of one or more family members who wanted to get their fingers on the family fortune. At least to the extent that it provides some formality by way of a Supreme Court application and the use of solicitors, barristers and a decision by a Supreme Court appointee, the present Section 39 procedure has some merit. It is not intended in this thesis to go into the question in any detail of precisely how the assets of mentally ill persons, whether involuntarily detained or not, ought to be dealt with or disposed of; suffice it to say here that in the view of this writer, the mere fact that a person is mentally ill and is in danger of committing financial mismanagement, should not in itself be a sufficient basis for involuntarily admitting that person to a mental hospital. Whether the present Section 39 procedure is a suitable one, or whether some simplified procedure as suggested by Ulrick is preferable, is a question

which remains to be worked out. No doubt some rational solution can be found to the problems posed. In any event, the present provision in the 1958 Act which permits the involuntary admission on the ground of the possibility of financial mismanagement, as Section 12 undoubtedly does, is most unsatisfactory and undesirable. We should not lock up people's bodies merely to safeguard their bank accounts. The vicissitudes of life are such that from time to time people fall under buses, get struck by lightning, or have heart attacks. It is proper to regard the person who unfortunately is afflicted by some manic disorder late in life which causes him, as Dr Ellard hypothesises, to fling his money about to his ruination and the ruination of his family as no more or less unfortunate than a person subject to any of the other kinds of misadventures referred to above.

# CHAPTER 9
# DANGER TO OTHERS

The most difficult problems arising in relation to the concept of "danger to others" as a ground for involuntary admission flow from an inevitable overlap with criminal law. This overlap is relevant in relation to self-destructive patients only in the sense that in certain jurisdictions (e.g., New South Wales) suicide is still a crime. But the criminal law is almost wholly concerned with proscriptive rules aimed at "the protection of others". It follows that in many cases the behaviour of a mentally ill person which is dangerous to others may very well constitute a criminal offence punishable by an appropriate criminal court. The vital question is then: "Should such cases be dealt with by involuntary admission to a mental hospital, or by trial in the normal courts?"

A number of careful studies in recent years have dealt at length with this issue: (Walker, 1968; Walker and McCabe, 1973; Butler, 1975; Gostin, 1977). Nevertheless, in the view of this writer, the Gordian knot of philosophical and practical complexities can be neatly severed if the following considerations are heeded:

1. Detention in a mental hospital for behaviour representing a "danger to others" should in no case be longer than detention in a penal institution following criminal trial for comparable behaviour. (This is not to say that "danger to the community" is entirely ignored by the ordinary criminal courts in setting sentences - it is not. But it

should not be accorded such weight that it is disproportionate to the behaviour in question, as the High Court pointed out recently in the landmark decision in Veen v. R (1979) 53 ALJR 305. The High Court referred to the kinds of difficulties involving the prediction of dangerousness adverted to above in chapter 5.) MIND said in its 1979 report on the law relating to mentally abnormal offenders (Gostin, 1977, 110):

> "The guiding principle in this report is that once an offender has been detained for a period proportional to the gravity of his offence, he should not be detained further, except through civil procedures."

2. In cases involving possible detention of persons on the ground of behaviour "dangerous to others", formal procedures permitting the ascertainment of the true facts with as much certainty as reasonably possible should be gone through. This should apply in relation to the involuntary admission process as well as to the ordinary criminal courts.

3. After ascertainment by a court of the facts relating to an instance of behaviour "dangerous to others", flexible arrangements should enable the mentally ill offender to be transferred for appropriate treatment in a mental hospital, subject of course to the first principle stated above.

It is not intended in this thesis to explore in detail all the problems involved in relation to mentally abnormal offenders. But so far as "choice of system" is concerned,

if these broad principles are followed, it will not matter crucially whether in any particular case the court/prison or the doctor/hospital procedure is followed. No dramatic harm will be done either way.

A system based on the abovementioned three principles would be calculated to avoid two main evils. First, a situation where the mentally ill are dealt with punitively by courts and prisons when the real underlying need is for treatment of a mental illness; second, a situation where behaviour which would not be punished heavily by the courts results in a long period of detention in a mental hospital. In this writer's experience, it will never be possible to design a system perfectly adapted to avoid these problems, because in many cases it is a matter of complex judgment whether the objective behaviour or the mental condition of the individual should be regarded as the more significant factor. Nonetheless, by minimizing the difference between the doctor/hospital procedure and the court/prison procedure, anomalies may be minimized.

In 1979 the Parliament of New South Wales enacted the Intoxicated Persons Act, removing the criminal offence of drunkeness in a public place. As at November 1979, the new Act is about to be proclaimed and arrangements are being made for so-called "proclaimed places" (welfare institutions and refuges) to be organised or established where drunks can be taken instead of being taken to police cells.

This new legislation is a recognition of the inappropriateness of using traditional police/court/prison procedures in relation to people whose mental condition makes them minor social nuisances. This inappropriateness was recognised long before the new Act came into effect.

Similarly it is widely recognised that many other types of minor offences are committed by mentally disordered individuals in respect of which utilization of the court/prison process would be pointless.

Section 12(1)(e) of the NSW Mental Health Act, 1958, permits involuntary admission where a person

> "...is taken to (an) admission centre by a member of the police force who in writing informs the superintendent of such admission centre that such member believes such person to be a mentally ill person and that such member found such person wandering at large or committing some offence against the law or in circumstances which reasonably led him to believe that such person was about to commit some offence against the law..."

The Edwards Committee (Edwards et al., 1975, 24, 25) recommended that such a provision be retained, subject to an amendment deleting the words "wandering at large" and making it clear that the power should not be used except to prevent criminal acts or to prevent harm to the person himself or to others.

It will be seen from the discussion in chapters 10 and 11 (following) that involuntary detention should not occur except after a proper hearing as proposed. Thus the problem of having vague and untested allegations left on a patient's record card - possibly untrue and in some cases highly prejudicial - would not arise. There would be, as suggested under the second principle declared at the commencement of this chapter, "...formal procedures permitting the ascertainment of the true facts with as much certainty as reasonably possible..." regardless of whether the police officer chose to take the individual to a court or to an admission centre. (Of course, it should not be forgotten that another choice the police officer has is a discretion not to charge at all. In many cases of mental illness the police will just take the individual home, or call a doctor, or otherwise dispose of the matter without formality.)

However, if an offence is a very serious one, causing great public concern and alarm (for example, a murder, or a violent sexual attack on a child) it is inevitable that the matter will be dealt with in the courts of criminal law. In such a case the objective facts of the behaviour will be regarded as being more immediately significant than the mental condition of the offender and his need for treatment. This is inevitable and proper.

It is not intended here to embark upon a detailed analysis of the McNaghten Rules as to criminal responsibility, nor the rules as to "fitness to plead", nor the policy governing transfers between prisons and mental hospitals. That is a matter for separate and full-scale treatment elsewhere.

Suffice it to say here that there ought to be appropriate rules permitting the transfer to and treatment in secure psychiatric facilies of persons charged with or convicted of serious criminal offences who are or become mentally ill. The report of the Edwards Committee (Edwards et al., 1975, pp. 50 to 74) represents a recent attempt to formulate appropriate rules in this area. The writer is in broad agreement with those recommendations (and indeed played the principal role in formulating and drafting them).

The Scope of "Danger to Others"

The various provisions in Australian mental health laws permitting involuntary admission to mental hospitals on the ground of "danger to others" are as broad and ill-defined as those concerning admission on the ground of "danger to self."

The statute given substantial legislative attention most recently (the Mental Health Act, 1976-1977, of South Australia) has no more refined a definition of this ground for admission than its predecessor or the corresponding statutes

in other states. Under section 14(1) of the new South Australian law, a medical practitioner may make an order for immediate admission and detention of a person suffering from a mental illness where he is satisfied (inter alia)

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

Arguably this is marginally more restricted than the formula under the New South Wales Mental Health Act, 1958, "...for his own good or in the public interest", but for practical purposes there is no significant difference between these formulae, or the corresponding language in the statutes of the other Australian jurisdictions.

It is submitted that such formulations are unacceptably wide, and constitute a serious and unjustifiable restriction on the civil liberties of citizens. Phrases such as "for the protection of other persons", without more precise definition, allow an interpretation which authorizes detention of individuals who may be nothing more than a slight nuisance to others. As Livermore, Malmquist and Meehl point out in their excellent paper on justifications for civil commitment (Livermore et al., 1968 , 82):

> "...the man who walks the street repeating, in a loud monotone, 'fuck, fuck, fuck,' is going to wound many sensibilities even if he does not violate the criminal law. Other examples would be the man, found in most cities, striding about town lecturing at the top of his lungs, or the similar character in San Francisco who spends his time shadow boxing in public. If such people are dangerous, it is not because they threaten physical harm but because we are made uncomfortable when we see aberrancies."

Another instance in which a feeling of psychological discomfort is induced is, as these authors point out (Livermore et al., 1968, 87), when a person

> "...insists on sharing his paranoid delusions or hallucinations with us. For reasons that are unclear, most of us are extremely uncomfortable in the presence of an aberrant individual, whether or not we owe him any duty, and whether or not he is in fact a danger to us in any defensible use of that concept."

The question is, against what danger should the mental health laws seek to protect citizens? Danger of psychological discomfort? Danger of having property stolen or smashed? Danger of homicidal attack only? The Australian statutory provisions are not clear, and the decisions of the courts do not enlighten us. Nor indeed can we look to the speeches of the legislators for guidance. For example, in debate in the

Queensland State Parliament relating to a Mental Health Bill on 28th November, 1962, Mr Donald, Member for Ipswich East, cast these pearls before the House (Queensland Hansard, volume 234, p. 2015):

> "I have an acquaintance who claims that his brother, who is an inmate of the mental hospital at Goodna, is an example of the ease with which patients who are not ready to leave may be given leave. Members of the man's family are very concerned, because on several occasions when on leave he has drunk freely, become very intoxicated, hired a taxi and brought his friends to his brother's home, and the brother has had to meet the cost of hiring a taxi from Brisbane to Ipswich."

According to the view of this parliamentarian, the danger from which protection was needed appears to have been the danger of embarrassment caused by drunken and foolish behaviour. (It hardly needs to be pointed out that if the sane who behaved badly when drunk were all to be subject to incarceration, an uncomfortably high proportion of the population would be under lock and key.)

In 1974, when a new Mental Health Bill was debated in the Queensland Parliament, there was no discussion of the precise meaning of the formula "...or with a view to the protection of other persons" occurring in clause (now section) 18(2)(b). In fact the Minister for Health, the Hon. S.D. Tooth, specifically argued (Queensland Hansard, 12th March, 1974, p. 2817) that

> "...it is not in a patient's interests that the provision of treatment should depend upon rigid criteria, on argument about fine points of law, or on the existence of legal loopholes. The determination of a person's mental state for this purpose must depend on responsible professional assessment."

The extent to which this approach departs from traditional concern for the protection of individual rights can be seen if the above quotation is reformulated slightly:

> "...it is not in a (taxpayer's) interests that the (payment of tax) should depend upon rigid criteria, on argument about fine points of law, or on the existence of legal loopholes. The determination of a person's (tax liability) for this purpose must depend on responsible professional assessment."

One can be fairly confident that these words could not be uttered in any Australian legislature (especially in the Queensland State Parliament) without provoking shrieks of outrage. The mere suggestion that the Commissioner for Taxation, being the fair and sensible fellow that he is, could be trusted to do the right thing by striking as he saw fit a just and equitable taxation assessment on each citizen, would be treated as the vilest heresy. Legal authorities from Dicey back to Moses would be invoked against the proposal.

Yet what is unacceptable in relation to the assessment of tax is perfectly acceptable, it would appear, in relation to the involuntary admission of the mentally ill.

One is tempted to conclude that contemporary Australian legislatures accord more importance to the protection of the rights of taxpayers than they do to the rights of the mentally ill. The Hon. S.D. Tooth was supported in the abovementioned Parliamentary exercise by the Hon. Dr Scott-Young, member for Townsville, whose training as a surgeon permitted him to declare roundly (Queensland Hansard, 12th March, 1974, p. 2835) that

> "As I have already said, people who attempt to commit suicide are homicidal."

With equally grandiloquent inaccuracy, he swept aside criticism about the wording of the proposed legislation (Queensland Hansard, 12th March 1974, p. 2834):

> "I suggest that anyone who says that the rights of the individual are not safeguarded under the Bill should re-read it and disregard all the submissions made by psychologists, social workers, do-gooders and humbugs, because all of the procedures are laid down in the Bill in plain English."

With respect to the learned doctor, it is suggested that if he believed that the expression "with a view to the protection of other persons" was plain English, incapable of

misinterpretation, he was in error. In fact, as the words of the Minister for Health made clear, it was never intended that the "plain English" should be anything other than a general guide for the exercise of broad medical discretion.

The consequence is that at the present time all Australian jurisdictions permit the involuntary detention of the mentally ill on a ground which may be broadly described under the rubric "danger to others", but the precise meaning of which is nowhere spelt out.

These formulations are largely the product of the optimism generated by the "mental health revolution" of the 1950s, when the introduction of new and very effective anti-psychotic and calming drugs made the management and treatment of the mentally ill much easier.

Common Law Tradition

However benevolently motivated, the authors of the new laws broke with a strong common law tradition of concern to protect the non-dangerous mentally ill person from interference. The strength of this common law tradition, as manifested in England, Australia and the United States, is exemplified in certain major cases.

The facts of Sinclair v. Broughton (1882) 47 L.T. 170, arose in India under the British Raj, and the matter finally reached the judicial committee of the Privy Council. The military officer commanding a military establishment was

informed that a man was acting in a strange and agitated manner. The commander ordered that two medical officers examine the man so as to determine his mental condition. He was placed under the guard of several unarmed soldiers so that he could be observed for the purposes of assessment. The Privy Council concluded that an award of damages for false imprisonment was justified. The detention of the individual would have been lawful had he in fact been a "dangerous lunatic", but merely behaving in an excited or agitated manner so as to provoke a neighbour to concern was not sufficient to permit detention merely for observation.

In the Australian case of Watson v. Marshall (1971) 45 ALJR 444, the facts were as set out in the report at pp. 446, 447:

> "A few days before 25th July, 1967, the defendant, a detective in the Victorian Police, received two telephone calls. It may clearly be inferred that these calls referred to conduct or statements of the plaintiff which were regarded as abnormal. The defendant went to see the plaintiff and had a long conversation with him. The plaintiff spoke of his earlier activities and referred to a solicitor in Sydney as a Russian spy and to a conspiracy to harm the plaintiff by putting him into a mental institution and by exiling him from Australia.

"After that interview the defendant made certain inquiries from the police in Sydney and from Mrs Watson (as she now is). On 25th July, he went with Dr Birrell to the plaintiff's rooms in East Melbourne. He did not disclose that Birrell was a doctor but introduced him as a colleague. The plaintiff was invited to recount once more what he had said to the defendant at the earlier interview. No doubt the defendant had already reported to Birrell the results of his earlier inquiries. It seems plain that both men had it in mind when they went to see the plaintiff that it might be a case in which he ought to be admitted to hospital in accordance with s. 42 of the Mental Health Act 1959-1969 (Vic.) (the Act)."

Because of a defect in drafting, the precise statutory requirements for apprehending Dr Watson (the supposed mentally ill person) were not met. Watson sued the police officer in question for trespass to the person, and the issue arose whether - regardless of the statute - the apprehension and transfer of the plaintiff to a mental hospital could be justified by common law.

Walsh J. said in the High Court (at 446, 447):

"I think that the evidence falls short of establishing that there was a necessity to protect the plaintiff or to protect others such as would justify at common law the action taken by the defendant. His evidence does

not suggest to me that he acted because of an awareness of such a necessity. I have no doubt that he thought it was right that the plaintiff should be admitted to a hospital, but it is not shown that either the defendant or Dr Birrell apprehended an immediate danger of injury to the plaintiff himself or to others, if he were not taken forthwith into custody. It is true that Dr Birrell gave evidence in cross-examination, that in recommending the plaintiff's admission to hospital, one consideration that he had in mind was a possibility that the plaintiff might do harm to other people. But I did not obtain the impression from his evidence that there was, in his opinion, such a danger that it was imperative that the plaintiff should not be at large. He was primarily concerned with what he believed to be the plaintiff's state of health and with securing relief for him from his illness and from the effects of the excessive consumption of drugs, in which the doctor believed the plaintiff was indulging. So far as the defendant was concerned, he believed that he was acting under the authority of the Act, rather than under an impelling necessity to avert an immediate danger of injury to the plaintiff or to others."

The formula "...an impelling necessity to avert an immediate danger of injury to the plaintiff or to others..." makes it clear that common law regards the harmless madman as entitled to his liberty. Detention is only justified

where the necessity is "impelling", and the danger must be "immediate". "Injury", not merely some vague impingement on the "public interest", must be threatened.

Walsh J. also referred in Watson v. Marshall at page 446 to a formula employed by Harvey J. in In Re Hawke (1923) 40 WN (NSW) 58, 59, to the effect that the lawfulness at common law of the detention of an insane person depends on the existence of an "overriding necessity for the protection of himself and others."

The facts of Watson v. Marshall were similar to those of Anderdon v. Burrows, M.D. et al., (1830) 4 C. and P. 210, a matter also referred to by Walsh J. as indicating the narrow scope of common law powers. In that case, relatives of an eccentric young man from a wealthy family arranged for Dr Burrows to investigate his mental condition. He merely sent out two men to apprehend Anderdon, on the basis entirely of the secondhand information he had received. At a trial for damages for trespass to the person, it came out that the main evidence of "insanity" was (p. 212) that he

> "...kept no servant in his own house, that he bought his own food, carried his pie to the baker's, went with his beard of a weeks growth...and wore a large flopping straw hat in the month of November."

Lord Tenterden C.J. pointed out in his summing up to the jury (p. 213) that it was clear that there had been no necessity

"...to prevent the party from doing some immediate injury either to himself or others."

In the United States there has been over the last decade a considerable volume of litigation concerning whether involuntary admission procedures offend against constitutional rights to individual liberty. Neither in Australia nor England is there any written constitutional equivalent to the "due process" requirements of the American Bill of Rights, but it is reasonable to say that the "due process" conception is historically derived from and related to certain notions about personal freedom which are deeply rooted in the English (and thus the Australian) common law. In a sense, therefore, the celebrated US Supreme Court decision in O'Connor v. Donaldson (1975) 422 US 563, is a philosophical equivalent of the Privy Council decision in Sinclair v. Broughton and of the Australian High Court decision in Watson v. Marshall.

The facts of O'Connor v. Donaldson constituted an appalling saga of medico-legal abuse. Donaldson was originally committed to state institution in Florida on a diagnosis of "paranoid schizophrenia". He was detained there for fifteen years, even though (as Mr Justice Stewart in delivering the court's opinion pointed out at p. 568):

"O'Connor himself conceded that he had no personal or secondhand knowledge that Donaldson had ever committed a dangerous act."

In fact Donaldson made repeated requests for release, supported by competent and responsible persons willing to care for him, but O'Connor always refused. One refusal was based on the ground that Donaldson could be released only to his parents - who were known to O'Connor to be too old and sick for that responsibility.

The US Supreme Court held that Donaldson's detention was not justified and said (at pp. 575, 576):

> "A finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. ...there is...no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.
>
> "...May the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.
>
> "...In short, a State cannot constitutionally confine without more a nondangerous individual..."

This principle of "due process" is broadly comparable to the English common law as stated in Sinclair v. Broughton and the Australian common law as stated in Watson v. Marshall. The crucial difference, of course, is that whereas in England and Australia this principle has been abrogated by statute, no such abrogation can take place under US law because of the primacy of the written federal constitution.

Although what may be loosely termed the "common law tradition" against nondangerous involuntary admission is certainly less vague and less accepting of medical discretion than the present statutory provisions applicable in Australia, the difference is only one of degree. Neither in Watson v. Marshall (1971) 45 ALJR 444, nor in any of the earlier cases such as Anderdon v. Burrows, M.D. et al. (1830) 4 C. and P. 210 or In Re Hawke (1923) 40 W.W. (NSW) 58, is there any attempt to spell out in detail the exact types of injury which must be threatened before involuntary admission may be said to be justified. In the view of this writer, public policy demands that such types of threat and injury should be spelt out.

Review Committee Proposals

The proposals of the NSW Mental Healt Act Review Committee for a detailed statement of the types of "danger to others" which could base involuntary admission were in the following terms (Proceedings, 1975, 18, 19):

"For the purposes of the definition of 'mentally ill person' set out in section four of this Act, the requirement of the words 'for the protection of others' shall be satisfied only where the person has either:

(a) recently attempted (or recently made a reasonably credible threat) to inflict serious bodily harm upon another person, or has in fact recently inflicted serious bodily harm upon another person; or

(b) recently performed an act of violence (whether against person property or animal) of such a kind or quality as reasonably indicates a likelihood that the person will inflict serious bodily harm on another person; or

(c) recently done any act or engaged in any course of activity, or constructed or set up any device or arrangement, likely to result in the infliction of serious bodily harm upon another person; or

(d) repeatedly engaged in a course of behaviour or nuisance or harrassment, directed at one or more persons other than members of the person's family or household, of a kind reasonably likely to lead to a breach of the peace, and of a degree so far beyond normal limits of social behaviour that a reasonable person would consider it intolerable."

Clauses (a) and (b) exclude situations where a threat of injury is "mere talk" or is so slight that it would not really be a matter of concern. A slap on the hand, or the threat of it, ought not be sufficient to cause a mentally ill person to be locked up. The essential issue, it is submitted, is whether the individual has committed or is likely to commit some act of serious physical injury upon another person. If the objection be made that the requirement of serious injury is excessive, it must be kept in mind that the deprivation of personal liberty is a drastic sanction. In the system of criminal law, defendants are usually not sentenced to imprisonment for minor offences, even minor assaults. The requirement that the threat or act be "recent" prevents long past behaviour from being resuscitated to justify detention. It will be recalled that in chapter 5 there was considerable discussion about the difficulties of predicting dangerousness. It was pointed out that most of the literature deals with the prediction of future dangerousness after the person has spent a substantial time under detention, whereas prediction of dangerousness in "on-the-spot" situations, so to speak, has not been much investigated. The requirement that a threat of injury or actual injury be "recent" takes account of this. Clearly, the more recent be the relevant behaviour, threatened or completed, the more powerful it is as a predictor.

Clause (c) refers in particular to situations such as one which occurred in the Sydney suburb of Granville in 1971 where a mentally ill person wired his entire house from the

electricity supply so that any unsuspecting visitor could be instantly electrocuted. In this situation, paranoia took the form not of assaultive behaviour, but certainly of conduct likely to be fatal. It would be unfortunate if such situations were not covered by involuntary admission powers.

Clause (d) refers to behaviour which is not likely to cause a fatality or serious bodily injury, but which constitutes "harrassment". This writer admits to considerable hesitation and uncertainty about this provision. It was the subject of intense debate between the members of the Review Committee. On the one hand, it may be said that mentally ill people can be very annoying, their delusions prompting them to diabolically worrying and upsetting behaviour. The accusations of spying which paranoids indulge in can undoubtedly cause intense nervous upset to innocent neighbours. Minor nuisances such as the throwing of bottles over the back fence, or constantly spraying imaginary insects with a noisesome fly-spray, or lighting acrid fires to get rid of rubbish, may cause upset and anguish to those affected.

It can be argued that it is preferable, especially in situations between neighbours, that the mentally ill person who "repeatedly engages in a course of conduct of nuisance or harrassment" should be liable to involuntary admission rather than that other people should be driven to despair (or even to violence) by the behaviour. According to this argument, it is better than delusions be treated than that neighbourhoods break up in bitterness and acrimony over unacceptable conduct by crazy people.

On the other hand, it may be said that sane people often indulge in outrageous or aggravating behaviour which is deliberately aimed at annoying neighbours, and there is no provision for them to be locked up. Certainly, the police may take action against loud motor engines roaring for hours (for example) but there are other, more subtle ways to harrass or annoy which cannot be proven. We live in a free society; if somebody annoys you, you may always move. That - rather than having your tormentors locked up - is the correct solution to the problem. The danger in permitting the mentally ill to be involuntarily admitted on the ground of "harrassment" is that behaviour which is no more than mildly offensive may be wrongly used to justify incarceration.

On balance - and not without some uncertainty - this writer is inclined to agree that clause (d) of the draft is in substance a proper and justifiable provision. It is all very well to say that people may move away if their neighbour gives them trouble, but of course that may not always be economically feasible. For a variety of reasons (particularly age or length of residence) it may not be fair.

Provided that the behaviour is indeed "nuisance or harrassment", it is repeated, it is a "course" of conduct, it is directed outside the family, and it is "...of a degree so far beyond normal limits of social behaviour that a reasonable person would consider it intolerable", then involuntary admission may be justified.

In May 1976, when the revised proposals by the Edwards Committee were sent to the Minister, the words underlined in the phrase "...directed at one or more persons other than members of the person's family or household" were deleted.

This change came about as the result of various criticisms such as that by Dr John Ellard (Edwards, 1975, 130):

> "...the family is excluded from the particular subsection and the ground given is that families should be tolerant of its (sic) own members. That is not unreasonable, and families are often repositories of love, but there can also be more destructiveness and vidictiveness and malignancy in a family than anywhere else. If you add mental illness to this the results can be catastrophic. I would be inclined to strike out those words and let people approach each other equally whether they are members of the same family or not."

This writer remains unmoved by such comments, and suspicious that it would always be easy to show within the family - for example, between husband and wife - "a course of behaviour of nuisance or harrassment." In many marriages of sane people there is more or less continuous harrassment. The remedy lies in the family courts - in divorce, separation, or some other order. It should not be thought to be in involuntary admission to mental hospital. What if the family relationship is that of child and parent? Who is to say what

psychological harm the parent may inflict on a child? Dr W.B. Grant asked (Edwards, et al., 1975, 138, 139):

> "...what about the considerable psychological danger that seems to me to accrue to families of chronically ill but nonetheless socially mild parents? (Sic.) For example, the chronically paranoid parent who may do very frighteningly threatening things to a number of children and there seems to be evidence, when one sees the family, that his or her behaviour, although relatively quiet, is having considerable ill effects. I agree that the family may well have recourse to civil legal procedures, but when one raises these issues with the family, often the wife is too frightened or too ignorant, or may have tried and found that this seems to lead nowhere. I would ask that these issues be considered further and that some provisions may be made, whilst protecting the rights of people, nonetheless also to protect the rights of growing children."

These are easy questions to ask, but difficult questions to answer in a society which attaches great importance - indeed almost inviolability - to the parent/child relationship. In the absence of physical injury or starvation, how do we define "psychological cruelty" to children without trespassing on territory traditionally viewed as reserved for the proper educative influence of parents. Many sane parents bring their children up by "brainwashing" them with views and attitudes others consider reprehensible. Some people deplore

religious education, and consider it a perversion of the child's mind. But should the quietly schizophrenic mother who demands that her children polish metal crucifixes each night be subject to involuntary admission? Is that a campaign of harrassment against her children? Surely not, for the purposes of involuntary detention. What then of the mother, in a case known to the writer, who obsessively demanded that each time the children and her husband came into the house they should be washed all over, and the floors washed down with multiple buckets of water? (Eventually, the floor rotted.) Surely if the children really were being neglected or harmed, child welfare legislation provided an answer - and of course the father could have just taken the children and left, having a remedy in the Family Law Court in the event of a custody dispute. Inevitably value judgments are involved, but in this latter case the writer would not see involuntary admission as the solution to the problem.

In any event, whatever be the correct policy to adopt in relation to the question of a ground centred on "nuisance or harrassment" (and the writer freely concedes some uncertainty about this) the other clear and limited grounds as spelled out in the Edwards Report do provide, it is submitted, the correct basis for a law of involuntary admission and detention. The current Australian laws represent too great a departure from the restrictive approach towards "arresting the insane" adopted (Lanham, 1974, 515) under the common law.

It is necessary, finally, to deal with a certain mental condition (if it can be so described) which has been introduced into the English law as a basis for involuntary admission, and which by adoption has had a certain influence in Australia: See the Tasmanian Mental Health Act (1963) and the Queensland Mental Health Act (1974).

Psychopathy

This writer expresses a strong view that "psychopathy", so called, should not be treated as a ground for involuntary admission or detention.

Without question the Report of the Royal Commission On The Law Relating To Mental Illness And Mental Deficiency 1954-1957 (Percy, 1957) is the classic document in the modern era for those concerned with problems of mental health law and policy. It is a prodigious work of practical research and scholarship. Nonetheless it is not without flaws, the most egregious of which is its treatment of psychopathy, and its recommendations which led to the concept of "psychopathic disorder" being introduced into the English Mental Health Act of 1959.

The Report stated (Percy, 1957, p. 6) that:

> "We use the term 'psychopathic personality' in a wider sense than that in which it is often used at present and intend it to include any type of aggressive or

inadequate personality which does not render the patient severely sub-normal...but which is recognised medically as a pathological condition."

It referred (Percy, 1957, p. 53) to evidence put before it about the nature of this condition:

"Psychopaths are mentally abnormal patients 'whose daily behaviour shows a want of social responsibility and of consideration for others, of prudence, of foresight and of ability to act in their own best interests. Their persistent anti-social mode of conduct may include inefficiency and lack of interest in any form of occupation: pathological lying, swindling and slandering; alcoholism and drug addiction; sexual offences and violent actions with little motivation and an entire absence of self-restraint which may go as far as homicide.'"

In the result, although the Percy recommendations were not accepted <u>in toto</u>, the 1959 Act did incorporate the conception of "psychopathic disorder" in the following terms (section 4(4)):

"...a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment."

This covers a lot more than personal violence, as the Butler Report points out (Butler, 1975, p. 81):

> "It is important to note that the statutory definition of 'psychopathic disorder' includes not only the abnormally aggressive person but also, under the criterion of serious irresponsibility, such a person as the compulsive gambler." (Emphasis added.)

The concept of psychopathy has a history reaching back probably as far as the seventeenth century (Walker and McCabe, 1973, Ch. 9). In the nineteenth century, French psychiatrist Pinel referred (in 1801) to insanity without disturbance of the powers of reasoning, American Benjamin Rush referred in 1812 to "moral derangement" and in 1835 the Englishman Prichard referred to "moral imbecility". (Blair, 1975, 52). How broad is the concept of psychopathy? Some classifications are dangerously wide. As Blair points out (Blair, 1975, 54):

> "...some writers include under the term almost every variant personality that is not insane, neurotic, intellectually defective or epileptic, when the concept is so wide as to be meaningless."

So meaningless, indeed, that many take the view that "psychopathy" so called, is merely "the extreme expression of normal biological variation." (Butler, 1975, 79).

Nonetheless, Blair says (Blair, 1975, 54):

"There is...general agreement that an uncommon but characteristic type of individual exists marked by the following features:

1. A consistent lack of evidence of a normal conscience and of the ability to feel in a normal way for other people and to feel guilt or remorse.

2. An habitual tendency from an early age to act impulsively in antisocial ways with no prudent forethought of the inevitable consequences.

3. A failure to profit from experience and therefore a failure to be deterred by punishment.

4. Freedom from any other form of mental disorder."

People with experience in psychiatry or criminal law are usually familiar with some individuals who exhibit these characteristics - no doubt it is for this reason that the diagnosis of psychopathy continues to be made. The absence of normal guilt is a striking phenomenon when coupled with a failure to learn from past punishment. It is particularly striking in those of normal or above average intelligence.

There are various causal theories, amongst the most popular of which is the "maternal deprivation" concept. (Bowlby, 1946; Rutter, 1972.) Some argue that it is not a question of psychological disturbance at a particular point

of time but a failure of general social learning - hence the common American usage "sociopath" for the person the English describe as a psychopath. Bettelheim (Bettelheim, 1971) emphasises in relation to kibbutz education that general social learning may determine a level of "affect" in the individual different from that applicable in "normal" western society - thus by implication possibly supporting a view of the psychopath as an extreme of a Gaussian distribution within the population.

The problems of using the concept of "psychopathic disorder" as a basis for involuntary admission derive from its uncertainty. The Butler Report set out the main arguments for abandonment of it (Butler, 1975, 84, 85):

"(a) Psychiatrists disagree about the meaning of the term 'psychopathic disorder' and about its diagnosis in particular cases. While some would narrow it to a narrow group of dangerously anti-social individuals, others seek to extend the concept to cover inadequates of all descriptions...

(b) It was suggested that the concept of psychopathy is logically defective insofar as it infers mental disorder from anti-social behaviour, while purporting to explain the anti-social behaviour by mental disorder.

(c) ...Some psychopaths act normally for some of the time and there may be no clear distinction between their behaviour and that of offenders not diagnosed as psychpaths...

(d) ...labelling people as psychopaths has proved stigmatic, harmful and indelible, and in practice makes those so labelled more difficult to handle both in institutions and in the community, since it carries the popular implication that they are both dangerous and incurable.

...

(f) (In other jurisdictions) it has not been found necessary to make use of this term in legislation."

Despite these powerful (one might say, compelling) arguments, the Butler Committee failed to recommend the abandonment of psychopathy as a ground for involuntary admission. This lack of decisiveness (characteristic of the Butler report as a whole) was marked by the half-hearted proposal that "psychopathic disorder" should be deleted from the Act and that "personality disorder" should be substituted in its place. This extraordinary suggestion was made in the teeth of the Committee's own comment (Butler, 1975, 86) that:

"It would not be possible to provide a usable definition in the Act for 'personality disorder' which, as we have indicated, is a group of disorders."

But, as Blair points out (Blair, 1975, 56):

> "Throughout the history of psychiatry there has been one recognized condition after another which has tended to be the dump-heap for cases of uncertain diagnosis - hysteria, neurasthenia, mental defectiveness, schizophrenia, psychopathy and now personality disorder..."

The Butler recommendation to replace "psychopathic disorder" with "personality disorder" would be absurd. Its failure to deal a clear death blow to the concept of psychopathy appears to have encouraged the English government to retain and widen it. The current White Paper (Home Office, 1978, 8, 22) indicates that not only will psychopathy remain as a ground for involuntary admission, but the present restriction of it to persons under the age of 21 years will be removed.

In the submission of this writer, the enactment of the White Paper proposals will merely lead to a situation where the criminal law and the law of involuntary admission will develop as competing rather than as complementary systems, a result which it was suggested earlier in this chapter ought to be avoided.

# CHAPTER 10

## PROTECTION AND ADVOCACY OF PATIENTS' INTERESTS

What might be called the extreme medical view is that lawyers, magistrates and judges have no role at all to play in relation to the involuntary admission of the mentally ill.

The Legal Representation Committee (Young, et al., 1978, 6) quotes a Sydney psychiatrist to the following effect:

> "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."

That is the view of an Australian doctor. A similarly inclined American psychiatrist has been quoted as follows (Chaikin, 1965, 119):

> "There is no need to have any definition in the law since there are safeguards before an individual can be committed. Psychiatrists should be free to determine by themselves through through observation based on experience whether an individual is mentally ill or not...

"Doctors have their reputation to cherish, and therefore, will be careful not to put people away indiscriminately."

It is submitted that the extreme view enunciated above, giving carte blanche to psychiatrists in the involuntary admission of the mentally ill, simply should not be acceptable politically in any democracy; nor, for many of the reasons detailed in Part 1, is it philosophically justifiable. Lawyers, not doctors, are the people in society who are most frequently concerned with questions relating to the propriety or otherwise of the detention in custody of citizens. That they should have some involvement in the involuntary admission and detention process is not (in this writer's view) debatable. But what should that involvement be, and what problems surround it?

First, it is suggested there should be a court hearing as to whether or not the admission is proper. If that concept be accepted in general terms, the next issue is as to whether or not such court review ought to be applicable in relation to each and every patient, or only in relation to some.

Automatic Legal Review?

In New South Wales there is automatic legal review of every patient whose involuntary admission is sought. An inquiry is conducted, under section 12(9), by a magistrate. Leaving aside for the moment the adequacy or otherwise of this procedure, it is pertinent to ask whether it is necessary in each and every case. George, writing of the situation in

South Australia (George, 1971-2, 349) says:

> "In my opinion the most satisfactory solution recognises not only the right to a hearing, but also the fact that a hearing is unnecessary or undesirable in many cases. This solution can be achieved by what is called "non-protested admission", whereby a person is certified and then notified of his right to be heard if he so desires." (Footnote deleted).

It might equally be argued that there are many criminal cases where a person does not really "need" a hearing. Over eighty per cent of criminal defendants plead guilty. But there are two vital differences. The first is that in criminal cases, at least the defendant always does come before a court, even if only to plead guilty. The second is that people whose admission to mental hospitals is sought are frequently mentally ill, distressed, and in any event incapable of making a rational assessment of their own best interests. On admission, they may be drugged. How could it be fair only to have a legal hearing for those who protest? Inevitably, this would mean that the paranoids would get their legal rights and the depressives and those suffering from catatonia or crippling anxiety would not. Commonly if a patient is willing to enter the hospital for treatment, he will enter as a voluntary or informal patient. If it be necessary to use the involuntary admission procedures, with the attendant serious legal consequences thereof, surely it is an absolute minimum of protection to ensure that at the very least the patient is taken before a court for a hearing - in each and every case.

It is on this point that the NSW system is most clearly distinguished from the systems in other states and England and New Zealand. Even the most recent updating of the laws of another state - the South Australian legislation of 1977 - has not introduced automatic legal review. Medical discretion thus remains medical licence.

Once it has been determined as a matter of policy that there should be a court hearing as to the propriety of involuntary admission, it is necessary to consider the legal procedures which might be applicable. As to what such procedures should be, the writer makes a number of detailed proposals as set out in the next chapter.

However, four general issues arise which will be dealt with at this point:

(1) When should the initial hearing take place?

(2) Should the lawyer perform his functions of advocacy in an adverserial manner?

(3) The problem of the patient under medication.

(4) The question of legal representation and legal aid.

The Timing of Legal Review

There is no doubt that problems of mental illness are very often urgent and demand an immediate attempt to find a solution. This is particularly so where the behaviour which is associated with the mental illness is violent, aggressive

or dangerous either to the person himself or to others. It is submitted that in the same way that the police arrest a person and then take him before a magistrate in a criminal matter as soon as possible thereafter, it is proper that in appropriate cases detention of a mentally ill person should occur before the judicial process gets under way. In the criminal law, if a robbery occurs, it is obviously impractical and impossible to convene a special court sitting outside a bank and determine judicially the rights and wrongs of the matter then and there prior to the taking of any preventive action. As the learned Dr Johnson said in 1776 (Boswell, 1791):

> "If a madman were to come into this room with a stick in his hand, no doubt we should pity the state of his mind; but our primary consideration would be to take care of ourselves. We should knock him down first, and pity him afterwards."

Nonetheless it is important that the judicial hearing should occur very promptly after the involuntary admission of a person to a mental hospital. Of course in the case of a person who is extremely disturbed, it may require some days for a complete psychiatric evaluation to be made. That, however, should not prevent the individual being seen by a lawyer made available for that purpose to advise, if it be possible in the circumstances, on the admitted person's legal rights. This should be the very first involvement of the lawyer in the process of involuntary admission.

Especially taking into account the fact that many involuntary admissions involve poor people who cannot afford their own legal representation, this writer would argue that all centres to which persons are brought as mentally ill to be involuntarily admitted ought to have on the premises independent, salaried legal advisers whose function it would be to attempt to convey to persons brought to the centre what may be the legal rights and obligations of such persons. In many instances it would no doubt be impossible to communicate with the person brought in because he was too aggressive, disturbed, depressed or otherwise out of contact with reality. But this factor should not prevent the effort being made. There is a view that this function could be performed by persons without legal training - that is, by social workers or other similar officers. This is a matter which will be explored subsequently. Suffice it to say at this point that notswithstanding the matter of the person being seen by the psychiatrists, he ought also be seen by a person who informs him as to his legal rights. It is unrealistic to imagine that the medical officers themselves can fulfil this function satisfactorily. Their principal concern is with the mental health or illness of the individual, and although of course some medical practitioners are fully conversant with and attuned to questions of civil liberties, that is not their primary orientation.

According to section 12(6) of the NSW Mental Health Act, 1958, once the two admitting doctors recommend "further observation and treatment", the superintendent "shall cause such person to be brought as soon as conveniently may be before a stipendiary magistrate." (Emphasis added.) In practice the magistrate normally visits each hospital once per week so that a person might be held for a maximum of six days after medical recommendation.

The two doctors providing the examinations required in section 12(4) may not cause delay be taking undue time over this task. This subsection (and section 12(1)) demand that the two examinations should take place "as soon as practicable" after the admission. The meaning of the expression "as soon as practicable" was considered by Mr Justice Meares of the New South Wales Supreme Court in Ex parte Allen v. Superintendent of Callan Park Hospital (unreported, April 1970). He held that it meant not "as soon as reasonable" (the interpretation argued for by the hospital) but "as soon as feasible". That is, the examining medical practitioners could not delay their examination merely because at some later time their evaluation might possibly be more valuable and accurate. On the other hand, the examination must be "feasible". (Presumably it would not be feasible if the patient were unconscious.)

By contrast, Mr Justice Walsh held in Watson v. Cade (1971) 45 ALJR 449, that a requirement under section 42 of the Victorian Mental Health Act (1959) that "Every person admitted under this section...shall without delay be examined by the superintendent" was not breached when a patient was brought in about midday but not seen by the superintendent until the following day. No reference was made to the decision of Meares J. in Allen (cited above). Walsh J. said (at 450):

> "...the words 'without delay'...have not a rigid meaning. They should not be read as requiring that no more time should elapse between admission and examination than is necessary, in a physical sense, for the superintendent to go to see the patient. What is required, in order to comply with the provision, must depend upon the circumstances. It is not possible to specify a period of time and say that an examination within that period satisfies this provision and an examination outside it does not. In my opinion it should not be held that an examination must necessarily be made on the day of admission. A person might be admitted so late in the day as to make impracticable an examination of him or her on that day."

Yet in this case there was nothing at all to suggest that the person had been admitted "late in the day"; in fact he was admitted about midday. Walsh J. seems, with respect, to have bent over backwards to protect Dr Cade, the psychiatrist defendant.

No evidence was given of any extraordinary circumstance (such as a sudden flood of patients, for example) which would have made it impossible for him to see Watson that day. In fact the evidence appeared to be (at p. 450) that it was simply a practice:

> "that patients who were admitted on one day were seen by the superintendent on the following morning."

His Honour said (again at p. 450):

> "I do not think that this provision should be construed as imposing a more stringent obligation than that which is imposed by the proviso of s. 12(1) of the Mental Health Act, 1958 (NSW)."

Since the obligation under the NSW section is that the examinations must be conducted "as soon as practicable" after admission, and since in this case there appears to have been nothing rendering examination that same day "impracticable", it appears that Walsh J. has interpreted "without delay" to mean, in effect, "without unreasonable delay". This interpretation sits unhappily with the traditional requirement that in matters affecting the liberty of the citizen,

> "...supposition as to the intention of the legislature has no place...the function of the court is limited to interpreting and giving effect to its will as expressed in the statute." (Per Walsh J. in Watson v. Marshall (1971) 45 ALJR 444 at 447.)

It is difficult to accept that there was not "delay", in its plain meaning, in Watson v. Cade.

No doubt the judge was influenced by the fact that Watson appeared to be a difficult fellow; that Dr Cade was a psychiatrist of world renown; and that he had a difficult job to perform. In any event, a trace of judicial embarrassment comes through in the judgment in the way of stern suggestions to the legislature as to administrative and statutory changes which might in the future ensure that delay in examination is prevented from occurring. One is reminded of the apocryphal jury verdict on a trial for cattle stealing: "Not guilty on condition that he gives the cows back." Although Dr Cade got the verdict, the decision makes it clear that delay in the medical examination of the person taken to a mental hospital by involuntary process is highly undesirable.

In any event, returning to general policy issues, two points are clear: one, a requirement that no involuntary process at all should occur until and after a legal hearing had been completed would be completely inconsistent with the concept of "emergency" preventive action which is surely at the heart of the procedure; two, once the process of involuntary admission is initiated and the person is taken to an admission centre or mental hospital, then the process of psychiatric examination, legal advice and a court hearing should go forward as fast as is humanly and administratively possible.

It is worthwhile noting that in the New South Wales Act of 1958, "admission centres" and "mental hospitals" were defined separately, the idea being that an admission centre would be legally distinct from a mental hospital and situated on an area of land physically separate from the mental hospital proper - as it were, like the enclave constituted by an embassy on foreign soil. No doubt the purpose of this was and is to emphasise the notional separateness of the time spent in custody before the magisterial hearing. (It will have been remarked that the linguistic distinction between "admission centre" and "mental hospital" has not been consistently utilized throughout this thesis, since various jurisdictions use various terms to describe differing types of institution. Obviously "mental hospital" is a convenient generic term.)

Inquisition or Adversary Contest?

Once it has been determined that there shall be a court hearing of some kind, and its timing has been decided upon, the next issue is as to the general nature of the hearing. In short, the question is, should it be an inquisition (inquiry) or an adversary contest?

Under section 12(9) of the New South Wales Act, the magistrate conducts an "inquiry"; i.e., he seeks by whatever procedures he thinks reasonable to ascertain the truth of the matters in question. This does not mean, of course, that the

magistrate may simply ignore what the patient might have to say. As Campbell and Whitmore point out, (Campbell and Whitmore, 1973, 225):

> "The...legislation...does not absolve the stipendiary magistrate from the duty to observe the rules of natural justice. He is, after all, deciding an issue affecting a person's personal freedom and is most certainly under a duty to act judicially. This means, amongst other things, that the person whose rights are liable to be affected by his decision, is entitled to be heard."

Yet the fact that the proceedings place the magistrate under an obligation to act judicially does not automatically mean that there is a right to be legally represented. Proper legislation should, it is submitted, make the right to legal representation an absolute entitlement. In fact, from this writer's experience in hearings in New South Wales, no person ever has been denied the right to be represented by counsel or an attorney where a lawyer has been employed - nor is it likely that this would happen. Nonetheless the legal position should be made absolutely clear. Furthermore very few patients are in fact represented by a lawyer (Young et al., 1978; less than one per cent).

The question of whether or when free legal representation should be provided will be dealt with later in this chapter. The important question is whether or not (there being a hearing at which a potential detainee is legally represented) the lawyer should or should not "go in boots and all" (so to speak) in defence of his client.

There is no doubt that when the lawyer vigorously advocates the position that a particular patient ought not to be detained, it is in that function that he will be most likely to be seen by the doctors involved as interfering, aggressive, ignorant and a threat to the prerogatives of the medical profession.

It has been said in the American context that (Yale Law Journal, 1975, 1548):

> "...no consensus has emerged as to what role counsel should assume when representing a client in the civil commitment process. Numerous adherents of both the best interest and adversary roles are found among the commitment bar."

The "best interest" theory is that counsel should not act as an aggressive advocate of the patient's desire to be released, but rather that he should regard the patient as a person in need of care and attention for his own protection. According to this view, the lawyer must make a decision in his own mind about whether or not the individual really is mentally ill and really needs to be treated in the hospital. It may be perfectly obvious to everyone concerned that a particular patient is paranoid, psychotic, dangerous to himself and to others, and in clear need of psychiatric attention which would be made available to him if he were to be admitted. In such a case, according to this view, it would be improper for a lawyer aggressively to contest the involuntary admission.

It would be in the best interests of his own client for the client to be involuntarily admitted. The best interests of the client should always prevail, even when the client is not able, because of mental illness, himself to identify what those best interests are. In effect, this means that the lawyer substitutes his own view for the patient's.

In contrast to the "best interests" theory, advocates of the adversary approach would argue that it is never proper for a legal representative to substitute his own view of the client's best interests for the view which is taken by the client himself. Supporters of this approach are inclined to make reference to another well-known dictum by the learned Dr Johnson (Boswell, 1791):

> "A lawyer has no business with the justice or injustice of the cause which he undertakes, unless his client asks his opinion, and then he is bound to give it honestly. The justice or injustice of the cause is to be decided by the judge."

According to this view, the lawyer is excused from any moral obloquy which might attend his advocacy of a position in which he himself does not believe, by the nature of the judicial process itself: that is, the provision of an independent judge or tribunal for the determination of an issue. Thomas Szasz has argued (Szasz, 1961) that an adversary contest as to admission, rather than constituting a setback to the mental condition of the patient, in fact constitutes a therapeutic procedure which assists him to work

out what Szasz describes as his "problems in living". This writer is reluctant to concede that an adversary contest as to the state of one's mind would necessarily be a desirable or therapeutic procedure. But the opposite view involves the belief that there is something to be gained by hiding from a particular patient the real truth of opinions of other people about his own behaviour. Can this ever be so? One particular type of case in which doctors are wont to suggest that an adversary procedure might be harmful is the instance of the paranoid patient. The problem of paranoia is that the patient wrongly and unrealistically believes that certain people are, or the world in general is, disposed against him. If in an open court hearing the medical practitioners with whom he is dealing stand up and say that the man is mad, the result will be that the patient may believe the medical practitioner is one of his enemies. This, it is argued, is inevitably harmful to any attempt by the doctor to communicate with and break down the patient's feelings of paranoia. The doctor should not be put in the position of publicly aligning himself against the patient.

A related matter which concerns doctors is that they may obtain information from confidential sources about the patient and be unwilling to reveal those confidential sources in open court. For example, there may be a close relative or friend who has given information to the doctor, out of concern for the patient, which would be interpreted by the patient as malicious and antagonistic. Doctors tend to believe that this type of information would be jeopardised by a full scale adversary contest.

There may be some validity in these arguments. But on the other hand, there are many areas of the law in which the same type of argument is not allowed to prevail. In the common law tradition, there is a tendency on the part of the law to require that allegations made against the interest of a particular citizen should be substantiated in open court in such a way that they can be contested by the person against whom they are being made. It may well be that there are certain cases of criminal assault which are never brought to trial because particular witnesses are not prepared to stand up in open court in public and to denounce a thug, bully or criminal. It may be that there is a fear of later retribution. That is, of course, a bad thing. It is a perversion of justice. However, it is less of a perversion of justice than would occur if it were permitted that assault cases could be tried on the basis of whispered information put before the court in secret without the defendant being given any opportunity to cross-examine those who put forward the information. The scope for victimisation (if such a procedure were permitted) would be boundless. The perversion of justice would know no end. It would be possible for those with a grudge against another or others to manufacture evidence against which an accused person would have no possible defence.

For these reasons this writer believes that an adversary role for the lawyer in mental health hearings can best be justified on grounds of simple fairness and equity, rather than on the basis put forward by Szasz; i.e., that an adversary

contest itself constitutes a therapeutic process, a working through of problems or a confrontation of the patient with his own problems which will be beneficial to him. It may be that in some cases that will be so, but the better approach, surely, is to say that an adversary function for the mental health lawyer is one best suited to minimising the wrongful admission of citizens to mental hospitals.

Several strong arguments in favour of an adversary theory are put in an American article referred to above (Yale Law Journal, 1975, 1560-1561):

> "Faced with the opinion of an apparently competent psychiatrist that his client constitutes a danger to himself if not committed, counsel's natural reaction will often be to nod in agreement and decide that, indeed, his client's best interests demand hospitalisation. The tendency to defer to expert judgment and counsel's probable unfamiliarity with the psychiatric jargon with which the opinion will be delivered stand as strong deterrents to the best interest lawyers deciding to fight commitment. An attorney placed in the role of advocate, however, cannot acquiesce as easily in the psychiatrist's opinion. The incentive will be greater to ferret out facts and opinions in support of his client's desire for release and thereby fulfil his adversary role...Should a client be committed, the adversary lawyer is more apt to explore possible avenues leading to discharge. Thus mistaken commitments stand

> the possibility of rectification. Where the best interest lawyer acquiesces in his client's commitment, however, no such possibility of redress exists."

The question frequently arises of whether, although the lawyer should in general act as an advocate in an adversary manner, he should not in certain obvious instances of gross mental illness and need for treatment, convert his position from one of adversary advocacy to one of concern for the "best interests" of his client. That is, according to this view, the lawyer should generally fight as hard as he can against admission, but in certain cases he should accede to it. In the view of this writer such an approach almost constitutes a dereliction of duty. Of course there will be some cases which might be described as borderline, and some cases where it is obvious to even the most skilled and knowledgeable lawyer that the patient will certainly be admitted, but nonetheless an adversary stance should be maintained, albeit hopelessly. Once counsel "nods his head", so to speak, in the case of a client whose opposition to commitment he judges as hopeless, he is in effect usurping the role of the court. He will then have to make up his mind, in subsequent cases, whether the case is one worth contesting or not. In effect, this means slipping back into a "best interests" role. Of course, if the client gives instructions - as frequently happens - that he <u>wishes</u> to be admitted, the lawyer must accede to that view.

The "Committee On Mentally Disabled" in Michigan has developed certain guidelines for defence counsel in commitment cases (Committee On Mentally Disabled, 1977, 1005). The guidelines say:

> "In some cases, however, defence counsel is presented with a client with whom communication is so difficult, that the client's objectives cannot be ascertained. In these cases, counsel must first exhaust every reasonable effort to establish rapport with the client...If the client's objectives still cannot be ascertained, or his assistance in the preparation of the case cannot be obtained after these special efforts are made, counsel must then proceed even without the assistance of the client. In these cases, the attorney, acting as an advocate, must determine what disposition would be perceived <u>by the client</u> as most satisfactory to him and then advocate zealously for that disposition." (Emphasis added.)

Accordingly if the client says "I want to get out", then of course counsel must advocate that, even against his own feeling that the client should preferably stay in. If the client does not communicate what he wants, the lawyer must advocate not his (the lawyer's) view of what is in the best interests of the client, but his (the lawyer's) view of <u>what the client would want to do if he could communicate</u>. Obviously counsel is to some extent "flying blind" in attempting to discover what the client would or might have wanted to do.

The only apparent alternatives are: (1) always to accede on the client's behalf to involuntary admission; (2) always to contest it.

In the view of this writer, the Michigan formulation is interesting and useful, but ultimately unworkable. In many cases counsel will simply not be able to "determine what disposition would be perceived by the client as most satisfactory..." It is preferable to have a flat rule that in such cases, counsel must contest the involuntary admission, even without specific instructions. The Michigan approach involves a pretence that there are instructions by the client when there are in fact none. The absence of instructions in mental health hearing cases must simply be accepted as an inevitable problem.

A further point worth noting is that the lawyer representing a patient in a mental health hearing should not permit himself to believe that he is acting for the relatives rather than the patient, however tempting this may be. The interests and concerns of relatives ought to be taken into account by the relevant judicial or tribunal officer. Relatives may possibly have hidden motives to distort factual information. They may, consciously or unconsciously, wish to revenge themselves for years of having had to tolerate difficult behaviour. They may simply wish to be rid of the patient. They may even, in odd cases, actually wish to "get their hands on" the money or property owned by the person sought to be admitted.

It would be unfair and wrong to suggest that the relatives of the mentally ill usually, or even often, have these motives. The uncaring relative will have usually been driven away by difficult behaviour long before any question of involuntary hospitalization arises. Those left at the last, so to speak, will usually be loyal, patient and caring. Yet nonetheless in some cases the improper motives referred to above will be present. For this reason alone counsel for the mental patient must carefully keep in mind that his responsibility is to the client, not to the relatives. Their case or cases may be put by another advocate.

It is apt in this regard to draw an analogy with representation of the criminal defendant. Counsel may have the utmost sympathy with the victim of a dreadful crime. But for the due administration of justice that sympathy must be set aside and all proper efforts bent towards the protection of the interests of the criminal defendant.

In drawing this analogy, however, it needs to be kept in mind that whereas in a criminal trial there is a prosecutor whose function it is (inter alia) to protect the interests of the community and of the victims of crimes, there may be no such figure clearly identified in the mental health hearing situation.

In fact the psychiatrist writing the report on the patient does perform a prosecutorial function, although he will usually go to great pains to deny it. There is no doubt

that the general rule is that a doctor must act on behalf of his patient, and cannot compromise the patient's interest by (for example) disclosing personal information to another person.

Equally clearly, however, when a doctor is performing the statutory function of examining a person in order to ascertain his liability to be involuntarily admitted, the normal doctor/patient relationship does not arise. Clearly the doctor is empowered, even perhaps obliged, to publish information about the patient which may be adverse to the patient's wishes. For example, under section 12(4) of the NSW Mental Health Act, 1958,

> "The Superintendent of an admission centre shall as soon as practicable after the admission of a person to such an admission centre cause such person to be examined by two medical practitioners separately and apart from each other."

According to section 12(6),

> "If after examination as aforesaid two medical practitioners recommend that further observation and treatment in a mental hospital or authorised hospital is necessary, such superintendent shall cause such person to be brought as soon as conveniently may be before a stipendiary magistrate."

Where legislation in such or similar terms is in force, it is a serious error for doctors to believe, and an even more serious error for lawyers to believe, that the examining and recommending medical practitioner is merely acting in his traditional role as medical adviser.

There is a clear distinction, in professional relationships, between acting on the instructions of the client, and acting in the interests of the client. If the professional person were empowered at all times to act in what he saw as the best interests of the client, regardless of the client's views about the matter, there would be tyranny by professions. The doctor could say, "You need this leg amputated, you must have it off, it is in your own interest - do as I direct." The leg could be amputated over the patient's protests.

In fact, of course, the law does not permit this. The general rule of legal and medical ethics is that the client or patient must be advised, not ordered, to do what the professional person sees as being in the best interests of the client.

Involuntary admission to mental hospitals provides for a reversal of the normal ethical rule. Like it or not, the recommending doctor acts in fact as a kind of prosecutor, however much he might squirm under and deny that description.

It follows that the counsel representing a person whose involuntary admission is sought should not be lulled into believing that the examining and recommending doctor is

necessarily acting in the best interests of the patient. The doctor is performing a statutory function which puts his role in the same category as that of a prosecutor. He is recommending that the patient be locked up. In making such a recommendation, the doctor will usually of course be acting in good faith, and no doubt he will usually believe that he is acting in the patient's best interests. But his perception of "best interests" may not coincide with those of the patient.

Although the "prosecutor" in mental health hearings is disguised as a doctor, and will vehemently deny being so described, he still <u>is</u> in effect a prosecutor. It is an error for a lawyer in such a case to be less protective of his client's rights merely because the recommending doctors may give an outward appearance of neutrality.

<u>The Client Under Medication</u>

In the great majority of cases where a person is taken to a mental hospital involuntarily, he will be given medication - that is, some form of a drug or drugs - for the purpose of calming his behaviour. The nature of such medication will of course vary as between particular kinds of illness. The volume given will vary in accordance not only with what might be regarded as a medically or psychiatrically proper dosage in given circumstances, but also with the ability of the number of hospital staff to cope with the particular number of patients they have to deal with. So effective are modern

tranquillisers and similar drugs in controlling disturbed behaviour and in pacifying difficult patients that it is one of the continuing dilemmas of modern institutional psychiatry to ensure that the use of such agents is primarily for the benefit of the health of the patient, and not merely for the maintenance of good order and discipline within the institution.

In most psychiatric hospitals which are funded by State or Federal Governments the pressure on the public purse puts considerably pressures on staffing. In such places from time to time the "discipline and good order" purpose of the tranquillising agents takes over as the dominant purpose of their use. Of course, competent medical staff are well aware of this problem; nonetheless abuses do from time to time occur.

Regardless of whether the use of a tranquillising agent in relation to a particular person taken to hospital is justified or not, lawyers dealing with such cases will from time to time be confronted with the problem of attempting to take instructions and to act for a client whose consciousness is either totally negated, or seriously dulled, by the effects of medically administered drugs.

The first point to be made about this problem is that it is impossible clearly to state that the use of tranquillising agents in relation to client/patients is necessarily either a good thing or a bad thing. The crucial time (from the viewpoint of the lawyer) is when the client appears before the

magistrate or judge or tribunal. According to one experienced mental health hearing advocate (Dawidoff, 1975, 89):

> "It is...the fact that the court looks upon the patient's behaviour in the hospital and his courtroom demeanor as more important evidence than past behaviour."

If he is in a condition of semi-consciousness in court, due to the effects of drugs, it will obviously be impossible for his case to be presented fairly before the tribunal. He will not understand properly what is put to him or what is said about him. He will not be fit for the hearing. In these circumstances, it would be reasonable to say that he could not fairly be treated in a manner appropriate to the protection of his civil rights. On the other hand a disturbed individual may respond very well to the use of a particular type of drug. It occurs from time to time that patients who are taken off the use of a particular drug present themselves very badly, as disturbed, tense, agitated and generally mentally ill. If such an individual were to be presented to the magistrate or tribunal without the benefit, over the preceding few days, of the tranquillising agents to which he has normally been subject, it might be suggested that there is an equal but opposite unfairness to the one previously described; that is, the case of the comatose client. (The unfairness of withholding drugs which would normally be made available to him from a mentally ill defendant who is about to stand trial is pointed out by Scrignar (Scrignar, 1967). Buschman and

Reed point out the delicacy of the dilemmas in this area (Buschman and Reed, 1968). These authors cite the statement of an anonymous judge, in a case studied by them, to the following effect:

> "...his trial while under the influence of such medication, would not in the opinion of the Court be consistent with the requirement that he be able to understand the nature of the charges against him and to participate in his own defence...".

This refers to a criminal case, but the principle is applicable also to the situation of involuntary detention. Buschman and Reed point out that while some judges regard it as only fair that a defendant should be able to be supported during the course of legal proceedings by medication upon which he would normally rely, other judges hold the view that the procedure of permitting drug use in the circumstances of legal procedures in effect amounts to the falsification of evidence and the misleading of the legal tribunal. Steingarten says (Steingarten, 1976, 121):

> "And some psychiatrists feel that it is harmful for patients to stew in their hallucinations for a month before medication suppresses them."

These matters have not yet arisen for litigation in Australia, but it is easy enough to predict that the same divisions of opinion would arise here if litigation were to ensue.

The important matter, it might be said, is that the court or tribunal should be put in a position where it can properly evaluate the real mental condition of the person in question. But, as Heraclitus said, "You cannot step twice into the same river..." (Russell, 1945, 45). Humans are constantly in evolution. There is something artificial about seeking to encapsulate the "real personality" of a particular person at a particular point in time as if he were an insect caught in amber. A judgement must be made, it is submitted, not that the court is able to perceive the inner psyche of a particular individual, but that it is able to evaluate his likely behaviour, under conditions of stress, in everyday situations which he would be likely to encounter if released from custody. It may well be that for a particular patient, support will be available so that the continued taking by him of appropriate medication would be likely. On the other hand, it may be that for a particular person the continued taking of appropriate medication would be very unlikely indeed. Many patients have in the past refused to take medication and, it might be predicted, would be likely to do so in the future.

It is obvious therefore that the doctors, lawyers and tribunals involve in considering the question of involuntary admission must make quite complex judgments about these matters. There is no easy answer.

Perhaps from a realistic viewpoint the most important thing for the lawyer to do in relation to the medication of the people he sees is for him to ensure that there is no

serious abuse such as the situation described by Kutner as follows (Kutner, 1962, 385):

> "...doctors at the Mental Health Clinic keep all the 'patients' under such heavy sedation that many of them appear stuporous at their hearings and are unable to defend themselves for that reason alone."

The mental health lawyer would have to be astute to ensure that no such general practice as this affected his clients, or that no particular client was affected in this way.

In an important article in the Arizona Law Review (Wexler, Scoville et al., 1971, 67-68) it is said that:

> "...Perhaps doctors should be authorised to medicate a patient prior to the proceedings if, after consultation with the doctor, it is the attorney's opinion that medication would seem likely to <u>enhance</u> the patient's ability to participate effectively at the hearing..."

At the same place Wexler et al. say:

> "The goal we must hope to achieve for each patient is to strike a balance by administering drugs, if required, to remove psychotic, disabling and disruptive symptoms without impairing the patient's right to converse with his attorney and to carry out his defence effectively. The patient's attorney should play an active part in helping to strike the appropriate balance."

And again (id.):

> "Perhaps what is needed is an insistence, framed in some legally enforceable terms, that even if medication is necessary for treatment or for permitting the patient to participate in the hearing only the minimum required dosage should be administered."

This writer is inclined to agree with the conclusions of Wexler et al. on this subject. It would of course be extremely difficult to enforce any rule which might be framed as to the administration of drugs prior to the mental health hearing; nonetheless it may well be that in the very framing of such rule an appropriate educative effect could be achieved.

Certainly it is clear that it would be impossible to enunciate any blanket rule, either that the patient must always come to the mental health hearing in the full blossom of his mental illness, unalleviated by any medication, or on the other hand, that he should always be medicated before and during such hearings.

In each case it will depend upon the tribunal itself, on the application either of the counsel for the mentally ill person or on the application of the doctor, to make a decision about whether at a particular time a hearing with regard to a particular patient should proceed. The tribunal should be able to make a decision about whether a particular

person is under-medicated or over-medicated at a certain time, and either then hear the case, or adjourn it to another appropriate time.

Legal Representation and Legal Aid

It is submitted that every person involuntarily dealt with by reason of mental illness or supposed mental illness should have, at every hearing before a court, magistrate or tribunal which may affect his or her admission, continued detention or treatment:

(a) an absolute entitlement to representation if it be desired;

(b) the free provision of such competent representation.

Such entitlement ought logically to flow from the recognition of the system of involuntary admission as second only to the system of criminal justice in impact on the rights of citizens to individual liberty. Nobody is sentenced to imprisonment in Australia without trial; very few go to prison these days without having had the benefit of legal representation. In simple fairness, it ought not be possible to be incarcerated in a mental hospital without having had protections, including the right to counsel, as substantial as those accorded to the criminal defendant. On the contrary, the person whose mental health is in question is probably more in need of counsel or representation than

many criminal defendants. Mental disorder inhibits the capacity of persons to argue their cases, to find alternative courses of action and generally to look after their rights.

On the other hand, there is a view that adequate protection of rights can be ensured by the judicial officer at the hearing. It is commonly argued by those who oppose change in this regard in New South Wales that the magisterial inquiry under section 12 is sufficient protection in itself. The magistrate is an independent lawyer; he conducts an unbiased inquiry and comes to a certain conclusion. Why, it is said, do we need <u>two</u> lawyers to do the job when <u>one</u> can do it?

Firstly, it may be answered, the function of determining rights is best performed where two or more opposing views are clearly presented and a judicial officer can choose between them. A judge or magistrate cannot be expected to "dig out" the case for one side and then for the other, and choose between them. He is not trained to do this, and he generally does not have the facilities to do it. In an adversary contest, the arguments for competing sides are vigorously presented and attacked. The judge or magistrate can choose impartially between them. A dispute as to whether or not an individual ought or ought not be involuntarily admitted is preeminently a matter suitable for adversary contest. The issues are clearly defined. Those with a European or civil law background are sometimes inclined to be critical of the attachment by Anglo-Australian common lawyers to the idea that an adversary contest is preferable to an

inquisitional mode of determining issues, and no doubt in some regards this critical attitude is justified. However, it is submitted that where there is a blunt dispute over whether a person is or is not mentally ill and ought to be admitted involuntarily, the advantages of adversary contest are manifest. The magistrate at a section 12 inquiry is not able himself to make full inquiries as to whether or not appropriate alternative facilities - such as a friend or relative willing to care for the person - might be available. Even more clearly, he is certainly not equipped to inquire into factual matters, such as whether (for example) the individual in question actually does have enemies following him, which may be of vital importance. In short, he is not equipped to "play the detective" as a lawyer of course can and does do. This is as much a matter of history and tradition as anything else. Even in situations where English or Australian judges or magistrates do perform an inquisitional role (for example, in Commissions of Inquiry) they are invariably assisted by counsel who carry out the necessary basic investigations. It is perhaps not wrong in theory, but certainly wrong in practice, to suppose that a magistrate can come to a section 12 inquiry situation and so change his fundamental approach to his job that he can perform his task as judicial officer and as well act as counsel for both sides.

Secondly, it is unfortunately true that magistrates and judges tend to be unduly influenced by the evidence of psychiatrists. This has been amply demonstrated to be so in

the USA in different jurisdictions; for example, Arizona (Wexler and Scoville, 1971), North Carolina (Hiday, 1977), Texas (Cohen, 1966). The writer's own observations and experience would suggest that this is certainly so in New South Wales. It is understandable how this may occur. Unless a judge or magistrate happens to be learned in the field of abnormal psychology, he will naturally be reluctant to question or reject the evidence of a trained and apparently competent psychiatrist to the effect that a certain individual is mentally ill and in need of treatment. If there is no competent representation, including skilled cross-examination of medical witnesses, psychiatric testimony tends to go unchallenged.

This writer proposed, and the Edwards Committee recommended (Edwards et. al., 1975, 99) the establishment of a "Mental Health Representation Committee" to supervise a pilot scheme of legal representation at one major Sydney psychiatric centre. In due course this recommendation was taken up, and that scheme operated at Rozelle Hospital during 1976 and 1977.

As a general indication of the inadequacy of section 12 inquiries, statistics produced by the "Legal Representation Committee" (as it was called) brought forth the following comments in the report (Young et al., 1975, 7):

" - the Edwards Committee estimated that less than one in ten persons appearing before a magistrate is legally represented. Having monitored over nine hundred inquiries at admission centres other than Rozelle it can be confidently stated that the actual rate of representation is less than one in a hundred;

- inquiries are typically very brief. At Newcastle admission centre the median duration of inquiry was only three minutes, with every case, except one that was privately represented, resulting in a committal order for the maximum period allowable;

- orders for committal for a maximum period allowable by law tend to be made routinely by some magistrates. For example, at Newcastle, Kenmore and Gladesville Hospitals 284 of a total of 291 orders made (i.e. 98%) were for the six months period...;

- attendance of medical staff at inquiries is low, often leaving the magistrate to consider written evidence only and preventing the magistrate or patient from questioning either of the assessing doctors or from clarifying possible ambiguities in their written reports. Medical staff attended only 3% of inquiries at Gladesville, 5% of inquiries at Rydalmere and 6% at North Ryde. Attendance was greatest at Bloomfield where medical staff were present at 19% of inquiries;

" - attendance of relatives is also low, often depriving the magistrate of any information about alternative means of support. Attendance ranged from 8% at Bloomfield to 43% at Rydalmere. In some cases this low attendance can be at least partly attributable to inadequate administrative procedures for notifying relatives used by the hospital. At Morisset a standard telegram sent to relatives proclaims 'A magisterial inquiry into the mental condition of ... is to be held on ... Your attendance at this inquiry is not obligatory. Medical Superintendent, Morisset Hospital.'"

This damns a system which is supposed to provide protection but which, clearly, provides only the appearance of it. No doubt it is true that the original examining medical practitioners do act as an effective screen in many cases, so that by the time the matter gets to the magistrate, some potential detainees have been sent away by the doctors as not appropriate for admission (Briscoe, 1968). Nonetheless the impact of the "pilot scheme" of legal representation at Rozelle was clear. As might have been expected, the numbers of those admitted was reduced, and the lengths of detention ordered were reduced. A comparison was made between outcomes of inquiries held during the pilot scheme at Rozelle with those held before. The percentage discharged outright increased from 2% before the project to 8% during the project where the person was represented. The numbers of those committed for one month or less similarly increased from 2%

to 16%, while those committed for the maximum period of six months decreased from 89% to 50% (Young et al., 1978, Table 3).

It is clear that these significant changes were wrought by the fact of representation, and its spin-off effect on hospital practice. It is probable, in this writer's view, that these apparent effects would have been greater, but for two factors:

(1) The hospital chosen was one where the superintendent was disposed to consider questions of civil liberties as very important, and hence was favourably inclined to having the scheme operate in his hospital. It is likely that even prior to the project, there were proportionately fewer unnecessary admissions at Rozelle than at some other hospitals, and therefore the scope for decreasing these by adversary procedure in hearings was probably significantly less than it might have been at other hospitals.

(2) A senior magistrate who heard many of the cases under the scheme was very ill-disposed to the idea of representation in hearings and thus was perhaps less willing to be influenced by legal argument or involvement than some other magistrates may have been.

The Young Committee were generally highly critical of the manner in which section 12 inquiries are conducted; (certain of these criticisms will be referred to in the next

chapter). Its main recommendation was that the Health Commission adopt a policy of providing a representation service to patients at all authorised admission centres. That is a view with which this writer agrees.

Are Lawyers Really Necessary?

The only issue upon which the Young Committee split was the question of whether effective representation could or could not be carried out by non-lawyers. That such a division of views should occur is understandable, because this question is a difficult one which has not yet been satisfactorily resolved.

One of the original representation services for mental health hearings was established in New York in 1965, and involved a mixture of lawyers and social workers performing representation duties. In the two city Departments of the state, most representation was by lawyers; in the two rural ("upstate") Departments, most representation was by social workers. This division of the "Mental Health Information" Service" (as the overall system is called) was perhaps influenced by the relative availability of lawyers but presumably also by a division of opinion as to the relative usefulness of lawyers as against others in providing a representative service.

In a study of the Mental Health Information Service, Gupta (Gupta, 1970-71, 431) said it was preferable to have

a mixture of social workers and lawyers on the Mental Health Information staff, the latter representing those who desired representation. He was critical of the ability of non-lawyers to inform patients with accuracy and clarity about their rights. He said (at 443) that there is a tendency for the social workers just to read out the printed form referring to a right to counsel (and other rights) without there being effective communication:

> "The social workers duly performed their duty according to the letter of the law, but not to spirit...social workers are being asked to perform a task beyond the pale of their training when they are required to discharge this 'informational' role."

In an addendum to the Legal Representation Committee Report (Young et al., 1978, 38), the three legal members of the committee dissented from the main Report in the following terms:

> "We do not agree with the statement made in the Report that -
>
> 'Experience with the Rozelle project demonstrated that in the majority of cases representation could be done as effectively by persons without formal legal training.'
>
> In fact we formed the contrary view, i.e. that persons who lacked formal legal training experienced difficulties in presenting an argument to the

the magistrate, particularly when that argument sought to persuade the magistrate that he should not commit the patient to an institution."

It was certainly the intention when the Rozelle Project was established that it should explore the question of whether representation could be effectively provided by non-legal persons. Clearly no consensus of opinion about that resulted.

Obviously lawyers would generally be inclined to believe that they are better at representing people in court than are non-lawyers. This is a natural professional prejudice, by which this writer frankly concedes he is affected. Certainly lawyers are commonly seen as greedy, overbearing, self-seeking and aggressive. No doubt they often are. But some (at least those with training and experience as advocates) have a skill in interrogation and the presentation of argument which can cut away falsehood and permit the just resolution of conflict in circumstances where, in the absence of the application of such skills, injustice might well occur. The presentation of argument is indeed a skill which requires training. It is a common misconception that if an honest person simply "presents the facts", then the truth will automatically come out, and justice will be done. Unfortunately the discovery of truth is in practice often much more difficult than this. The writer is willing to be persuaded on this point, but until so persuaded would take the view that representation of

potential and actual mentally ill detainees should be undertaken primarily by trained lawyers, although no doubt with other professional or lay assistance.

But it must at once be conceded that unless legal representation is effected properly, it may be simply a charade. In his classic study of the system in Texas, Cohen pointed out (Cohen, 1966) that it is pointless to have lawyers attend on the very day of the hearing, having had no real opportunity to consult with the clients beforehand, and in any event attempting to "represent" a vast number of patients. This type of "assembly-line" legal representation provides no protection at all and is simply a waste of money.

This style of "mis-representation" is described by Wexler and Scoville as having occurred in Arizona (Wexler and Scoville, 1971, 54):

> "Attorneys are often appointed the morning of the trial and have, at best, only a few minutes before the hearing to meet with the patient. In many instances, the attorney may never meet with the patient until the case is called."

In England, the National Association for Mental Health (MIND) has at one stage expressed a view that lawyers are probably not really necessary at hearings (MIND, 1973, 13):

> "A project of the National Council for Civil Liberties in the years up to 1967 provided lay assistance to patients in presenting their case; it produced the striking result that of 78 patients who were assisted 32 (or 41%) were successful, against a general average of 12½%. Representation by a lay "patient's friend", it appears, results in a fuller and more effective case for the patient being presented.
>
> ...We urge that finance be made available to provide a service of lay representation for all patients at Mental Health Review Tribunals."

There could be no doubt that enthusiastic and articulate volunteers, with a knowledge of mental illness and some knowledge of community facilities would be better at representing patients than would the ignorant and careless lawyers referred to by Cohen and Wexler and Scoville.

No doubt the lawyer members of the Young Committee who dissented on the question of legal/lay representation would not contest this point; undoubtedly, good lay representation may be better than bad legal representation. But presumably they would say that, assuming equal enthusiasm, preparation and knowledge of mental illness, representation by a trained lawyer would be better than representation by a lay person.

Further to the 1973 report cited above, MIND foreshadowed (Gostin, 1975, 93) some experimentation in this area:

> "MIND's Legal and Welfare Rights Service will recruit volunteers from several disciplines (law, social work, psychiatry, nursing and so on) to represent persons at tribunals. In order to ensure a high standard of representation, all volunteers will have to demonstrate their knowledge and understanding of the tribunal system...A training guide will be prepared..."

It is clear that the MIND people have an understanding of the basic problems (Gostin, 1975, 93):

> "...the quality of representation is variable and often inadequate. The absence of interdisciplinary training for representation produces certain weaknesses: lawyers acting as representatives often place an undue reliance on unnecessary procedures and rules of evidence, or may be insensitive to the importance of the psychiatric or social factors in the patient's situation. Social workers, on the other hand, are expert in these areas, but they lack a detailed knowledge of the Mental Health Act and its procedures, and do not have cross-examination skills and a genuine scepticism towards uncorroborated evidence."

The conclusions of this writer on the issue of lay versus legal representation are twofold:

(1) Further experimentation in the use of various types of representation systems is needed;

(2) Probably the best system will be one where the court representative is a trained lawyer and experienced advocate, but who has some appropriate training and interest in the field of mental illness and the provision of social services, and is supported by specialists in the latter areas.

The Functions of the Lawyer

This writer would submit that the lawyer who appears for patients in the mental health process should have three main functions:

(1) To advise generally concerning patients' rights;

(2) To prepare for and appear in cases before magistrates or tribunals in which a client's status or interests are placed in jeopardy;

(3) Generally to constitute a "legal presence" in the mental hospital promoting an atmosphere of concern for legal and civil rights of patients.

The first of these functions involves the lawyer in conducting interviews with the patient himself or herself,

with relevant medical staff and with relatives if they are available. It is obviously most important that not only the particular person himself be advised of any rights which he may have but that others who may be able to act in his interests are also so advised. The lawyer will generally be expert in and familiar with the laws relating to the patient's presence at the hospital, and his entitlements in relation to contesting any involuntary admission contemplated against him. However, it is equally important that he be made aware of other peripheral rights such as those concerned with social service payments, the custody of any children and related matters not directly concerned with the issue of involuntary admission. It will often be the case that the lawyer must take advice about these matters from social workers and lawyers who practise in other jurisdictions. This is a fairly common kind of exercise for lawyers to undertake and one for which they would normally be expected to be adequately equipped.

Often, of course, it will be very difficult if not impossible to communicate with the patient what his rights are. He may be comatose, disturbed or agitated. In such a case it is necessary for the lawyer to choose another time to see him and to make such arrangements with hospital staff as are appropriate to ensure that the next time the client or patient is seen, he will be in a condition in which communication becomes possible. In some cases such communication will never be possible. Obviously there is no answer to this problem.

Communication will be assisted, obviously, by appropriate training of the advocate. As Patch says (Patch, 1974, 38):

> "...the first requirement for adequate patient advocacy is clinical training. The need for members of the legal profession to have a greater understanding of psychological phenomena and psychiatric resources has found increasing response in the curriculae of our law schools and the growing number of written source materials. But books and lectures are not enough.
>
> For the problem here is not simply that of cold assimilation of abstract scientific facts and theories. On the contrary, only through the personal experience of relating with disabled persons and with their doctors can the specialist lawyer acquire that kind of full understanding and empathy which is so essential to his acceptance of his client with the confidence which is needed to assist him. In the course of this training experience, any conscientious lawyer can risk that needed identification with his client's cause only if he can transcend his own fears, bewilderment and anxieties through increased self-understanding.
>
> In this way the lawyer can discover, without fear, that his own feelings and weaknesses are not essentially different from those of his client, except in degree or duration. Then, equipped with such understanding and patient concern, the attorney can effectively listen and communicate - even in those difficult cases where his client's disability may render him incoherent."

(Footnotes deleted.)

(The reference to "increasing response in the curriculae of our law schools" refers, of course, to the American situation. One hopes that a similar development may take place in Australia.)

Case Preparation

The second function mentioned above (that is, to prepare and appear in cases before the relevant tribunal) is mostly concerned with the actual law laid down in the statute relating to involuntary admission. Statutory provisions apart, it is necessary that the counsel should thoroughly investigate the possibility of any reasonable alternative disposition of the person which might be available to the tribunal. For example, if there is some relative or friend who might be able to take the patient under his care and control, then that matter should be looked at. Under certain legislative provisions, it might be required that the tribunal itself actively investigate this question, but whatever arrangements are made for social workers from the hospital or elsewhere to make such investigations as to an alternative possible disposition, the legal representative of the patient himself should always personally ensure that these matters have been thoroughly investigated.

Another area which the representing lawyer will carefully prepare is material relating to the actual facts of the case itself; that is, the facts immediately leading up to the admission itself and any relevant facts in the background of the patient. It is obviously true, for example, that even paranoids have real enemies. It does happen in occasional cases that the persecution to which a person who is mentally ill refers has some factual basis. Factual matters must be carefully investigated to ensure that statements by the client are not mistakenly thought to be evidence of mental illness, while in fact they are based on reality. This writer recalls a case in which he was involved where the admission of a person was sought to a mental hospital in Sydney on the ground of certain disturbed behaviour in a private nursing home in which he had been living. One symptom referred to as indicative of a mental illness on his part was grandiosity in his claims to familiarity with certain wealthy people and influential political figures. Indeed, such claims had at first hearing an absurd ring to them, in view of the condition to which the particular person in question had been reduced, and to his financial circumstances at that time; but it turned out, on investigation of the claims he made, that he was in fact an associate of the said influential and well-known people, and that his claims to have moved in these circles were quite true. In this case the magistrate quite properly decided that there should be

no involuntary admission. But it would have been quite possible, had there been no factual investigation of these matters, for this man to have been involuntarily admitted quite unfairly. It is not suggested that the ravings of the mentally disturbed will generally turn out to represent truth, but the significant possibility of some basis in reality should never be overlooked and should always be carefully investigated.

The other vital area in which the lawyer should undertake preparation is in relation to the actual mental condition of the patient himself. It is obviously necessary for the lawyer to have some knowledge of mental processes and mental illness in general. He should be aware of the main literature concerning the type of illness to which the person is said, by the doctors, to be subject, so that he may put relevant questions to the doctors if they appear at the hearing, and may make appropriate submissions to the magistrate or tribunal as to the issue. Questioning and submissions as to the mental illness of the patient may profitably be directed to the issue of whether or not the patient is <u>seriously</u> affected by the illness in question, or whether he is only mildly affected. Questioning as to the usefulness or otherwise of medication in relation to the condition will usually be of some use. As in all litigation counsel will have to make up his mind whether he seeks to attack the evidence head on, or to conduct an outflanking movement in order to weaken its impact.

Generally, in the experience of this writer, it would seem to be inappropriate to attempt to belittle or attack directly the medical evidence given by qualified psychiatrists. Magistrates and tribunals generally give considerable respect to such evidence and there is little point in butting one's head against a brick wall.

As Dawidoff says (Dawidoff, 1975, 88-89):

> "The tack of counsel for the patient "grilling" the hospital's psychiatrist is not as helpful in gaining release for the patient as in emphasis upon the patient's composure and the willingness of someone or some outpatient alternative facility to harbor him."

"Legal Presence"

The third function of the lawyer in the mental health process should be to constitute a "legal presence" in the mental hospital, promoting an atmosphere of concern for legal rights. It is most important that this legal presence should not be interpreted by the hospital staff as constituting an all-out attack on their personal integrity. In general it is suggested that a courteous, considerate but nonetheless insistent presence by legal personnel engaged in mental health hearings is the best way to ensure a process of continuing education for medical

staff in the important requirement that the legal and civil rights of involuntary patients be respected.

There cannot be a "legal presence" in this sense without continuity. A good patient advocacy service must be based on continuous presence in the hospital by caring people. Again, to quote Patch (Patch, 1974, 38-39):

> "Any lawyer who offers to assist and represent a mentally disabled person - whether retarded or ill - will usually find that the amount of time and effort required of him is substantially greater and more prolonged than that required for a fully functional client. In addition, the clientele of mentally disabled persons generally does not offer the same degree of financial reward as that offered by other clients. For these reasons it appears clear that to meet the requirements of due process, our society must create a specialty of advocacy for the mentally disabled which is as well defined and well funded as that of the public defender for criminal cases."

This can only be achieved by the establishment of a state-funded patient advocacy service, although it is not necessarily desirable that outside, private counsel be excluded from the jurisdiction; on the contrary. But the substance of an adequate patient advocacy service can surely only be provided by full time, paid, specialist attorneys, based in the hospital - but independent of its

administration - who can visit patients at any time, who know the hospital intimately, and who are prepared to be insistent on their clients' rights.

This "legal presence" would of course be constituted not only by qualified lawyers, but also by social workers and others - all, again, independent of the hospital administration - with a primary concern for the protection of rights.

Arons explains that a psychiatric consultant, responsible to the mental health advocacy service rather than to the hospital, is helpful not only in providing independent advice but also in mediating between advocates and ward psychiatrists (Arons, 1976, 12):

> "I would either promote and encourage contact with the appropriate psychiatrist or would make the contact personally with the ward psychiatrist... I would explain that I was working with the lawyers with an educational purpose foremost in mind. In no case did the ward psychiatrist hesitate to talk with me. The ward psychiatrist often had hesitated to talk with the attorney. During our conversation, the ward psychiatrist would express reservations or complaints about the Public Defender Service. These reservations and complaints clarified that the hesitancy to speak with the attorney was often unrelated to the present situation, but based on past experiences, misunderstandings,

> or faulty communication. The legal staff also realized the extent to which their present actions affected the future willingness of the ward psychiatrist to be cooperative with their efforts."

The Rozelle experience showed that friction can easily develop between lawyers and psychiatrists over questions of patient representation. Some doctors are implacably opposed to the very idea and feel threatened by the prospect (and the actuality) of being interrogated about their opinions. It might very well be important to consider some such role as that outlined by Arons as necessary to the effective functioning of an adequate patient advocacy service.

Most importantly, however, the "legal presence" of a patient advocacy service in the hospital would perform the political function of advocating patients rights in the broadest sense. Quite apart from the interests and rights of individual patients, the mentally ill as a class have common interests, neglect of which constitutes an injury to all. Just as the great body of attorneys who may be described as "commercial lawyers" act not only for individual clients but as well lobby for the interests of the commercial community generally in public organizations and politics, the establishment of salaried "patient advocacy" services would (one hopes) lead to broad lobbying for the interests of the mentally ill. Since the mentally ill as a group are disadvantaged in many ways, it is the firm view of this writer that such action would be socially

desirable. That, of course, is a political or value judgment with which others may disagree.

These are the broad issues relevant to the general matter of protecting patients' rights by legal process or legal presence. We will turn in the next chapter to consider in detail what might be regarded as a minimum standard of procedural safeguards in hearings.

# CHAPTER 11

## PROCEDURES AND EVIDENCE

If there are to be court procedures concerning involuntary admission,* exactly how "legalistic" should they be? The most important considerations relevant in this regard (apart from the matters raised in the previous chapter) are:

* independence of a judicial officer;
* a proper venue for hearing;
* notice to relevant parties;
* admissibility of prior psychiatric history;
* admissibility of hearsay evidence;
* evidence on oath;
* the calling of witnesses;
* burden and standard of proof;
* record of proceedings;
* reasons for judgment;
* rights of appeal.

### Judicial Independence

It scarcely needs to be argued that where there is to be a court hearing in relation to the question of involuntary admission, the judicial officer, be he Judge, Magistrate or other person, must be independent of and unrelated to the hospital to which the admission is to be made, or to anybody else involved in the admission process. In New South Wales, this is usually no problem so far as a Magistrate or Judge is concerned. However, since doctors sometimes sit on Tribunals,

*In most jurisdictions legal provision is made for the sequestration of persons suffering from seriously infective diseases. (E.g., part III of the N.S.W. Public Health Act, 1902). Involuntary detention on this ground is liable, in the case of widespread disease, to be the subject of publicity and political comment, hence no "tribunal" structure seems necessary. As for individual persons, the traditional right to invoke habeas corpus is probably adequate protection. The writer has never heard of complaint in this regard.

it is important to be certain in each such case that there is an appropriate degree of independence.

Proper Venue

Should the hearing before the court or magistrate take place within the grounds of the hospital itself, or in some external location? No doubt an external location would make the enquiry appear to be more independent, but against this there is the argument that the mental condition and physical condition of many patients is such that they would pose considerable problems if it were required that they should be transported any distance to a separate outside court. That is, there is great convenience attached to having the judicial inquiry take place in a normal court.

It is undoubtedly important in the carrying out of judicial functions that the circumstances should be such as to encourage an atmosphere of seriousness and gravity with respect to the proceedings in hand. Mere outmoded judicial pomp and ceremony apart, like the wearing of wigs and gowns and possibly other ceremonial features of the legal process, those with experience in courtroom practice will be aware that a certain minimal standard in physical facilities is useful in permitting those engaged in the job at hand to concentrate their attention on the issues before them and to come to a correct decision with an appropriate degree of unhurried care. An unfortunate feature of the way in which some inquiries are

conducted in New South Wales before magistrates is that the proceeding is carried out in quarters which are too cramped, or intruded upon by bustle and clatter related to the normal course of activity in the hospital.

In the view of the writer, the argument of convenience in terms of having the judicial inquiry inside the hospital itself is very strong. But if the inquiry is to be held in the hospital, it surely must be held under conditions which are conducive to calm and considered reflection. It is not appropriate that an inquiry be held in a room the size of a broom cupboard, or (except in the most extraordinary circumstances) at the bedside of a patient in a busy ward. At the very least, the room should be a large one in which the magistrate is able actually to set himself apart from the other participants in the exercise, and there should be an appropriate waiting room or waiting area in which persons not directly concerned with the instant case might be able to wait without intruding upon the then current proceedings.

A related aspect is that the practice has developed in New South Wales hospitals of bringing patients before the magistrate in pyjamas. According to the Young report (Young, et. al., 1978, 18):

> "...during the pilot scheme at Rozelle Hospital approximately 60% of patients were presented to the magistrate in pyjamas instead of in their usual street

clothes. We believe that this practice reflects a presumption of mental illness that is contrary to the spirit of the Act."

Undoubtedly, if there were a requirement that the judicial inquiry be held outside the hospital, this kind of practice would be diminished. That is one good reason for having the court in an outside location. The problem could possibly be overcome by simply having a statutory rule or regulation that all patients brought before the magistrate or a tribunal under the statute should be brought wearing their normal street clothes rather than their pyjamas.

Possibly some kind of exception could be made for unusual cases, but the general rule ought to be that the patient should come wearing his ordinary clothes. No doubt the not too subtle inference to be drawn from the fact that the patient is wearing pyjamas is that he is an ill person who needs treatment. It is the mental health equivalent of the bringing a criminal defendant before a court wearing rough clothes with arrows on them to indicate that he is a prisoner.

Notwithstanding the problems of physical facilities and clothing, this writer reluntantly takes the view that it is on balance preferable to hold the inquiry inside the hospital rather than take the whole show, as it were, to an outside court. Nonetheless, this opinion is very much conditioned on the understanding that in a proper system the two problems to which reference has been made above would be overcome in some manner.

Notice to Relevant Parties

Under Section 12(8) of the New South Wales Mental Health Act, 1958, it is required that the Superintendent give due notice to the nearest known relative or a friend of such person, of his (the Superintendent's) intention to have such person brought before a Stipendiary Magistrate.

It is undoubtedly of absolutely crucial importance in mental health litigation that every possible effort be made to ensure that those friends or relatives of the patient who can assist him in any possible way should be available to do so. The importance of this cannot be over-stressed. If a person is isolated, his chances of being involuntarily admitted are much greater than if there is some friend or relative able to take an interest in the case.

The Edwards Committee recommended that a more positive requirement be placed upon the magistrate to ensure that all reasonable efforts have been made for any persons who might be interested in the involuntary admission of the patient to be contacted with regard to the matter. The Report proposed that it be not merely one lone relative or friend who should be contacted, but possibly a number. The proposed provision is in the following terms (Edwards Report, 1975, 31):

> "Before giving a direction or making an order under paragraph (b) of subsection (4) of section 12, the magistrate shall satisfy himself, firstly, that the superintendent has caused all reasonable efforts to be

made for there to be given to interested persons due notice of the superintendent's intention to have a person brought before a stipendiary magistrate under paragraph (a) of subsection (4) of Section 12; and secondly, that the person who is the subject of the proceedings has been informed, within due time, of the obligation that attempts to contact interested persons should be made.

"For the purposes of this provision, 'interested persons' means:

(i) The nearest relative of the person, if there be one, or relatives up to three in number if there be so many;

(ii) Any personal friend or friends of the person, up to two in number, who are either known as or said by the person to be his friends;

(iii) Any other persons in Australia up to two in number, whom the person says he wishes to be notified of his detention."

It will be seen that it may be necessary under this provision for the hospital authorities to attempt to contact up to seven people on behalf of the patient. Presumably this would be a sufficient number to ensure that if the person did genuinely have some relative or friend outside who might be interested in his case, there would be a good chance that he or she would hear of it. On the other hand, it would not reasonably be possible to require the hospital authorities to

contact any number, as nominated by the patient. One could well imagine certain kinds of patients virtually wanting the hospital authorities to go through the 'phone book contacting people who might attend at a hearing. It is suggested that the proposed provision adequately ensures that the patient is protected, and that the hospital is not subjected to undue administrative burden in this regard.

Prior Psychiatric History

Under the rules of evidence applicable in criminal cases, it is generally not possible to adduce in evidence against a person charged with a crime, facts relating to his previous criminal history. Any such material is not admissible merely in order to demonstrate that the accused is a person with a criminal disposition who would be likely to do such an act as that with which he is charged in the particular trial where the question arises. For example, a person is charged with armed robbery, and the prosecution puts in evidence his criminal record relating to arson, theft, burglary and assault. Now it may well be true that a jury at the later trial on the charge of armed robbery would be most interested to know that the defendant had a criminal record as suggested above. However, it is precisely because of this possible interest that such material is excluded. It is recognised that in the nature of human judgment, the later jury would be liable to be unduly influenced by the fact that the offender had a criminal record. The jury might be inclined to say "Well, he did all those other crimes, so he must have done this one."

There is of course, an exception to this general evidentiary principle, in that evidence can be brought of prior criminal acts if they come within the so-called "similar facts" rule. Evidence is inadmissible to show that past misconduct of a person demonstrates a disposition on his part towards wrongdoing, but if the evidence more specifically indicates that the person has a tendency towards a particular method or technique of wrong-doing, as opposed to a particular kind of wrong-doing, it may be admitted (R.v. Boardman [1975] A.C. 421).

The Legal Representation Committee (Young et al., 1978, 17) bluntly said that:

> "Hospital files containing details of previous admissions should not be placed before the magistrate".

It said that:

> "Under current administrative arrangements in Schedule 5 hospitals, the magistrate is handed the entire hospital file. This file contains full details of any previous admissions. Often the magistrate spends the major portion of the hearing reading the file, which may contain detailed information on numerous previous admissions, and very scanty information on the current admission.
>
> "The Committee believes that the magistrate should not have access to details of the patient's past behaviour, unless these can be demonstrated to be directly relevant

to the matter at hand. We also believe that a patient's chance of a fair hearing is prejudiced when a magistrate has a very thick file placed before him and spends his time reading accounts of the patient's past actions.

"We recommend that a suitable staff member in each hospital be delegated to prepare the information on each person due to appear before the magistrate. This information should consist of the relevant legal documents (schedule, medical report, notification of patients and relatives) and the current treatment file. The magistrate should not be given any file containing details of previous admissions. If, after making a determination that the person before him is a mentally ill person, the magistrate has reason to inquire about the person's past actions, he should direct his inquiries to the attending doctor who should answer verbally."

This writer is in strong agreement with the views of the Legal Representation Committee on this point. It is blatantly unfair that the entire psychiatric record of a patient be made available to the judicial officer for his consideration during the inquiry itself. No doubt in most cases, the bulk of the material contained in the report is correct, and in most cases the past record will be a very good guide to the magistrate. But of course there will be many cases where inaccurate or unfair material is contained in the file, and it is expecting a quite extraordinary and incredible mental compartmentalisation

on the part of a magistrate to require that he should be able to divorce his mind entirely from the material he reads in the file about the patient's past history. It is quite clearly an impossible task.

The medical view would no doubt be, on the contrary, that a patient's mental condition is very often cyclic in nature, and the regularity and pattern of past incidents of distrubance is a clear pointer to what is happening in a current case. There may be some validity in this approach, but it leads inevitably to a tendency on the part of the magistrate to judge the present performance of the patient by his present conduct. That is unsatisfactory. The rule ought to be that if the hospital seeks to have a person admitted involuntarily at a given point in time, it should collect evidence from whatever sources are available as to his condition and behaviour in the immediately preceding period - not as to his previous mental condition or any conduct that he may have engaged in in the far distant past.

The need to exclude material relating to past psychiatric history is made all the more compelling by virtue of the well-recognised fact that magistrates and judges are inclined, no doubt by virtue of their own relative ignorance of psychiatric matters, to defer somewhat excessively to psychiatric or medical opinion. A study by Hiday of judicial behaviour in mental health cases in North Carolina shows that following recent statutory changes and judicial decisions in that state,

there has been a significant reduction in the degree of deference shown to psychiatric opinion by judges. (Hiday, 1977.)

Hiday quotes one case in which a judge with unreconstructed attitudes towards psychiatrists refused to liberate a patient even though his counsel had fairly clearly demonstrated by cross-examination that there was no basis for the opinion expressed by the doctor that a patient should be detained. Hiday quotes a courtroom interchange to the following effect:

> "Counsel: How can he (the psychiatrist) say my client is dangerous? There is no evidence.
>
> Judge: They (psychiatrists) have ways of knowing - tests and tricks not known to us."

This rustic credulity is not entirely absent from hearings in which New South Wales magistrates participate. The basic problem is that magistrates in this state, as elsewhere, have little education about abnormal psychology and hence are inclined, no doubt due to fear of being considered foolish, to defer to psychiatric opinion. The significance of this in relation to the availability at hearings of the psychiatric history of a patient, is that such a history will contain a number of psychiatric reports, assessments and so on, the cumulative effect of which, upon a fairly brief reading, may be to submerge the magistrate's own willingness to make an independent judgment.

What then, of the so called "similar facts" exception in the general law of evidence? Are we to say that there should be a similar rule in relation to admission of previous psychiatric incidents? That is, that they should not be admissible merely to show that the person has in the past been mentally ill, but should be admissible to show that he has been subjected to a certain kind of mental illness of the same type to which he is currently subject?

The question which arises here is whether the purpose of the hearing should be to concentrate upon the external behavioural aspects of situation, or to concentrate on what is going on or has gone on inside the patient's head. In the view of this writer, both aspects are vital and cannot be ignored. A proper procedure is one which concentrates upon the patient's externally directed behaviour and mental condition at or just prior to the relevant time. If a person has been behaving in a bizarre manner, has threatened another, has behaved in a manner which represented a danger to himself, these things ought to be ascertainable by factual evidence which can be available to the inquiry. Equally, if there has been a display of symptoms of mental illness, such as paranoid statements, hallucinations or delusions, evidence about these things can be led as indicating present mental illness. (These symptoms may be indistinguishable, of course, from externally directed behaviour - e.g. loud paranoid accusations made against other people.) For a psychiatrist or for the judge or magistrate to rely on behaviour or

manifestations of mental illness substantially previous in time as a guide to whether or not the person is currently mentally ill is dangerous and unfair.

The answer of this writer, then, to the question of whether there should be a "similar fact" exception in mental health hearing procedure, is that there ought to be no such exception. The hearing ought to be conducted wholly and solely upon the basis of evidence as to immediately recent and present behaviour or mental state.

Admissibility of Hearsay Evidence

Medical reports as to necessity for involuntary detention often contain statements made by third parties about behaviour, recent or current, of the patient.

Much of the evidence which is put before magisterial inquiries under the current New South Wales system is based on hearsay material. Frequently a doctor's report will relate an incident or incidents which occurred involving a patient where the doctor is dependent for his information about it on statements made by third parties who may have been present at the scene. Such third parties will frequently not be present at the hearing and will not be available for cross-examination either by the patient himself or by anyone acting on his behalf. It is fairly obvious that there are dangers in such a procedure, because second hand or hearsay material frequently gets distorted in the telling from one person to another.

It is often suggested that one of the kinds of due process to which the patient ought to be entitled is to have hearsay evidence excluded from the commitment proceeding, as it mostly would be under the general civil or criminal law. No doubt if this rule were to be followed it would result in very considerable inconvenience for the hospital and the doctors. It would force the calling of many witnesses as to incidents and would very strongly tend to make the proceedings more legalistic than they currently are. It would virtually require that the hospital appoint somebody who performed the task of a formal prosecutor, in order that the evidence on behalf of the hospital should be presented in an adequate fashion.

In the view of this writer, it is unnecessary and would be inappropriate to introduce the full hearsay rule into mental health and commitment proceedings. Provided that the recommendation referred to above were put into effect (that is, that magistrates should not have before them the prior psychiatric record of the patient) it would be necessary for considerable evidence as to the need for the patient's own protection or as to the need for the protection of others, to be introduced. If it were in hearsay form, it could easily be argued by the patient or by his counsel that it was weak and not sufficiently probative to satisfy the requirements of the relevant statute. Thus although the doctor might refer to hearsay material in his report, it would be wise for him or the hospital to call any relevant eye-witnesses to give evidence so as to ensure that the patient would in fact be committed, if they saw that as the appropriate outcome.

In this regard, this writer would submit that it is most important that those appearing on behalf of the patient should have the opportunity to examine the doctors' reports prior to the hearing, and to be able to call any witnesses to the hearing who might be able to cast a doubt upon any factual matters referred to by the doctor or by any other relevant person making a report, or to contest a psychiatric diagnosis.

As Young et al. (1978) say (page 13):

> "Currently a patient has no right to be informed of the written evidence being placed before the magistrate to justify his/her committal. The Committee regards the right of the patient's representative to have access to such evidence as an essential pre-condition for an effective representation service."

It has been suggested elsewhere that one of the principle functions of the legal representative of the patient will be to enquire whether, as a factual matter, there are relatives or friends willing to care for and look after the patient as an alternative to involuntary admission, or whether there is some program in the community which might be more suitable for him than involuntary admission. A second function is to enquire into the factual basis of the allegation that the patient is mentally ill and dangerous to himself or to others. It is the second function which is relevant here. The lawyer or his representative ought to make the kind of positive enquiries about factual matters which are made in criminal

cases in order to ascertain whether or not there really is strong evidence against the defendant or patient.

Although those who insist on strict legalism in the enforced admission process and argue that it is no different at all from a criminal proceeding would insist on the rigid application of the hearsay rule in hearings, this writer takes the view that it is inappropriate to attempt to introduce all of the criminal law protections into the mental health hearing situation. On balance, therefore, taking into account the abovementioned proposal that the legal representative ought to positively have access to written evidence being placed before the magistrate prior to the hearing so as to be able to investigate any factual questions, it is submitted that it can reasonably be left to the discretion of the magistrate or tribunal to exclude any material which might be excessively distant from the true factual situation; or alternatively to accord to it so much less a probative weight than it could be accorded if a witness were brought along to testify to it directly.

Evidence on Oath

Although Young et al. (Young et al., 1978, 19) suggest it is not necessary for witnesses to be required to take the oath in a magisterial hearing, this writer submits that there is no good reason why, in order to emphasise the necessity for honesty and the seriousness of the proceeding, witnesses should not be required to take the oath. It is perhaps a minor point, but there is no reason why the magistrate should not himself

be able to administer the oath to witnesses, and it is this writer's view that the administration of the oath does appear to have some impact on people's willingness to tell lies.

It is suggested, however, that it would be inappropriate to require the patient himself, if he were to give evidence, to take the oath. It is precisely his mental condition which is in question. A decision to permit him to take the oath would pre-empt the very decision to be made. In many cases, of course, the patient would simply be incapable of taking the oath.

The Calling of Witnesses

It hardly needs saying that both the magistrate at the initial inquiry and the tribunal at a subsequent inquiry ought to be empowered to call witnesses. Equally both the hospital and the patient himself ought to be empowered to call witnesses, on enforceable process, before the relevant body. Mental health hearings are proceedings of great significance in terms of the patient's liberty and he ought to be entitled to produce evidence which he would have in another court. Perhaps most significantly, he ought to be entitled to call independent psychiatric evidence for the purpose of putting forward a different view about his mental condition from that which might be advanced on behalf of the hospital. These matters demand little debate.

Burden and Standard of Proof

Far more contentious is the question of who should be required to prove the various matters which are the basis for involuntary admission. Where a judge or magistrate undertakes what is regarded as an administrative inquiry, there is really no burden of proof at all. The judge or magistrate takes evidence or material from any source and utilises it as he sees fit for the purpose of coming to an appropriate conclusion.

Under Section 12(9) of the NSW Mental Health Act, 1958, the magistrate is required to be

> "satisfied after consideration of the recommendations by the medical practitioners as aforesaid and such other evidence as may be placed before him, that such person is a mentally ill person..."

What does it mean to say that the magistrate must be "satisfied"? This has never been the subject of any litigation in New South Wales. In practice it is interpreted as meaning that the magistrate is required to be satisfied on the balance of probabilities. That is, if the magistrate believes it is more likely than not that the person is mentally ill, he will direct that such person be detained. There is certainly nothing in the legislation to suggest that any higher standard of satisfaction is required than satisfaction on the balance of probabilities. Those who advocate the stringent application

of all of the criminal standards in the field of mental health hearings would no doubt urge that the test for involuntary admission to a mental hospital, like the test for criminal conviction, should be that the factual basis has been proven beyond reasonable doubt.

One possible variation of the present arrangement could be to require that the factual matters relevant to the involuntary admission should be proven beyond reasonable doubt but that the mental illness be proven on probabilities. There is some superficial attractiveness about this proposal because if it is to be proven, for example, that a particular person threatened another with a knife, that appears at first glance to be much the same sort of thing which has to be proven in a criminal charge for assault. One could argue by analogy, since in both the criminal process and the involuntary admission process, people are locked up and deprived of their liberty, there ought to be a similar standard of proof required. One could further argue that it would be impossible, however, to prove a person's mental condition beyond reasonable doubt, simply because mental states are internal and not amenable to eye witness evidence like externally directed behaviour such as threatening another person with a knife. One could urge in support of this view that it has traditionally been the view of the law, under the McNaghten Rules, that when a defence of insanity is raised in a criminal trial, the standard of proof is based on the balance of probabilities only.

However there are compelling reasons against any attempt to split the standard of proof as to the externally directed behaviour of the individual and his internal mental condition. The law has long recognised that the state of a person's mind is as much a fact as the state of a person's stomach. Nobody has photographed, filmed, taperecorded or otherwise reproduced or identified a person's mind. Despite millenia of philosophical disputation since the time of Aristotle about the so-called "mind-body" problem, the philosophical problem of the relationship between the body and the mind has not been solved. Whether or not there is a "ghost in the machine" remains a matter of speculation.

In any event, we are still forced to rely on factual evidence as indicating the state of what we see fit to describe verbally as a person's "mind". No doubt what a person thinks is internal, in the sense that it occurs inside his head. But we only know about it because he says something about it, or because his mouth droops at the corners, his shoulders sag and he looks depressed; or because he picks up a knife and shouts and screams; or because certain electrical impulses recorded on a graph or visual display unit indicate to us that electrical impulses within the head are normal or abnormal. Once it is accepted that the words a person utters, the lines that appear on a graph, or his facial appearance are themselves external factual matters, it becomes virtually impossible to distinguish between his "mental state" and "externally directed behaviour".

In the view of this writer, it would simply make for unnecessary legal complexity to attempt this impossible division and then to ascribe to one area a certain onus of proof and to another area a different standard of proof. By no means should the operation of the McNaghten rules in the area of criminal liability be taken as a good guide to what might be a desirable practice in the area of involuntary admission on the grounds of mental illness.

The next question is whether or not there ought to be specifically an onus of proof cast upon those who seek the involuntary admission. Surely the answer is that there ought to be such an onus and that it ought to be cast upon either the doctors or the hospital itself. As has been emphasised before at a number of points, in a practical sense, the doctors who sign the forms which are the basis of the proposed admission are acting as quasi-prosecutors, and there is an air of unreality in simply regarding them as disinterested observers. No doubt of course they believe that they are doing the right thing by the patient but, as far as he is concerned, they are attempting to deprive him of his liberty. It is unrealistic not to regard the proceedings as being a contest.

What, then, ought to be the standard of proof required? Is it sufficient that the test ought to be whether or not the magistrate is satisfied on the balance of probabilities? Or ought there be some higher standard, in particular, the criminal standard of proof "beyond reasonable doubt"?

The principal difficulty with a requirement of proof beyond reasonable doubt is that the state of a person's mind is a factual matter subject to only a limited range of types of proof. Whereas in the proof of other types of facts, there may well be a wide array of circumstances which can be led as evidence, what may be taken as proof of mental illness is somewhat confined. Proof of mental illness can only ever be inferential. Confession or admission which, in other areas of law, might be taken to be decisive, can hardly ever be taken to be decisive in the area of mental illness. If a man says "I am mad", that is hardly the same kind of evidence as a person saying "I stole the money", for example. In general, the proof of either sanity or insanity is a very difficult matter. In the general law, there is a presumption that every person is sane. If there were no such presumption, it would follow that in every criminal prosecution, the prosecutor would have to prove the sanity of the defendant. It is obvious that this would be a virtually impossible task. The proof of insanity is not quite so difficult, but it is nonetheless more difficult than proof of other kinds of facts commonly alleged in criminal trials. The major objection, then, to a requirement of proof beyond reasonable doubt, is that it would in most cases be very difficult to show.

The principal argument in favour of a requirement for proof beyond reasonable doubt is that, since the involuntary admission procedure has the affect of depriving the individual concerned of his liberty, no lesser standard that that

applicable in the criminal process ought to be acceptable. Reputation as well as liberty may be affected by an order for involuntary admission. Although the proof of mental illness may always be inferential and circumstantial only, in many cases the circumstantial evidence is so strong as to be overwhelming. For example, the patient with a manic psychosis who engages in hyperkinesis to an alarming and extraordinary degree could scarcely be mistaken, even by a lay person, for someone who is sane. Or a person who babbles constantly about illusions or hallucinations may, in particular circumstances, be regarded as proven beyond reasonable doubt to be mentally ill. Of course in such cases, it is always possible that the delusion might be, for example, fabricated for some unknown reason - but of course that would be extremely unlikely. It is always possible in a criminal case that a particular confession might be fabricated for some reason, but it will usually be regarded as constituting proof beyond reasonable doubt.

A third alternative might be to adopt some alternative standard of proof between that "beyond reasonable doubt" and proof on the "balance of probabilities": For example, the Americans have developed a standard described in terms of "clear and cogent evidence". If it were to be required that magistrates must be satisfied by "clear and cogent evidence", this would be a standard somewhere between the civil standard and the criminal standard in our current law. That might possibly be an alternative worth considering.

However, in general, this writer is not convinced that it will make any considerable difference which standard is adopted. By and large, the magistrate will come to a view about the matter regardless of whichever notional standard he is obliged to follow. Apparently, no empirical work has been done on this question, but that is a conclusion which this writer's experience would lead him to think likely. It could be said that a requirement of proof beyond reasonable doubt would be a better protection for the rights of the individual patient but it is probably not a matter of any great weight. The vigorous advocacy of patients' rights is in all probability a better protection for the patient than the mere formulation in abstract of particular standards or rights. Without effective enforcement, any legal formulation (for example, as to standards of proof) is mere verbiage.

Record of Proceedings

The existence of a record of legal proceedings is very important in matters of significance. The hearings under consideration are undoubtedly proceedings of considerable significance. It is, of course, rather expensive to engage full-time shorthand-typists for the purpose of taking records of proceedings. Nonetheless, without a record, the person's rights of appeal are inhibited. In these times when taperecorders are widely used and very inexpensive, it is virtually unarguable that the obtainment of a record is unduly expensive. In the overwhelming majority of cases it would

not even be necessary for the taped record to be typed up. Tapes could be held for a year or 18 months or some other appropriate period and then destroyed if that was thought appropriate. Certainly, if there is any question which may arise as to the correctness of anything said at the hearings, it should be available for any court which hears an appeal (for example, by way of prerogative writ or by way of statutory habeas corpus).

It could hardly be suggested that the presence of a taperecording device would inhibit the conduct of a mental health hearing, or would be likely to make it excessively legalistic. Such devices are not particularly intrusive. Making them available is simply a matter of administrative effort.

Reasons for Judgment

It is a fundamental tradition in our legal system, where any issue of the liberty of the citizen is involved, that persons should be told why a certain process of law is being operated against them. So arrestees must be told upon arrest the reason for the detention (Christie v. Leachinsky [1947] A.C. 573); and in civil as well as criminal cases upon judgment a litigant is given reasons as to why he must pay the money, or desist from making the noise, or go to gaol or whatever. This is a rule of fundamental fairness: citizens should generally be entitled to know why action under legal process is being taken against them.

In the light of this principle, it hardly needs to be argued that magistrates and Tribunals should in mental health hearings give reasons for their decisions. Any suggestion that deference to the sensitivities of a mentally disordered person about his condition should be permitted to override this rule ought, it is submitted, be dismissed. No doubt there will be cases where the individual involved is too disordered to comprehend the given reasons, but this ought not be assumed in any case. Proceedings should never be permitted to degenerate into a "rubber stamping", speedy, unexplained and understood only by the official participants.

There is another argument also, as to why reasons for judgment should always be spelt out. If an appeal be contemplated, the process of appeal is greatly hampered unless reasons are given for the decision. The person affected is entitled to know precisely what he is appealing against, so that he can frame his arguments with precision. This leads to the next matter.

Rights of Appeal

The notion that an individual's right to freedom might be determined by one unappealable judicial decision is antithetical to traditional Australian standards of law and justice. Involuntary admission to mental hospital (as has been emphasised in this thesis repeatedly) is clearly a matter of great significance to the individual concerned.

It is almost axiomatic that there should be a right of appeal. A magistrate or Tribunal may take an unfair view or be misled or mistaken. Errors in decision making are, of course, common in the judicial process, and the structure of the court system as an hierarchy of authority is designed in part to provide a systematic method for appeals.

Section 29B of the New South Wales Mental Health Act, 1958, requires that where a patient has been involuntarily detained for six months, he must be brought before a Mental Health Tribunal for determination of whether or not he should be detained for further observation and treatment. This is an automatic review procedure, rather than an appeal in the strict sense. The Mental Health Tribunal, as established under section 13, comprises a psychiatrist, another medical practitioner, and a solicitor or barrister.

The section 29B procedure is inadequate, albeit automatic. It is a "once-and-for-all" review, not a continuing option. In this sense it is the equivalent of an appeal, which can only be exercised once.

The most significant right of appeal and review is the "statutory habeas corpus" procedure which is embodied in section 18 of the Act:

> "Where the Court receives information upon oath, or a judge of the Court has reason or cause to suspect that any person who is not a mentally ill person is detained

in any admission centre, mental hospital or authorised hospital, the Court may order the superintendent of such admission centre, mental hospital or authorised hospital to bring such person before the Court for examination at a time to be specified in such order, and if upon the examination of such person, and of such superintendent, and of any medical or other witnesses, it appears to the Court that such person is not a mentally ill person, the Court may order that such person be immediately discharged from any admission centre, mental hospital or authorised hospital."

This procedure is a statutory derivative of the ancient writ of habeas corpus, the usage of which dates in English law from at least the thirteenth century, but which by the sixteenth century was established as a means for testing the legality of imprisonment. (Sharpe, 1976, 1, 9.) The habeas corpus procedure is universally recognised in the common law world as one of the foundation stones of constitutional liberty.

The section 18 procedure arguably does not derogate from the right of the Supreme Court of New South Wales (and the equivalent court in other states) to grant relief at common law by the traditional habeas corpus process to an applicant detained in a mental hospital. The decision in R. v. Governor of Pentonville Prison, ex parte Azam [1973] 2 W.L.R. 949 indicates that the availability of an alternate remedy is no ground for refusing habeas corpus. On the

other hand, Re Keogh (1889) 15 V.L.R. 395 suggests the contrary. Certainly in the field of criminal law the English and Australian courts take the view (in contrast to the American approach) that habeas corpus should not be used to review a conviction where a statutory right of appeal exists. (Ex parte Corke [1954] 2 All E.R. 440.)

Generally, the section 18 procedure is so similar to the traditional remedy that it is not terribly inaccurate to describe it as a "statutory habeas corpus". There would be little advantage, it is submitted, for an applicant to seek common law habeas corpus rather than a section 18 review, except possibly in regard to two matters: first, onus of proof; second, the certainty of an order being made.

As for onus of proof, section 18 clearly indicates that this rests with the applicant. No order for discharge will be made unless "...it appears to the Court that such person is not a mentally ill person..." (emphasis added.) Thus, in order to secure release, it is necessary for there to be proof before the Court sufficient to persuade it (no doubt on the balance of probabilities) that the applicant is not mentally ill. In a situation where the judge remained in doubt, he would not order discharge. Is the position under traditional common law habeas corpus different? Possibly not. In Greene v. Secretary of State for Home Affairs [1942] A.C. 284, the House of Lords held in a wartime internment case that the onus was on the detainee to adduce facts vitiating the

internment order. This decision was distinguished in R. v. Governor of Brixton Gaol Ex Parte Ahsan [1969] 2 Q.B. 222 where, in an immigration case, it was held that the legal burden of proof rested with the respondent called upon to justify the imprisonment. In principle, it is submitted, this latter approach ought to be regarded as correct, but according to Sharpe (Sharpe, 1976, 152)

> "...the courts have on occasion, taken a rather paternalistic attitude in these cases and refused to order the applicant's discharge unless it were also shown that he was not actually dangerous to himself or to others."

In short the courts have not clearly enunciated a rule that the detaining doctor or hospital has the onus of proof; hence there would be no certain advantage in this regard in using the traditional habeas corpus procedure as against using the section 18 procedure.

As for the certainty of an order being made, clearly section 18 is discretionary. If it appears to the court that the person is not mentally ill, "...the Court may order that such person be immediately discharged..." (emphasis added). While one might think that habeas corpus would not be discretionary - this has certainly been determined in certain cases such as R. v. Board of Control ex parte Rutty [1956] 2 B.Q. 109 - there are on the other hand cases which indicate that courts will exercise a

certain discretion as to release of the insane: Re Gregory (1900) 25 V.L.R. 539 and [1901] A.C. 128.

In the latter case the Victorian Supreme Court said (at pp. 541, 542):

> "Under ordinary circumstances, and on a return to an ordinary habeas corpus, all that would remain would be to order the discharge of the person detained. But here, clearly, that might be very unwise and imprudent."

In the event, the patient was remanded to the hospital for a determination of whether, despite the formal defect in the certificates originally made out by the doctors, he was nonetheless still "a dangerous lunatic." In ex parte Chidley (1916) 33, WN (NSW) 63, no examination was ordered, but in both cases the mere ascertainment of the technical illegality of the original detention, it was held, did not ensure release.

In general, it is submitted, there would be little certain advantage to an applicant in seeking to use the traditional kind of habeas corpus procedure as against what can be termed the "statutory habeas corpus" procedure in section 18.

Under the section, as under the common law, any number of applications can be made; and the statutory procedure has the possible advantage that there will certainly be an inquiry "as to the merits" (i.e. as to the question of mental illness) while historically the habeas corpus procedure has been directed particularly at formal rather than substantive

matters. It is clear from Re Gregory (cited above) that under the traditional procedure a medical examination may be ordered, but the precise circumstances when this will occur are not clear. That case does demonstrate, however, that a mere technicality will not lead to release by habeas corpus - nor will it under section 18. Indeed, the section does not advert at all to the circumstances of admission; merely to the question of whether, at the time of the application, the person appears to be mentally ill or not.

In general, the section provides a highly flexible and convenient method by which an aggrieved person may appeal against his detention. In the opinion of this writer, it is absolutely vital that any system of involuntary admission must permit the kind of procedure envisaged by section 18. However, it is equally vital that legal advice should be available to patients so that they may, in appropriate cases, take advantage of the section. It has been argued in the preceding chapter that there should be a system of legal advice available to all involuntarily detained patients. Without this, the statutory habeas corpus procedure is unlikely to be a genuine right of appeal.

# CHAPTER 12

## TREATMENT WITHOUT CONSENT

It is accepted that involuntary admission and detention can, under certain conditions, be justified. But what of involuntary treatment? Should the involuntarily detained mentally ill patient be compelled to submit to every or any kind of treatment which his doctors regard as appropriate for him? Or should he be entitled to say, with Macbeth,

"Throw physic to the dogs - I'll none of it."
(Act 5, Scene 3)?

According to Section 109A(2) of the NSW Mental Health Act (1958):

> "The superintendent of any admission centre, mental hospital or authorised hospital may authorise any member of the medical staff of such admission centre, mental hospital or authorised hospital to perform any surgical operation upon or apply any medical or therapeutic treatment to any patient, or, by writing under his hand, consent to any such operation being performed..."

As the Edwards Committee explained in its commentary on this section, it

> "...deals with the performance of operations such as appendectomies (etc) on patients who object. In some situations a very disturbed patient may refuse a necessary (indeed life-saving) operation on totally irrational grounds. (For example, that the surgeon who wishes to

take out an inflamed appendix is really a communist agent out to remove vital organs which will deprive the person of his manhood and thus prevent him from serving Queen and Country).

"Section 109A sensibly allows operations to be carried out where this kind of situation arises."
(Edwards Report, 1975, 94.)

Unfortunately, the Edwards Report glosses over the full extent to which this provision allows enforced treatment. The example of an urgent appendectomy is clear enough, but in fact the provision permits "...any medical or therapeutic treatment", whether urgent, life-saving or not.

The result is that when a person is an involuntary patient in NSW, he is at the complete disposition of those who might seek to impose medical treatment on him. No doubt the power in section 109A is usually exercised competently for the patient's benefit. But in any medical system, negligence, incompetence and thoughtlessness can occur. Certainly in a publicly funded system, subject to stringent financial limitations, this is always a risk. (See McClemens, 1961.)

It is submitted that it is wrong in principle that there should be medical "carte blanche" in relation to the imposition of treatments on involuntarily detained patients.

Anglo-American and Australian common law has long placed great importance on the entitlement of the individual person to choose whether or not to have medical treatment. In the

words of Justice Cardozo, a celebrated American jurist,

> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained." (Schloendorff v. Society of N.Y. Hospital (1914) 105 N.E. 92, 93)

Despite a dearth of authoritative case law on this subject in England and Australia, no doubt the words of Justice Cardozo represent the general law in NSW at the present time. But as we have seen from the words of section 109A, this great traditional principle of personal self-determination is completely overriden in the case of involuntarily detained mental patients. The question is, is it really necessary that the abrogation of the general principle should be so complete? The answer, it is submitted, should be in the negative.

The subject of enforced treatment is highly complex and requires analysis of a variety of factual situations. In the words of P.D. Skegg, the leading contemporary authority on the law of consent (Skegg, 1974, 515):

> "The situations which arise in practice are so diverse, and therefore involve such different policy considerations, that it is difficult to deal satisfactorily with them together."

In fact no single rule can properly govern the variety of problems which arise in relation to treatment of the involuntarily detained mentally ill. It is submitted that legislation should provide six distinct basic rules:

1. Where "basic nursing care and control" is involved, it should be possible - with some qualifications - for the absence of the patient's consent to be overridden.

2. In cases of immediate necessity to prevent death or permanent major injury to a patient's health, absence of consent might be overriden.

3. In the case of surgery and all other treatments (save electroshock treatment and psychosurgery) the rule ought to be that:

   (a) if a patient is capable of consenting and does consent to the proposed surgery or treatment, it may be performed without further formality;

   (b) if a patient is incapable of consenting to or does not consent to the proposed surgery or treatment, it may not be performed unless there is an application to a Mental Health Review Tribunal and agreement by that body.

4. Similarly, in the case of the administration of psychoactive drugs (in particular, tranquillizers and anti-depressants) the rule ought to be that:

(a) if a patient is capable of consenting and does consent to the proposed administration of the drug or course of drugs, these may be given without further formality;

(b) if a patient is incapable of consenting to or does not consent to the proposed drug or drugs, they may not be administered unless there is an application to a Mental Health Review Tribunal and agreement by that body.

5. Electroshock therapy should not under any circumstances be imposed upon a patient who cannot or does not consent to it. It ought to be available to any patient - involuntary or otherwise - who can and does consent to it. (This is a particularly controversial subject and is dealt with in detail in chapter 13 hereunder.)

6. Psychosurgery should not under any circumstances be imposed on any patient who cannot or does not consent to it. It ought to be available to any patient - involuntary or voluntary - who can and does consent to it, but only if the proposed operation is approved by a Psychosurgery Review Board. (This is another particularly controversial subject and is dealt with in detail in chapter 14. hereunder.)

A General Principle

It is not argued here that involuntarily detained mental patients should never have medical treatments imposed on them. That would be a foolishly extreme suggestion. It is important to avoid saying, on the one hand, that involuntarily detained patients should lose all their human rights by virtue of their detention and might be forced to undergo whatever treatment hospital doctors and nursing staff believe ought, for their own good, be imposed on them; or, on the other hand, that it is possible to cope with all involuntarily detained patients at the level of face to face, day to day nursing care, without the application on some occasions of at least a reasonable minimum of force and compulsion. Both of these views are dangerously fallacious. The former derogates excessively from traditional legal protections; the second is so grossly unrealistic that it would put psychiatric nursing staff in a position which would be intolerable (and which, from a practical industrial viewpoint, probably would not be tolerated).

However, of these two broadly competing views, it is submitted that both law and medical practice should lean wherever possible towards maximum individual self-determination and away from coercion in treatment. This is a general bias in accord with long held and important traditions in both law and medicine.

A Rule for Emergencies

Clearly the example given by the Edwards Committee of a patient who refuses an urgently needed appendectomy on irrational grounds is one where enforced treatment would be justifiable. The central problem is to define what constitutes an "emergency". Is an emergency only a situation where there is a pressing and immediate necessity to save the patient's life? Or is it sufficient if the "necessity" is merely necessity to prevent injury to the patient's health? And if the emergency can be constituted by a threat to health rather than to life, how pressing must the threat be?

In a Canadian case of Murray v. McMurchy (1949) 2 D.L.R. 442, a surgeon found, in the course of the performance of a Caesarian section, certain fibroid tumours in the uterus wall. Foreseeing risks from a future pregnancy, he tied off the fallopian tubes, thus sterilizing the woman. Being unconscious, she had not consented to this treatment. The question was whether the sterilization procedure was justifiable on the ground of immediate risk. The woman succeeded in her action and obtained damages. McFarlane J. said:

> "There is, however, no evidence that these tumours present at the time of the operation were dangerous to her life or health. The evidence is only that they might constitute a hazard in the event of a future pregnancy."

If this decision represents current Australian law, it suggests that an "emergency" situation justifying treatment without consent requires a pressing and immediate threat to

life or health which cannot reasonably be put off. It seems most unlikely that an Australian court would for the purposes of the general law say that consent could be overridden merely for the sake of convenience.

If the Murray v. McMurchy approach represents the law in Australia as for private citizens or voluntary patients (and it probably does) the question is then whether, as a matter of policy, this could or should be applied in relation to involuntarily detained mentally ill persons.

A major complicating consideration is the problem of a duty of care which the law imposes on persons who undertake or are assigned the custody or guardianship of others. For example, criminal liability for manslaughter may arise where a person undertakes to care for an elderly or sick relative, but negligently permits him or her to starve to death (R. v. Instan, [1893] 1 Q.B. 450). If the elderly person refuses to eat, it would seem that there is probably no power to force-feed, or compel the taking of medicine, but there is a duty to at least make an effort to contact social service or medical authorities. Failure to make any such effort may constitute a breach of duty resulting in liability for manslaughter. (This occurred in the case of R. v. Stone [1977] QB 354). So far as small children are concerned, parents undoubtedly have a duty to impose control or medical treatment for the benefit of the child's health. In the discharge of this duty, the parents may and indeed should - where it is called for - act over the child's unreasonable objections.

What is the appropriate duty of care where a person is detained? First, it would seem that there is a duty to ensure that the detainee does not deliberately kill himself or herself. Action to prevent this is not only lawful but required. Where a suicidal patient is detained, it certainly would be tortious - possibly criminal - negligence to leave within his reach a large bottle of potent sleeping pills, or a gun, or to place him near an open tenth-storey window.

What is the precise degree of care required under common law to be taken by a person detaining another as a precaution against the detainee's self-injury? There is little clear law. The extraordinary case of Leigh v. Gladstone (1909) 26 T.L.R. 139 gives some clue. There, Mrs Leigh, a feminist or "suffragette", was sentenced to four months imprisonment for her political activities. She went on a hunger strike in prison. After a while she of course began to lose weight and health. No doubt fearing a political uproar if the woman were allowed to die in prison, the authorities forcibly fed her, no doubt a painful and undignified process.

She subsequently sued for damages for assault. She lost, the jury being instructed by the judge that it was the duty of the prison officials "...to preserve the health and lives of the prisoners who were in the custody of the Crown."

Correspondingly it might be said that at common law there is a duty on the authorities in charge of a mental hospital "...to preserve the health and lives of the patients..." in

their custody and control. But does such a formulation give the hospital authorities "carte blanche" to enforce any and every treatment? Possibly not. Leigh v. Gladstone was a case where it was clear that if the behaviour was persisted in, death would have resulted (although not immediately). But the Leigh v. Gladstone formulation is very vague. What is the "health" which is sought to be preserved? Must the threat to health be imminent? Must it be serious? Presumably Mrs Leigh could not have been compelled under the "preservation of health" formulation to have a tooth out if she objected, or been compelled to have her hair cut.

No doubt it was in part uncertainty about the scope of the common law duty "to preserve life or health" which prompted the enactment of section 109A(2) in such broad terms.

It is submitted that it would be preferable to narrow the scope of section 109A(2) significantly by substituting for it provisions making it clear that the scope of the "emergency" principle is that hospital authorities have no duty or right to compel treatment of involuntary patients except in cases of immediate necessity to prevent death or permanent major injury to health. A formulation in the above terms would on the one hand permit operations and treatments genuinely necessary to meet an immediate serious emergency, but at the same time give appropriate recognition to the important principle of maximum self-determination in health care.

Obviously this approach would make it necessary for medical staff to make sometimes difficult judgments about what constitutes an emergency. This is a problem which can be avoided by retaining a section 109A type power in all its glorious breadth. Sometimes, however, elegant simplicity can only be achieved at the cost of principle. This is one area where, unfortunately, proper policy inevitably demands some complexity in the law.

Basic Nursing Care

A second exception to a general bias against the imposition of treatments on the involuntarily detained mentally ill ought to operate in relation to "basic nursing care".

It would be practically impossible to give such effect to the principle of individual self-determination in medical treatment that no non-consensual touching could lawfully occur in relation to the detained mentally ill. A hospital system operating under this bold principle would quickly disintegrate (Home Office, 1978, 74). Manifestly it must be possible for nursing staff forcibly to escort to the lavatory the demented patient with a penchant for defecating in the corridor. The well-known category of patient who enjoys breaking things must be subjected to some physical control. Examples could be multiplied of the minor quotidian problems of dealing with the detained mentally ill in an institution.

What may constitute "basic nursing care" for the purposes of the exception? Where should the line be drawn between "basic nursing care" and more serious interventions? It is submitted that a convenient cut-off point would be whenever (in non-emergency situations) there was involved:

(1) surgery of any kind;

(2) the administration of any psychoactive drug or course of drugs;

(3) the application of electrical or similar force for therapeutic purposes.

In addition to drawing a line between "basic nursing care" and the more serious procedures referred to above, it is necessary to indicate certain supplementary administrative principles and policies. It is suggested that the following guidelines for staff might be appropriate:

1. Basic physical control of patients should always be carried out with consent where possible. Every effort should be made to ask the patient whether he will move there or here, or do this or that. This should be the first and fundamental rule.

2. Nursing staff should always consult with a senior nurse or medical officer in the case of a patient refusing any nursing care.

3. Any refusal by a patient to co-operate with or accept any nursing care or administrative direction should be respected and tolerated unless it would seriously interfere with the running of the hospital or contribute to a deterioration in his or her physical or mental condition. For example (as mentioned above), if a patient decides that he should defecate in the corridor or his bed rather than in the lavatory, he might be taken there forcibly.

It is obvious that these "guidelines" involve some difficulties and complications. In fact this is an area where legal formulae matter little and the standard of humanity and concern on the part of the nursing and medical staff is the crucial factor. Failing a decent standard of medical care, the expression of such principles is so much hot air. If medical and nursing care <u>are</u> adequate - decent, humane and efficient - these "principles" will be applied anyway. It is not possible to legislate away the problems of mental hospitals. The law can only go a limited distance in ensuring proper treatment.

Certainly, it is submitted, the statute ought to provide that surgical procedures, the administration of drugs and ECT cannot be regarded as "basic nursing care". But whether the three "guidelines" stated above need to be set out in legislation is arguable. On the one hand, to do so may lead to a greater appreciation of the need for humanitarian concern;

but on the other hand they must necessarily be stated in such broad terms that their letter might be met by nursing behaviour not at all in accordance with their spirit. Perhaps their statutory or regulatory enunciation would provide at least a broad guide for staff and patients and might for that reason be desirable. However, it cannot be too strongly stressed that any guidelines will be meaningless in the absence of decent, humane and efficient nursing care. This can only be guaranteed by medical administration.

Surgery and Other Treatments

It has been suggested that an apt rule for surgery and other treatments more serious than "basic nursing care" would be that if a patient can and does properly consent, the surgery or treatment may be performed without further formality - but that if the patient cannot or does not consent, there must be approval by a Mental Health Review Tribunal before it may be performed.

The practical difficulties of enforced surgical treatment are illustrated by the facts of a case in which this writer appeared as counsel in a hearing under Section 12 of the NSW Mental Health Act, 1958, before a Stipendiary Magistrate in July 1979. A 75 year old woman was admitted for involuntary detention at a Sydney psychiatric hospital. Doctors wished to perform a minor operation to remove a mole from the woman's chin. It was suspected that the mole might possibly lead to malignancy, but in any event it was regarded as desirable -

although not immediately vital - to remove it. The patient was not completely senile, but her mind wandered a lot and it was difficult to communicate with her. The problem of communication was exacerbated by the fact that she was a New York German Jew and her native language was Yiddish. She did not consent to the surgical operation - indeed she objected to it, so far as could be gathered. Her 45 year old son, who visited her from time to time, learned that the operation was proposed. He did not trust the skill of the hospital doctors and, in any event, did not believe that the operation was necessary. He sought from the magistrate an order that his mother be released into the care and custody of him and his wife.

The hospital did not oppose this order, but it turned out that by the date of the hearing, the operation had in any event already been (successfully) performed.

The operation was clearly lawful under Section 109A. Apart from the literal terms of that section, in the view of this writer the circumstances could not reasonably have been characterised as involving an immediate threat of very serious injury to health. Had the mole been indicative of malignancy, cancerous growth could have occurred, leading to death, but this was not imminent and could scarcely have been regarded as an emergency.

It is submitted that this is an excellent example of the cavalier approach to consent engendered by the broad terms of

the all-permissive section 109A. Nothing would have been lost and much gained in terms of confidence in the system, if it had been necessary for the doctor to go before a tribunal and say something to this effect:

> "This is an old lady who really doesn't know who or where she is. She doesn't want to have the operation but she needs it because in 30% of such cases a malignant tumour results. Although it is not an immediate necessity, it should be done in her own interests. It is not merely something experimental. It is not dangerous. The operation will be performed by my colleague, Dr Slicer, who is a specialist surgeon."

A requirement of some procedure such as this is no great imposition on the administration of mental hospitals. It would not really matter whether the application were to be made to a tribunal, or magistrate or a judge, so long as some independent person or persons with a concern for the important legal consideration of enforcement looked at the proposed surgery or treatment and considered it appropriate in the circumstances.

A significant aspect of the case of the 75 year old woman referred to above is that at no stage was the 45 year old son - the next of kin - consulted or even notified. He found out about the proposed operation only fortuitously after she was removed from a nursing home to the mental hospital. He was unable to prevent or even delay the operation.

Surely, of course, he ought not to have been entitled to prevent or delay an operation or treatment in the nature of a genuine emergency. But in the case of non-emergency surgery such as this, he ought really have been entitled to proper notice. It may have been, for example, that he knew of some aspect of her medical history which bore upon her tolerance of anaesthetic, or her blood grouping, or whatever. He may have thought - indeed, known - that the doctor was incompetent to perform the operation. In this particular case, any worries on his part probably were misguided - but how was he to know? He ought to have had an opportunity to express his concerns, however misguided. If there is to be a power vested in the hospital or medical practitioners to treat without consent, that power should never be exercised arbitrarily and without concern for the feelings of relevant persons affected.

It is submitted, therefore, that where a patient cannot or does not consent to non-emergency, non-"basic nursing care" treatment (that is, serious treatment or therapy) and the doctor believes the surgery or treatment is desirable and seeks a tribunal's approval for it, proper efforts should be made to contact the next-of-kin and other relatives. These persons should be given an opportunity to present a point of view to the tribunal. The patient himself, of course, should have this entitlement and an opportunity to be represented by an advocate on his behalf.

When a question arises before a tribunal as to whether an involuntarily detained patient ought to be subjected to a certain treatment notwithstanding the absence of consent, by what criteria should the issue be determined?

The first principle ought always be that if the patient himself or herself expresses a positive objection to the treatment, that objection ought not to be overridden without clear and compelling need to protect the patient's health. If the patient expresses no objections, but merely cannot consent - for example, a patient who is both mentally defective and mentally ill, or senile - the question ought to be simply whether the operation or treatment is clearly needed and in the best interest of the patient.

Care should be taken by the tribunal to listen to any view put forward by relatives. If objection be made to the particular operation or procedure or to the competence of a particular doctor, that should be taken into account - and if no objection be made, that also should be given some weight.

Proposals for reform of the English law (Home Office, 1978, 73) single out "hazardous, irreversible" and "not fully established" treatments for particular concern where consent is in issue, following the Butler Report (Butler, 1975).

Obviously enough, irreversible operations (such as sterilization) ought only very rarely be imposed, as shown in the sensible decision of Heilbron J in Re D [1976] 1 All E.R. 326. As for "hazardous" and "not fully established" treatments, there should be a clear and compelling medical need. Detained patients ought not be used like white rats.

The Special Problem of Drugs

Since approximately the early 1950s, the reliance of mental hospital staff on the modern tranquillizing drugs and anti-depressants for the care and control of patients has been very extensive. A question arises as to whether their use is so routine as to amount to "basic nursing care". Great use is made of major tranquillizers such as chlorpromazine; minor tranquillizers such as meprobamate; and anti-depressants such as imipramine and the monoamineoxidase inhibitors.

There are a number of reasons why the use of such psychoactive drugs in psychiatry should not be regarded as merely "basic nursing care", even though it will commonly be the case that nursing staff administer them.

1. The side-effects of the major tranquillizers and anti-depressants can be very severe indeed. Feelings of nausea, trembling, sweating, sick feelings, outbreaks of skin irritation, problems in vision and movement, etc, can cause in themselves severe discomfort, physical and emotional, to persons under medication, quite independently of the illness itself.

2. Drug treatment should not be regarded, according to the best understanding of its usages, as a complete means to cure in itself. As Claridge says in relation to schizophrenia (Claridge, 1970, 216-7):

"The contribution to treatment made by a drug's chemical action is also much more decisive (than in relation to neurosis), though it is doubtful whether drugs given by themselves would materially alter the outcome of schizophrenia. In fact, treatment of the condition with tranquillizers is largely ineffective unless they are used in conjunction with an active program of social and industrial rehabilitation. It is a combination of both forms of treatment, rather than either alone, that seems to work best." (Emphasis added.)

This is a widely accepted view.

3. The causes of the major mental illnesses are not clearly understood, and accordingly the use of drugs in their treatment is empirical. It cannot always be clearly predicted which patients will or will not be assisted by a particular drug.

4. The effects of the administration of strong tranquillizing or anti-depressant drugs over a long period may be such as to induce unwanted and unpredicted personality change in the patient.

5. If it is possible to administer drugs without consent to involuntarily detained patients, frequently the pressure of work and inadequacies of staffing will lead to reliance on the use of the drug by staff as the sole (or at least predominant) mode of treatment, to the exclusion of environmental therapies.

Against these arguments it must be conceded that, as Claridge says, (Claridge, 1970, 214-5):

> "The most loudly applauded contribution of drugs to psychiatric care, however, is in the treatment of schizophrenia and the beginning of the 'modern drug era' in psychiatry is usually dated from the introduction of chlorpromazine. There is no doubt that this major tranquillizer and its derivatives have helped to bring under control crippling psychotic symptoms that would otherwise require intensive hospital custody. Now the schizophrenic patient stays a shorter time in hospital and is protected to some extent from the additional handicap of institutional neurosis, the insidious canker of social and emotional deterioration that follows prolonged hospitalization."

Whether, in view of the competing considerations mentioned above, the administration of psychoactive drugs to involuntarily detained patients who do not consent - particularly to those who actually object - ought to be permitted, proscribed or controlled, is an extremely difficult question. On the one hand, the abovementioned five caveats concerning the use of the major psychoactive therapeutic drugs in psychiatry clearly indicate serious possible dangers. On the other hand, as Claridge says, effective drug use may permit the avoidance of the "insidious canker" of institutionalization, the evil of which cannot be doubted (Goffman, 1968).

It is submitted, after considerable thought, that drug treatment in modern psychiatry is such a special case that involuntarily detained patients might properly be subject to the administration of appropriate psychoactive drugs, but not without severe limitations. Such limitations ought to relate to the duration of administration, the mode of decision to administer, and a procedure for recording and monitoring the decision and the administration of the drug.

It is submitted that the imposition of psychoactive drugs upon the involuntarily detained mentally ill should only occur after an application has been made by the appropriate medical officer to the Mental Health Review Committee indicating:

(a) the need for the treatment;

(b) previous drug treatment of the patient;

(c) the general program of treatment of which the proposed drug therapy is part;

(d) the proposed duration of the drug course;

(e) what steps will be taken to monitor the treatment; and

(f) possible side effects.

There should be a hearing on this application at which the patient may be represented by whomever he nominates, including a lawyer. Of course the patient should be given an opportunity to indicate his opposition and to call evidence, particularly medical evidence.

It would then be a matter for the tribunal to determine whether or not the proposed treatment should be allowed. No doubt the idea of such a hearing will be regarded by some medical practitioners as an unjustifiable intrusion into their traditional prerogatives. The answer to such objections is that traditional medical ethics do not allow compulsion in treatment. When, exceptionally, legal compulsion enters into the picture, it should correspondingly be subject to appropriate legal control.

It is submitted that the procedure as indicated above is an appropriate control. On the one hand the 'modern drug era' in psychiatry has undoubtedly been a tremendous boon to the mentally tortured; on the other hand the objections of those who find the drugs threatening or disturbing cannot humanely be ignored. The procedure of applying to an independent tribunal will serve to prevent the prescription of excessively large dosages, the administration of strong psychoactive drugs for an inappropriately long period, and to bring to light for consideration any painful side effects (such as blurred vision, nausea, etc) which frequently occur.

In respect of whom ought this restriction apply? There are three possibilities:

(a) all involuntary patients whom it is sought to treat with strong psychoactive drugs, regardless of consent;

(b) all those (as above) who do not give full and informed consent;

(c) all those (as above) who actually make a positive objection to the administration or continued administration of the drug.

The principal objection to (a) is that there may indeed be many involuntarily detained patients who do freely consent to the administration of the drug or course of drugs - indeed, many welcome it as a means of release from misery. These persons - provided they can and do give a proper consent - ought to be treated as capable individuals able to make proper decisions.

The principal objection to position (b) is that it may often be extremely difficult to distinguish between those who can and those who cannot give proper consent.

The principal objection to position (c) is that some who do not make an actual objection might simply be not capable of doing so. In the mental hospital situation, silence cannot reasonably be taken as assent - it may simply be intense depression.

On balance, it is submitted that position (b) is the one which best represents a workable policy and which is most consistent with desirable principle. The doctor will not feel compelled to make an application in respect of a person who clearly agrees to the use of the drug, but in the case of the positive objection, or silence, or a "consent" which is apparently not based on a clear understanding of why the medicine is being taken, the matter will have to go before the tribunal for determination.

# CHAPTER 13

## ELECTROCONVULSIVE THERAPY

Electroconvulsive therapy has been enthusiastically used by the psychiatric profession over the last few decades, especially in the treatment of depression. The treatment is described in the following extracts from a widely used text (Noyes and Kolb, 1967, 538, 539):

> "The apparatus operates on 110 volt, 60 cycle, alternating current and contains mainly a variable transformer, ohm, volt and ampere meters, and an automatic timer. The combined voltage and time settings constitute "the dose". Applications may range from 70 to 130 volts continuing from 0.1 to 0.5 seconds...
>
> "...Only generalized seizures are productive of desired results.
>
> "...The patient becomes unconscious immediately after the current is applied, even if no seizure follows. He will have no memory of a "shock". The convulsion conforms closely to those of spontaneous origin...
>
> "...Compression fractures of the spine are occasional complications...
>
> "...The patient is placed in a comfortable dorsal position, or the spine may be slightly flexed. The shoulders and arms are held lightly by a nurse to prevent extreme movements of the latter. Usually a restraint sheet is sufficient for the thighs, but if they are held,

the control should not be too rigid lest fractures of an acetabulum or of a femur result. A padded tongue depressor or other resilient mouth gag is placed between the teeth to prevent biting the tongue or other injury...

"...Electrode paste is rubbed into the skin on both sides of the forehead, and the electrodes, previously soaked in saturated salt solution, are applied to the prepared areas. The apparatus button is pressed and the patient becomes instantly unconscious.

"...It is well to roll the patient on his side to prevent inhalation of saliva. The patient remains unconsious for about five minutes, then slowly rouses during the next five to ten minutes...

"...Treatments are usually given three times a week...In depressive reactions, the patient may have received the maximum benefit after five to ten treatments. In disorders in which the patient is slowly but definitely improving, treatment may continue to 25 or 30 applications followed, if desirable, by maintenance treatments."

In the decade since Noyes and Kolb wrote this, it is fair to say that the psychiatric profession in general has become considerably less sanguine about the acceptability of delivering 100 volts of electricity with such regularity into the heads of depressed or otherwise disturbed patients. This change of attitude has come about largely as a result of increasing recognition of the seriousness of the adverse side-effects of ECT.

In 1967 Noyes and Kolb wrote (Noyes and Kolb, 1967, 540):

> "Scarcely to be called a complication is the almost constant impairment of memory that accompanies electro-convulsive therapy...It is often distressing to the patient and may continue to some degree for several weeks or a few months following the termination of treatment. Full return of memory finally occurs." (Emphasis added)

The bland statement that "full return of memory finally occurs" is very misleading. It could only have been asserted in 1967 on the basis of a highly selective view of the evidence. Over a decade later it is plainly wrong. In fact, whatever beneficial effects it may have, ECT causes in some cases serious and long lasting impairment of memory.

The main antagonist of the use of ECT as therapy is Friedberg, an American neurologist whose somewhat dramatic book "Shock Treatment is Not Good for Your Brain" (Friedberg, 1976) has been followed by more concise statements of his views in the "respectable" journals. Friedberg's view, succinctly put, (Friedberg, 1977, 1012) is that:

> "From a neurological point of view ECT produces a form of brain disease, with an estimated incidence of new cases in the range of 100,000 cases per year... Many psychiatrists are unaware that ECT causes brain damage and memory loss because numerous authorities and a leading psychiatric textbook...deny these facts. Others, who know

of its effects, argue that the interruption of unpleasant states of mind is worth the damage."

Friedberg refers to autopsies carried out following the deaths of patients during or shortly after ECT. He mentions studies reported in 1942, 1943, 1948, 1953, 1957, 1959 and 1963, some involving multiple subjects. He says (Friedberg, 1977, 1011):

"As in lower animals, bleeding is the most frequent non-specific tissue response to injury and the one seen most often after electric shock."

He refers to petechial hemorrhages, cellular changes, subarachnoid hemorrhage and degeneration of neurones as being variously mentioned in these reports. He concludes that:

"The damaging effects of ECT on the brain are thoroughly documented. All told, there have been 21 reports of neuropathology in humans...It is interesting that, despite the importance of a negative finding, there has not been a single detailed report of a normal human brain after shock." (Id.)

As for memory loss (which Noyes and Kolb described as being nil after the passage of time) Friedberg says:

"ECT is a common cause of severe retrograde amnesia, i.e., destruction of memories of events prior to any injury. The potency of ECT as an amnestic exceeds that of severe head injury with coma...

"...After ECT it takes 5 to 10 minutes just to remember who you are, where you are, and what day it is. In the first weeks after a full course, retrograde and, to a lesser extent, anterograde amnesia are evident to the casual observer. But as time passes, compensation occurs. As in other forms of brain injury, the subject is often oblivious to the residual deficit." (Id.)

Most of those psychiatrists who advocate and use ECT on their patients admit that they do not understand how it works - just that it does work, in their view, to lift depression more speedily than remission would otherwise occur. For example, Noyes and Kolb say (Noyes and Kolb, 1967, 542):

"The use of electroconvulsive shock is entirely empirical. Many theories, both psychogenic and physiogenic, have been suggested as explanations for its therapeutic action..."

Friedberg goes so far as to suggest that ECT should not be offered even for voluntary patients, since its supposed effect in lifting depression is not proven. But many psychiatrists take the view that, provided:

(1) care is taken to avoid spinal fracture by the use of an appropriate muscle relaxant;

(2) it is administered only four or five times rather than the 25 to 30 times recommended by (e.g.) Noyes and Kolb; and

(3) it is administered not bilaterally but unilaterally to the right hand side of the brain;

then it is still a proper and useful therapy.

As to the first point, it is clear that the use of curare or other appropriate muscle relaxant does in fact substantially negate the risk of spinal fracture reported in the earlier literature on ECT.

As to the second point, there is some evidence, and widespread belief, that the fewer treatments are just as efficacious, and less damaging, than the longer program. (Kiloh, 1977.) ("Just as efficacious" might mean, of course, not efficacious at all - as Friedberg would suggest.) One might be permitted to wonder whether the retreat from massive dosages of ECT to minor dosages is simply a reluctant concession in the face of public and professional pressure. Is not the proper logic: "If 5 treatments are better than 30, would not no treatment at all be better than 5?"

On the contrary, it is argued that there is a minimum dosage, previously exceeded unnecessarily, which is the least dosage required to trigger improvement.

It is not necessary, for present purposes, to come to any conclusion about whether ECT is a treatment which ought never be used at all. There is a widely held view among psychiatrists that, properly used, right unilateral ECT administered over a short course of treatments to suicidally depressed people saves lives that would otherwise be lost. Kiloh says (Kiloh, 1977, 11):

"The position now seems clear. To produce a therapeutic effect a full convulsion must be induced but to minimize the postconvulsive confusion and memory disturbance it is necessary to use the minimal quantity of electricity and to apply it to positions on the scalp which do the least harm. Pulsed current given unilaterally over the non-dominant hemisphere - as Goldman suggested - is now the technique of choice. It might now be considered unethical to use the older techniques."

On the other hand:

(1) There is evidence that ECT causes brain damage and in particular, memory loss (Friedberg, cited above; Templer, Ruff and Armstrong, 1973; Squire, 1977).

(2) One of the supposed advantages of unilateral ECT over bilateral is that unilateral results in significantly less memory loss than bilateral. (Squire, 1977). However, this result appears where the memory tests are <u>verbal</u> in nature. Verbal capacity is controlled by the left side of the brain. ECT administered unilaterally to the right side causes <u>visual and spatial</u> loss of memory, which is not so readily disclosed to test as loss of verbal memory (Cohen et al, 1968). Berent, Cohen and Silverman have demonstrated, in a neat and tightly controlled study, that a single right unilateral ECT

results in a significant impairment of spatial memory (form) and little impairment of verbal memory (words) while left unilateral ECT produces exactly the opposite result (Berent, et al., 1975.)

(3) Various other adverse effects of ECT have been reported: fatal heart block and cardiac arrest (Arneson and Butler, 1961; Malik, 1972); irreversible brain damage resulting in death (McKeaney and Panzetta, 1963); neuropsychiatric relapse following acute carbon monoxide poisoning (Smith and Mellick, 1975); significant rise in blood pressure (Medlicott, 1948).

Evidence of Advocates

In case it be thought that the above analysis is unreliable as being the result of research by an ignorant lawyer trespassing upon medical territory, let us turn to the words of an expert psychiatric authority which advocates the use of electroconvulsive therapy. It is an axiom of dialectics that the most effective way of undermining an opposition case is to turn the arguments of one's opponent against him, so that he is defeated - or at least rendered suspect - by his own words.

In 1977 a special committee of the Royal College of Psychiatrists reported on the use of electroconvulsive therapy, following the expression of concern by some members, particularly about non-consent. The memorandum concluded that (Royal College, 1977, 266):

"There is substantial and incontrovertible evidence that the ECT procedure is an effective treatment in severe depressive illness."

At the same time, however, it was recognized that it is not clearly established that ECT is necessarily any more effective than drug treatments (Royal College, 1977, 262):

"It appears that the response to ECT is at least as good as, and probably more rapid than, that to tricyclic medication." (Emphasis added.)

After reference to several comparison studies, it is said that (Royal College, 1977, 263):

"Some other comparisons of ECT and tricyclic anti-depressants (5-7) have shown only small differences or none at all in the effectiveness of these two treatments." (Emphasis added)

So far as memory loss is concerned, the Royal College Committee was very frank. It said (Royal College, 1977, 266):

"The question of the precise duration of objective memory loss following ECT, and the possibility that there may be relatively long term or even permanent losses had been too little investigated." (Emphasis added.)

Indeed the concluding words in the first part of the memorandum emphasise this point (Royal College, 1977, 267):

"...further research on possible long term effects of ECT is required."

These quotations are admittedly selective; nonetheless they are the words of those who advocate the use of ECT. The conclusion which the Committee members of the Royal College reached was that, despite the uncertainties surrounding the treatment, it could be used, even in the case of non-consenting detained patients. On the same material this writer would now conclude that, at least in the case of non-consenting detained patients, it should not be used. This is not a question of scientific expertise - it is a matter of making value judgments on the basis of an uncertain state of knowledge.

It should be noted, however, that the Royal College Committee does not appear to be very enthusiastic about the use of ECT without consent. It said (Royal College, 1977, 271):

> "For those patients who are unwilling to undergo ECT the alternative forms of treatment should be reconsidered."

It then goes on to say that if it is decided that absence of consent is to be overborne, there should be two medical opinions and the written consent of the nearest relative should be obtained. (The last two matters, of course, are not legal requirements.)

Professor Leslie Kiloh of the University of NSW has also been a strong advocate of the use of ECT. Yet at many points in Kiloh's detailed analysis of the evidence concerning ECT (Kiloh, 1977) material is presented which reasonably supports the viewpoint of those who are opposed to its enforced use.

This, of course, is to Kiloh's credit as a dispassionate scientific researcher presenting all the evidence.

He says (Kiloh, 1977, 30):

> "Objective evidence of memory disturbance may persist for up to 3 or 4 weeks after the course of treatment but seldom longer. Subjective memory impairment may continue for months or years and be a source of bitter complaint but as Cronholm and Ottosson (1963) have pointed out patients that (sic) improve with ECT seldom make such complaints and indeed may deny memory disturbance when it is evidently present." (Emphasis added.)

The implications of this are very disturbing. If it is true that some patients experience a subjective feeling of memory loss, which lasts for months or years, then:

(1) presumably the risk of such subjective feeling, if it be not real, will be considerably increased if compulsion is involved;

(2) it is possible that the subjective feeling of memory loss is indeed real, but has not been properly measured by an objective test. It appears (Cohen et al., 1968, Berent et al., 1975, supra) that loss of visual and spatial memory might well be unmeasurable by the verbal type memory test.

Kiloh says (Kiloh, 1977, 25):

"There are no absolute contraindications to the administration of ECT. If ECT is judged to be lifesaving, risks may be taken that in less severe cases would be regarded as unjustifiable." (Emphasis added.)

Yet given the difficulty of predicting suicide, there is really no way it can be said in any particular case that ECT is needed to save life, in the same way that it might be said that an appendectomy is necessary for the purposes of saving life when an appendix has ruptured. It would be nigh-on impossible to produce any case in which it could be said that, failing the immediate administration of ECT, the patient would certainly die. It is a gross exaggeration of the importance of ECT to say that it is a "lifesaving" procedure in the sense that not using it in a particular emergency will result in a death.

It may be "lifesaving" in the general statistical sense that some persons who have ECT may live who would otherwise have died. But where the compulsion of an uncertain and possibly brain damaging procedure is involved, people cannot be treated like percentage points. It may be true that ECT has saved some lives. But in the case of a particular individual in crisis, the choice of drug treatment or ECT is available. Even if it be true that ECT is slightly more effective than drug treatment - which is probably true - it is only more effective by a few percentage points, or by a few weeks in terms of time.

Thus it is sophistical to refer to ECT as a "lifesaving" procedure in the same way that open heart surgery or an emergency appendectomy is lifesaving. It is not a question of "life or death" in the immediate sense.

It is noteworthy from the Royal College Memorandum, from Kiloh's review and from the literature generally, that no study has ever been done as to the effectiveness of ECT when compulsorily administered. Even if it be true that ECT when administered to consenting patients is somewhat more effective than other forms of treatment, it is quite plausible that it will be less effective and more damaging when it is forced upon a patient against his will. One might postulate a "reverse placebo effect" where a patient forced to undergo a treatment of which he was initially suspicious exaggerates side effects he has been told about beforehand in whispered conversations in hospital corridors.

Since the application of ECT to unwilling patients has long been a disputed matter, it seems a serious gap in the literature that there should have been no study of the effectiveness of the treatment specifically taking this variable into account. At least until such research is done, this writer is disinclined to concede the propriety of using ECT in relation to non-consenting involuntarily detained patients.

A Change of Heart

The conclusion which the writer draws from presently available evidence is that while ECT may in general be an ethical treatment it is not one which should be given to an involuntary patient without consent or over objection. The uncertainty surrounding it and the seriousness of its possible effects are decisive. The writer's present view is to be contrasted with that which he expressed as a party to the Edwards Report (Proceedings, 1975, 92-93):

> "Firstly, we would point out that the Act does not allow the administration of ECT to a voluntary patient against his will. Generally a voluntary patient will consent to its administration, but failing such consent, it cannot legally be given. We are dealing here only with involuntary patients and forensic patients.
>
> "Secondly, it seems to us inadequate to rely on a simple distinction between consent and non-consent. A third concept is necessary: that of "objection". We have incorporated this into subsection (4).
>
> "What we propose will work in the following way. If the patient or forensic patient agrees to the administration of ECT, and understands its purposes and the risks which may be associated with it, then in a legal sense he consents to it. Even though he consents, the section still applies, however; according to subsection (3) as we

have proposed, the decision to give ECT must be taken by the superintendent or by two doctors. Generally under our proposal, the decision will be made by two doctors, and it must be expressed in writing. No book need be kept of such determinations but clearly as a matter of proof the sensible thing would be for both doctors to indicate the treatment on the patient's record card, perhaps both signing it.

"We suggest that two doctors should be required to endorse ECT treatment in relation to involuntary patients. At present the superintendent will (in theory) make the decision on the recommendation of one doctor, but since ECT is a fairly standard treatment for severe depression (one of the most common mental illnesses) the superintendent may not in fact have adequate time to allow thorough investigation in all cases.

"Our proposal means that if the patient or forensic patient consents to ECT, or does not consent in the true legal sense but at the same time does not object to it, then ECT can be administered upon the determination of two doctors.

"However if the patient or forensic patient actually objects to ECT, then the superintendent must be brought into the matter. The objection must be recorded in a book maintained for the purpose. If the superintendent agrees to the administration of ECT, it proceeds over

the (recorded) objection. If the superintendent does not agree, the treatment is not proceeded with.

"We return to the original question posed; should we allow a person detained in a mental hospital to be subjected to ECT against his or her will?

"Our view is that, provided the safeguards we suggest are adhered to, the involuntary administration of ECT is justified. The treatment is used almost solely in cases of severe depression, where the person is suffering from a serious mental disturbance evidencing itself in extreme feelings of self-hatred and unworthiness; the person probably indicated an intention or wish to kill himself. It has been shown in controlled studies, quite conclusively, we believe, that for unknown reason electroconvulsive therapy does considerably assist in lifting serious depressions. The mechanism by which ECT works is not clear, but it is certainly true that in very many cases it does work.

"We appreciate that medicine and coercion are usually antithetical the one to the other, but in the case of ECT we see a limited degree of coercion as necessary and morally justifiable. Our argument here is in terms similar to those we used earlier in this report when considering the justifiability of using the coercive processes of the state to prevent a person from committing suicide. Many people "come out the other side" of a

> suicide attempt glad to have been assisted, involuntarily, over an episode of irrationality and despair. Similarly, we suggest, the use of coercion in relation to ECT can in a limited number of cases and allowing appropriate safeguards be justified."

This argument reflects concern about ECT, coupled with trust that the medical profession can be properly vigilant to respect the rights of involuntary patients. However, the Royal College Memorandum of 1977 raises more doubts than it settles. Furthermore, this writer is persuaded that the work of Cohen, Berent et al., (cited above) has significantly affected the status of ECT. Bilateral ECT administered in large doses had been heavily discredited by about 1965 or 1970, but it was then thought that right unilateral ECT, applied in small doses to selected patients, was acceptable and useful. The Edwards Report was first compiled in draft form in December 1974. The evidence since then about brain asymmetry, and the realisation that unilateral ECT may not be the preferred form of treatment it was thought to be, and the failure of the researchers to undertake studies specifically dealing with the effectiveness of the treatment in relation to non-consenting patients, compel this writer at least to conclude that the limited safeguards proposed by the Edwards Committee are inadequate. ECT should not be forced upon anyone.

# CHAPTER 14

## PSYCHOSURGERY

When a person is involuntarily detained by reason of mental illness, it is improper that he should be subjected, without his full and informed consent, to psychosurgery in any of its forms. In order to substantiate this assertion, it is necessary to consider the history and background of the surgical procedures referred to by the name "psychosurgery" and in particular to take note of the present controversy which has continued, with no little venom being expressed on both sides, for approximately the last decade.

What is "psychosurgery"? An excellent example of an inadequate definition is one adopted by Greenblatt in a recent article (Greenblatt, 1976-77, at 968). That writer says:

> "For the purposes of this article, psychosurgery refers to surgical or electronic manipulation of the brain that destroys healthy or abnormal cells."

The deficiency of this definition is that it could cover virtually all operations on the brain. The preferable and clearer approach is that adopted in the pioneering Oregon Psychosurgery Law of 1971, which says:

> "'Psychosurgery' means any operation designed to irreversibly lesion or destroy brain tissue for the primary purpose of altering the thoughts, emotions or behaviour of a human being. 'Psychosurgery' does not

include procedures which may irreversibly lesion or destroy brain tissues when undertaken to cure well-defined diseased states such as brain tumour, epileptic foci and certain chronic pain syndromes."

Similarly, in the report of M.L. Foster QC and colleagues to the NSW Minister of Health in 1977 on the subject of psychosurgery (Foster, et al., 1977) psychosurgery was defined in the following terms:

"'Psychosurgery' means:

a) the creation of one or more lesions, whether made on the same or separate occasions, in the brain of a person by any surgical technique or any procedure, when it is done primarily for the purpose of altering the thoughts, emotions or behaviour of that person.

b) the use for such a purpose of intracerebral electrodes to produce such a lesion or lesions whether on the same or separate occasions.

c) the use on one or more occasions of intracerebral electrodes primarily for the purpose of influencing or altering the thoughts, emotions or behaviour of a person by stimulation through the electrodes without the production of a lesion in the brain of that person.

'Behaviour', for the purpose of this section,

a) does not include grand mal, petit mal or Jacksonian epilepsy.

b) does include complex apparently automatic behaviour whether presumed to be secondary to cerebral dysrhythmia or not."

The history of psychosurgery* is briefly described by Zwerdling as follows (Zwerdling, 1974-1975, 735-6):

"Brain surgery designed to modify human behaviour can be traced to the 1880s when Dr G. Burkhardt, a Swiss psychiatrist, began removing portions of patients' brains to control their behaviour. Although Burkhardt was successful in controlling his patients' violent behaviour, he discontinued his activities because of pressure from colleagues in the medical community who were disturbed by the ethical implications of using brain surgery to control behaviour.

"Further development of psychosurgery was delayed until 1935 when a Portuguese scientist, Egas Moniz, and a colleague conducted a series of experiments to determine whether the behaviour of disturbed patients could be controlled. At first Moniz tried cutting a small round hole in the skull near the temple and inserting alcohol to coagulate the fiber tracts between the frontal lobes

* Which certainly includes the use of cerebral isotope implants, as developed by Dr. G. Knight at St. Georges Hospital, London. This is a procedure where radioactive isotopic beads are implanted to burn out tissue. The procedure is discussed by Bridges, P.K., Gotkpe, E.O. and Maritos, J. in "Comparative Review of Patients With Obsessive Neurosis And With Depression Treated by Psychosurgery", (1973) 123 British Journal Of Psychiatry, 663.

and other parts of the brain. The alcohol coagulation did not work well, so Moniz began cutting the fibers with a special knife called a leucotome. After twenty such operations, the Portuguese government forced Muniz (sic) to stop.

"The lobotomy procedure nevertheless attracted world-wide attention and, from the late 1930s to the early 1960s, frontal lobotomies were hailed as an important breakthrough in the treatment of severely disturbed mental patients. Approximately 50,000 were performed in the United States between 1940 and 1960. Unfortunately, enthusiastic lobotomy advocates underplayed that this 'great breakthrough' often left patients apathetic, asocial and intellectually blunted. The use of lobotomies virtually disappeared in the United States with the development of powerful drugs called phenothiazines, by which the defects of a lobotomy could be achieved without surgery.

"Doctors in recent years have developed a surgical technique which utilizes electrodes composed of fine wires to penetrate the brain. Using a complicated coordinate system, a surgeon can implant the electrodes inside the brain and, by applying varying degrees of electrical shock, stimulate or destroy desired portions of brain tissue. This technique, called stereotaxic surgery, is far superior to the earlier forms of brain surgery which

required the surgeon manually to cut through or remove portions of the brain in order to reach areas under the skull." (Footnotes deleted)

In contemporary times, the kind of success rate which is commonly claimed for the use of psychosurgery in relation to a variety of conditions is about 50%. For example, in a follow up study of the affects of bi-frontal stereotactic tractotomy on 210 patients, Strom-Olsen and Carlisle say that (Strom-Olsen and Carlisle, 1971, 153):

"Of the 150 A cases 49 (33 per cent) recovered completely from their illness and a further 24 (16 per cent) only had minor residual symptoms and required no further treatment, making a total of 49 per cent. A further 35 (23 per cent) improved but still needed treatment, with persistent symptoms. 41 (27 per cent) were unchanged, and one patient was worse."

Yet despite claims of success for the modification of conditions such as depression, obsession, anxiety and simple aggression, there is considerable and widespread public fear about psychosurgery. For example, in a book review written in 1972, Gabel makes reference to certain comments by an optimistic supporter of psychosurgery (Gabel, 1974, 119):

"These remarks cannot but remind those of us who have followed the development of psychosurgery of the words of Walter Freeman, who introduced the pre-frontal

lobotomies in the United States. In his textbook on psychosurgery he states that lobotomy is most likely to be helpful for older people, women, blacks and those who perform simple occupational roles." (Footnote deleted)

The clear implication of Gabel's comments quoted above is that the social, political and philosophical assumptions which underpinned the "rash" of lobotomies in the 1950s were obnoxious. The metaphor commonly employed to describe the resultant condition of those who had undergone lobotomy by Freeman's crude "ice-pick" method was that the patients were turned into "human vegetables." It is, of course, grotesque to imagine that this consequence of a surgical procedure would be more tolerable when inflicted upon "older people, women, blacks and those who perform simple occupational roles." It is undoubtedly true that the more recently developed procedures utilising the stereotactic clamp and more precise surgical methods than the ice-pick do not generally produce the grossly dehumanising effects characteristic of the earlier lobotomy procedure. Nonetheless, very strong fears still persist, among the ignorant and the well-informed alike, that the medical profession which produced or at least tolerated widespread lobotomies has not changed much over the last three decades. The very titles of the kind of academic article being written in law journals during the 1970s indicate the measure of these fears and concerns. For example,

"Beyond the 'Cuckoo's Nest': A Proposal for Federal Regulation of Psychosurgery" (Knowles, 1975);

"Conditioning and Other Technologies Used to 'Treat?' 'Rehabilitate?' 'Demolish?' Prisoners and Mental Patients" (Spece, 1972);

"Legislating the Control of Behaviour Control: Autonomy and the Coercive Use of Organic Therapies" (Shapiro, 1974).

The widespread popularity of Crichton's novel "Terminal Man" (1973), a critical, if somewhat simplified, analysis of the possible adverse consequences of electrode implantation, is further evidence of public disaffection concerning psychosurgery.

However much improved psychosurgical methods might now be, and however exaggerated and unrealistic might be some of the more hysterical criticisms of it, one thing is certain; psychosurgery is still experimental. For example, in an article (Smith, Rushworth, Morrison and Grant, 1975, 93), those authors - all of whom are supporters and indeed practitioners of psychosurgery - refer to a case involving the treatment of severe anxiety with chronically implanted intracerebral electrodes in the following terms:

"A current of 1 mA was passed from each electrode in the orbitomedial white matter (the anode) to a lead forearm cuff (the cathode) to determine the effects of 'polarization'. Polarizing currents are said to have an electrotonic effect on the axones in the vicinity of the

electrode, blocking their function for a variable period without producing a lesion. An anxiolytic effect was produced by polarization at two electrodes, the effect lasting approximately five minutes."

It is to be noted that the sentence "polarizing currents are said to have an electrotonic effect on the axones in the vicinity of the electrode ..." is expressed in terms indicating that the authors are not at all certain about whether or not this is in fact true.

Another indication of the experimental nature of psychosurgery is an analysis by Jones (Jones, 1975, 110) of the unpredictability of brain stimulation in human beings. Jones refers to five factors which give rise to this unpredictability:

"1. Electrodes cannot be positioned with perfect precision because individuals differ in the gross physical dimensions of their brains.

2. The neural circuits responsible for the regulation of different reactions are so closely intertwined that it is almost impossible for electrodes to activate the same configuration of nerve cells in different individuals.

3. Brain stimulation often produces a general motivational state rather than specific 'goal-directed' behaviour.

4. Responses to stimulation are frequently 'situationally dependent'.

5. The responses evoked by stimulation may change with time."

(It should be pointed out that Jones is a moderate critic, rather than a practitioner of psychosurgery.)

Goldstein (Goldstein, 1974, 7) in a summary and evaluation of the status of biomedical research on brain and aggressive violent behaviour, concludes in the following terms:

"Here is an area of investigation that awaits the imaginative resources of well-trained basic and clinical neurobiologists and psychobiologists. The overriding importance of mapping the pharmacological properties of different neuronal subsystems was emphasized by all participants. Such investigations, coupled with rigorous and well-controlled neuroanatonical, physiologic, biochemical and behavioural studies, were viewed as the only sound scientific approach to the infinitely complex problem of defining the substrate for violent and abnormal aggressive behaviour, and for specifying the most humane approach to the problem of controlling such behaviours as can be clearly related to abnormal pathophysiologic processes of the brain." (Emphasis added.)

So far as the Foster Committee of Inquiry in NSW was concerned, the question of the experimental nature of psychosurgery was very much an issue. It was said in the report (Foster, 1977, 8, 9, 13):

"The words 'experiment' and 'research' have been much referred to in debate before us and, of course, appear with considerable frequency in the literature. The meaning ascribed to these words can differ from place to place and it is desirable that the Committee indicate its opinion as to the relationship of 'experiment' and 'research' to 'treatment'. It is the Committee's view that these three concepts are not mutally exclusive. A particular procedure can be accepted as a 'treatment' even though it is to a degree experimental in nature, in the sense that it has a basis in a reasoned theoretical hypothesis but its outcome cannot be predicted accurately because of lack of previous empirical data. Equally, such 'treatment', with an experimental component, may well find its place in a programme of 'research' in which the aim is to advance the acquisition of scientific knowledge as well as provide proper medical therapy to patients involved in the research programme. We feel it important to state, however, that we find difficulty in seeing how a treatment which is 'experimental' can at the same time be regarded as 'generally' accepted, even though it may be a perfectly proper treatment to apply to a particular patient in particular circumstances, as, for instance, where the patient's plight is desperate, and the particular 'experimental' treatment offers some reasonable hope of relieving his suffering...

"...The Committee is not unmindful of the submissions made to it, as to what factors may reasonably be taken into account in determining whether a procedure may properly be described as 'generally accepted'. Nevertheless, we feel that, upon no meaning which can reasonably be attributed to these words, can it be said that these procedures have yet won general acceptance.

"This is, of course, not to say that they are improper, unprofessional, disreputable or useless procedures or that they are not capable of becoming generally accepted in the future.

"The position simply is that the material before us leads us to the opinion that the procedures by way of chronic implantation of electrodes cannot currently be described as 'generally accepted'."

In 1952 there were introduced into the law in NSW certain provisions concerning the use of psychosurgery in relation to patients detained involuntarily in mental hospitals. As at the present time, those provisions (as amended) appear at Section 108 of the NSW Mental Health Act, 1958. The effect of these provisons is to permit the use of psychosurgery in relation to an involuntarily detained patient without his consent, although some restrictions are imposed. There is a Consultative Committee which is supposed to ensure that the operation is a proper one for the patient. It is required

that notice be given to the spouse, some other relative or the person considered the person in whose care, guardianship or custody the patient was prior to his admission. Disapproval by the spouse or relative or guardian can be overridden if it is considered to be unjustifiably or unreasonably expressed. There is a right of appeal to the Supreme Court concerning disapproval by the spouse, relative or guardian.

It is notable that the Consultative Committee might be comprised wholly of medical practitioners.

It is clear that at the present time Section 108 of the Mental Health Act, 1958, is regarded as inadequate for the control of psychosurgery. For example, it is notable that it does not cover the performance of psychosurgery in the general community, in private hospitals or in relation to voluntary patients in mental hospitals. The Edwards Committee commented upon the provision's inadequacy and came to the following conclusions (Edwards et al., 1975, 86):

"(1) Current knowledge about the medical and social effects of psychosurgery is seriously deficient, and accordingly our recommendations are designed (in part) to attempt to rectify this situation.

(2) Although we are in sympathy with the critics of psychosurgery, particularly so far as the difficult problem of consent is concerned, we cannot accede to the view, strongly put to us, that such operations ought to be flatly prohibited or stringently restricted.

"(3) Equally, although respectful of the view that medicine progresses most satisfactorily in the absence of legal restriction, we cannot fully accept it in this context.

(4) (a) Private patients or voluntary patients: we suggest a scheme whereby the performance of psychosurgery upon a private patient in the community or a voluntary patient is notified beforehand to the Health Commission, the acquiescence of a member of a small consultant panel is obtained, and systematic evaluation of the operation is undertaken.

(b) Involuntary patients: we simply suggest the retention of section 108 and the requirement that the consent of a Consultative Committee be necessary.

(c) Forensic patients and persons in prison or subject to criminal process: we suggest a double requirement; firstly that the consent of a Supreme Court judge be obtained and secondly that the consent of a Consultative Committee be obtained approximately in accordance with section 108."

It is possible to criticise these proposals on the basis that they are inadequate and unsatisfactory. The process whereby one member of a "small consultant panel" is consulted does not involve any element of lay representation such as the American reformers in this area have thought necessary to placate public concern about total medical control. For example, according to Annas and Glantz (Annas and Glantz, 1974, 263):

> "The State Legislature of Oregon has already enacted a statute regulating the performance of psychosurgery in that state. The statute provides that psychosurgery may be performed only with the affirmative vote of at least six members of a state-wide nine-member review board."

Certain of these members are required to be lay persons rather than doctors. However, as Annas and Glantz say (id.):

> "At least a majority and as many as seven members of the nine-member board may be physicians. Only one need be an attorney and only one is designated as a 'member of the general public'. The board is thus heavily biassed towards the scientific research community and may approve the performance of psychosurgery even against the dissent of all the 'lay' members."

So far as lay representation is concerned, the Edwards Committee recommendations are even less adequate than those in Oregon criticised by Annas and Glantz. The Foster Report recommends

strongly in favour of a significant element of lay representation, but again - as in Oregon - there is a numerical preponderance of doctors. According to the draft Bill,

> "The Board shall comprise seven members and shall consist of:
>
> a) a member of the Bar of New South Wales of not less than ten years standing, who shall be Chairman;
>
> b) a neurosurgeon, nominated by the Royal Australasian College of Surgeons;
>
> c) a neurologist, or neuroscientist, nominated by the Royal Australasian College of Physicians;
>
> d) a clinical psychologist, nominated by the Australian Psychological Society;
>
> e) a member of the general public, nominated by the Council for Civil Liberties or such other body as the Governor shall appoint for that purpose;
>
> f) a psychiatrist, nominated by the Minister for Health;
>
> g) a psychiatrist, nominated by the Australian and New Zealand College of Psychiatrists."

It is reasonable to suppose that if the Board as recommended by Foster et al, is introduced in NSW, its broadly based composition will go some way to allay concern about "a conspiracy of doctors."

It is unnecessary to detail the precise circumstances which gave rise to the establishment of the Foster Committee; suffice it to say that in 1976, certain allegations were made by a nursing sister at the Rozelle Hospital about the standard of care at the Neuro-psychiatric Institute and about the way in which psychosurgical operations were being conducted. In general, it is true to say that the particular allegations about experimentations on cats, burns inflicted on patients, suicide attempts and side effects of operations were not substantiated. It was found that one patient had removed certain electrodes from his head in circumstances when it might have been more prudent to have applied such restraints as would prevent this from occurring, but this was not thought to reflect improper medical practice on the part of the hospital staff. The significance of the report is its wide range across the whole field of psychosurgery, the depth of the research undertaken, and its powerful and cogent conclusions about proper controls in this field of medicine generally.

The view of the Committee was that psychosurgery should not be permitted on any patient without consent, and that the Board should have a central role in relation to all psychosurgical procedures whether performed on private patients in the community or upon involuntary patients in mental hospitals. So far as the involuntary patient is concerned, it was said (Foster, et al., 1977, 30):

"The Committee is of the opinion that special provisions should be made for persons who consent in fact, but whose consent could properly be regarded as vitiated in some way, quite apart from any question as to whether it was 'informed' consent. Such persons include those who are disabled by age or mental illness, and also those, such as convicted prisoners and others, who are not in a position to exercise true freedom of choice. Such persons should not, for that reason, be denied the benefit of a psychosurgical operation if it is otherwise desirable that they should have it, and they have not positively refused it. In such circumstances it is proper that provision be made for their consent to be ratified by a lawfully constituted authority before whom all information necessary for the formation of 'informed consent' has been placed. In the Committee's view, the proper authority for this purpose is a Justice of the Supreme Court. In the draft provisions, the Committee has sought to work out, in some detail, the manner in which the question of consent should be brought before the Justice.

"Needless to say, if a person legally able to give free and voluntary consent on his own behalf refuses the operation, then no question of the performance of the operation can arise, and no review of his refusal should be permitted.

"There possibly remains, however, a group of persons who lack necessary mental capacity either to consent to or to refuse psychosurgery and who therefore, in fact, neither consent or refuse in any sense. Such people would have such a severe emotional or intellectual disorder as to rob them of their power of decision either way. This group presents a very special problem, and it is felt that some legislative provision should be made. The main competing considerations are (i) should such a person be deprived of psychosurgery where it might be said that it would clearly be beneficial, and (ii) would the application of psychosurgery to such a person be an intolerable invasion of that person's ordinary rights as a human being. On balance, the Committee feels that the latter consideration should prevail. The law should provide that such a person should not be subjected to psychosurgery.

"In saying this, the Committee wishes to record that it recognizes the strength of the contrary view and that, if legislative control of psychosurgery eventuates, the contrary view could well prevail. However, if legislative provision should ever be made for the performance of psychosurgery upon a non-consenting patient, then the Committee feels that it should contain the most stringent safeguards to ensure that it is performed only to relieve severe and intractable suffering of that patient and for no other reason. In

> the circumstances, the Committee has not attempted to draft any provision to cover this situation, but expresses the opinion that such a provision should at least produce the result that no such operation take place unless authorized by a Supreme Court Judge after a full hearing in which the patient is represented and where the cases for and against the proposed psychosurgery are fully dealt with in evidence and argument; and that authority be not granted for the operation uless the Court be fully satisfied that it is absolutely vital to the patient's welfare."

This conclusion and recommendation, especially taking into account the authoritative membership of the Committee, chaired by Mr M.L. Foster, QC, and including three medical practitioners, must surely, it is suggested, be taken as virtually decisive against the proposition that psychosurgery might properly be performed upon persons detained involuntarily in mental hospitals.

There is of course an area of dispute as to whether or not persons involuntarily detained in mental hospitals or prisons ought ever be entitled to have psychosurgery performed in relation to them. In an American case of Kaimowitz (42 US Law Week 2063) it was decided that, by virtue of the oppressive and coercive nature of penal institutions, it could never be possible for prisoners to give a full, free and informed consent to psychosurgery. It is not inconceivable

that this issue might possibly arise in NSW. Kiloh and Smith (1978) argue in an article on the neural basis of aggression and its treatment by psychosurgery that (page 27):

> "...if the agressive behaviour is disruptive and disabling, irrespective of whether there is brain damage or not, treatment should be offered, even if it requires an attack on the brain. To deny such a person living in fear of the consequences of behaviour which is beyond his control, requesting and even begging for help, would seem to be a denial of human rights. Yet some who oppose the use of such operations would deny them on the grounds that the treatment itself is a denial of human rights."

Professor Norval Morris, Dean of the University of Chicago Law School and a distinguished writer on prisons, has taken a view opposed to that represented by the decision in Kaimowitz and has endorsed the proposition that any medical operation, lawfully available in the general community, should equally be available to a fully consenting person confined as a prisoner, or by legal extension, as a mental patient. He says (Morris, 1974, 25):

> "I adhere to the view that it is possible to protect the inmate's freedom to consent or not; that we must be highly septical of consent in captivity, particularly to any riskyand not well-established procedures; but

there seems little value in arbitrarily excluding all prisoners from any treatment, experimental or not."

Morris takes the view that, if a prisoner is offered the opportunity of a psychosurgical operation, we must be highly sceptical about whether or not he truly consents to it. The Kaimowitz argument is that the person under detention must inevitably feel that the only alternative to his consenting is for him to remain locked up: i.e., the consent is no more real than the submission of a woman who assents to sexual intercourse under threat of violence. The Morris view, which is that implicitly adopted by the Foster Committee, is that it is conceivable that a person under detention might possibly be able to give full and informed consent. That possibility should be viewed with the greatest possible scepticism, and only accepted as valid after notice and thorough scrutiny. But it is a possibility which can only be denied at the risk of denying the detained person the opportunity of medical treatment which would be available to a person free in the general community. *

It is notable that Kiloh and Smith (1978, 27) appear not to have the same degree of sensitivity to the question of consent as was demonstrated by the Foster Committee. They say:

"In view of what some have termed the 'experimental' nature of the treatment and the disquiet felt in some influential - though not necessarily informed - circles

* Similar considerations arise in relation to the castration of sex offenders in prison, as practised by Dr. G. Sturup and his colleagues at Herstedvester in Denmark. This operation was discontinued in about 1970. The view of this writer is that no such operation ought ever be permitted upon a prisoner except after thorough scrutiny by a genuinely independent tribunal.

about these operations, it would be wise, if only for the protection of the doctors involved, if decisions were placed in the hands of a tribunal with medical, lay and legal representation. For patients in mental hospitals incapable of giving consent, such a mechanism would be obligatory. In the present climate, it might be wise to accept that those unwilling to have the operation should not have it."

It seems extraordinary and indeed difficult to believe that these authors should, by implication, dismiss the Foster Committee as "not...informed". The language used by Kiloh and Smith seems to indicate the greatest reluctance on their part "to accept that those unwilling to have the operation should not have it."

The last word on this subject might aptly go to a psychiatrist at Rozelle Hospital writing before the 1976 controversy. According to White (White, 1974):

"An experimental scientist might be enthusiastic about the results of amygdaloidotomy, but a clinician would have misgivings about a procedure which involves a small definite immediate risk and the prospect of long-term improvement in less than 50% of cases. On current information I would not personally recommend such an operation. Other therapists, cognizant of the distress of the patient, may feel that the 50:50 chance of

improvement warrants amygdaloidotomy. I suspect that most of them will eschew coercion of any kind, in which case they will require the informed free consent of a rational patient."

# CHAPTER 15
# CONCLUSION

This thesis is the product of curiosity and concern about whether the arguments of radical abolitionists such as Thomas Szasz actually do compel an honest conclusion that the system of involuntary admission of the mentally ill as we know it deserves to be scrapped.

In some ways it would have been simpler and more attractive for this writer to conclude that Szasz was correct and that all the Mental Health Acts ought simply be repealed. That would be a neat and satisfying solution. It might have been equally neat and satisfying to have concluded, on the contrary, that Szasz and his followers are charlatans, that doctors can always be trusted to behave responsibly and that a system of involuntary admission of the mentally ill based on complete and unqualified medical discretion ought to be endorsed.

This writer has been compelled to reject both of these views, however attractively unequivocal each be.

So far as Szasz is concerned, although his ideas are in some regards interesting and useful, they are subject to the criticism that they are, at their very centre, wrong and misconceived. The radical abolitionists following Szasz have usually based their attack on the notion that the argument in "The Myth of Mental Illness" (possibly one of the most rewritten and renamed books in recent times) is correct. On the contrary, it is ludicrous and false. The words of a famous political commentator of the 1920's (Mencken, 1960, 51-52)

although directed towards another derisible notion, are apt:

> "The imbecility of the doctrine is so obvious that it is hard to imagine even an audience of lawyers listening to its exposition without bombarding its father with dead cats."

Yet is is largely an audience of lawyers who have listened to and endorsed the argument that mental illness is a myth; often, one suspects, on the basis of little or no experience in actually observing or dealing with mentally ill persons.

It is principally experience and observation of the mentally ill which compels this writer to acceptance of the reality of mental illness. It is certainly true that the aetiology of the major mental illnesses have not been definitely established. Theories about the causes of the schizophrenias abound. It is not fully known how or why the tranquillizing and anti-depressive medications work. Nonetheless, ignorance of causal theory does not entitle us to declare, as Szasz does, that the hallucinations of the schizophrenic are mere pretence.

Szasz's erroneous insistence on the non-existence of mental illness has led to an underestimation of the power of certain of the other arguments against involuntary admission; in particular, the arguments in relation to prediction and discrimination. These arguments are substantial, as their analysis in Part 1 demonstrates; so substantial that this writer is led to the conclusion that involuntary admission

and detention can only be held to be justified if serious restrictions - as suggested in Part 2 - are provided in law and practice.

The significance of the argument as to the inaccuracy of diagnosis also has been obscured in this debate by the overemphasis on the question of whether there is or is not such a thing as mental illness. The undoubted problems of diagnosis and definition of mental illness lead to the necessity for the kind of "limiting definition" as proposed in chapter 7, and the further restrictions on grounds for admission as proposed in chapters 8 and 9.

The absurdity of Szasz's basic contention is, of course, mirrored in the absurdity of the views of those who contend for the opposite - complete medical discretion in relation to involuntary admission and detention. So far as this approach is concerned, bombardment with dead cats, as prescribed by Mencken, would again seem to be a sensible way of responding. Yet many medical practitioners believe and assert fiercely that involuntary admission is just another case of medical practice, interference by the law and lawyers being no more justified here than in relation to private consultations concerning the common cold.

That this view should be as widely and strongly held as it is amongst doctors, and particularly amongst psychiatrists, is a frightening demonstration of the extent to which the elitism of medical education promotes authoritarian and

reactionary political attitudes. It surely should not be too difficult to grasp that locking people up and doing things to them against their will is a political matter, albeit to some extent also medical. The thrust of criticism against conventional psychiatry on this point is undeniably justified.

The "medical discretion" model of involuntary admission is the basis for the present laws in England, New Zealand and all of the Australian states with the qualified exception of New South Wales. This model was constructed in the 1950s, when the outdated lunacy laws of the 1890s were no longer capable of dealing with the problems of mental illness. Much as the loss of some of the restrictions and protections under the old laws were lamented by some (e.g. Myers, 1961) they were designed for the period before the advent of the new tranquillizers and mood-elevating drugs and certainly needed overhaul. As it turns out, they were substantially done away with and replaced by systems giving doctors very broad and ill-controlled powers. Blom-Cooper and Jeffreys describe the movement in England towards medical discretion as follows (Gostin, 1975, 6):

> "Those who were at all aware of the misery of the sufferers of mental illness hailed the Mental Health Act, 1959, as a signal advance in the conditions for humane treatment. The scales fell from our eyes; we saw the existing laws relating to lunacy and mental deficiency,

devised in the ostracism of the late Victorian era, as the main obstacle to treating those whose bizarre behaviour disturbed or threatened others.

"...By contrast, the 1959 Act encouraged us to look upon mental illness leading to aberrant behaviour, as equivalent to illness of the body leading to physical malfunction.

"...The Act reflected the enlightened view that in such cases the decision to restrict the freedom of an individual should be taken in a medical and not a legal context.

"...In our view, the willingness to leave so much power in the hands of the medical profession was the result of a general wave of optimism about the capacity of mankind to solve most of its age-long problems of poverty, ignorance, squalor, disease and deviance. In particular, science applied to medicine was thought to be making spectacular progress in the treatment and prevention of infectious diseases; it seemed equally legitimate to expect that pharmacological advances - this was the period of the advent of transquillisers - and discoveries in the physical treatment of mental disorders would equip psychiatrists with the means to reduce dramatically the number of disturbed individuals who had hitherto had to be physically restrained in padded cells or locked wards.

> These advances were taken as signs that psychiatry was well on the way to dealing quickly and effectively with most forms of mental illness, and that it was the role of legislation to ensure that deviant behaviour thought to be outside the conscious control of the perpetrator be treated in a benign medical way, rather than in an austere, awesome legal setting. Medicine was almost universally perceived as manifestly humane..."

As Blom-Cooper and Jeffreys point out, the optimism of the 1950s about the abilities of the medical profession to deal with the problems of involuntary care, uncontrolled or unassisted by an adequate legal structure, has given way to scepticism, if not pessimism.

In retrospect, this ought to have been predicted. There has always been negligence and stupidity in the medical profession as in all other professions. But in the excitement over the introduction of the new tranquillisers and anti-depressants, this seems to have been forgotten, as was the uncomfortable fact that the diagnosis and definition of mental illness were still imprecise. It was apparently assumed as a matter of course that the rules and principles applicable in the treatment of voluntary or informal patients could be applied, willy-nilly, in dealing with the involuntarily detained.

The analysis developed in chapters 12, 13 and 14 of this thesis makes plain the writer's view that the crucial fact

of the absence of consent makes the treatment of the involuntarily detained a very special case indeed, demanding a complex of protections against overbearing medical behaviour.

However progressive the "complete medical discretion" model might have seemed in the 1950s, it is no longer tenable. In recent years the community perception of the doctor as omniscient and untouchable has altered. In a better educated community, "Doctor says..." is not necessarily a good enough reason for persons to permit themselves to be subjected to treatments they do not trust.

The analysis of English mental health laws by MIND (Gostin, 1975) (to which Blom-Cooper and Jeffreys' words cited above were a foreword) is comparable in broad thrust with the recent review of the New South Wales Mental Health Act (Edwards, et al., 1975). Both reflected dissatisfaction with the operation of legislation over a decade and a half old based (more or less) on a "medical discretion" model; in neither review was the complete abolition of involuntary admission proposed; in both there was suggested a narrowing of grounds for admission, increased scope for legal review, and systems of specialised advocacy for the protection of patients' rights.

Particularly so far as treatment without consent is concerned, this writer would go further in the imposition of restrictions than either the MIND or Edwards reports.

What the future might bring by way of increased understanding or treatment of mental illness remains to be seen, but we can be fairly confident that changes will occur in the future in areas such as housing, the facilities made available for aged persons, the numbers unemployed, and in other matters that bear politically upon the use and functioning of mental hospitals. Legislatures must be flexible enough to take these changes into account as they occur. But if the element of compulsion remains as a constant factor in relation to treatment of the mentally ill - as apparently it will - it must be subject to constant scrutiny. Compulsion should be the last resort in a civilized legal system. Where it is used, it should be minimal and subject to systematic legal review.

Those who are caught by involuntary admission procedures are usually poor, often infuriating and sometimes frankly nasty people. But they are nonetheless helpless against both the affliction of psychosis and the coercive power of the state. Common humanity demands that they be looked after. They should be abandoned neither to the absurd ideology of neglect promoted by Dr Szasz and his tax-reductionist followers, nor to the uninhibited medical zealotry of those who believe that the ice-pick and the electrode mark the way to mental salvation for the willing and unwilling alike.

Ultimately, the justification for involuntary admission rests in common humanity and love of one's fellow man, just as the necessity for limitation and restriction of involuntary admission rests in scepticism about one's fellow man.

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