COMMENT

MENTAL HEALTH ACT 1958 (N.S.W.)

BY PAT O'SHANE*

I INTRODUCTION

The present Act was legislated to replace the Lunacy Act 1898 (N.S.W.). At the time that the Lunacy Act was implemented (and for many years afterwards) the state of being a "lunatic" was an offence.[1] Consequently the procedures by which persons were declared to be lunatics were fairly rigorous.[2] By 1958 there had been some significant shifts. First, in general attitudes towards people who were seen to be of "unsound mind" (or whatever term enjoys vogue at any particular time) and, secondly, there was greater acceptance of psychiatry as a validly "respectable" area of medicine. For all that persons subject to such legislation as the Mental Health Act 1958 were, and still are, considered to be incapable of reason.

The single most significant aspect of the present Act is that it attempted to shift the *locus* of control from the legal profession (or to be precise, the judiciary) to the medical profession.[3] However, this change was effected in a most clumsy manner and far from assuring a better deal for persons coming within the ambit of the Act's operations, the Act carries some serious implications with respect to civil liberties. Despite these implications the legal profession has avoided the area. There are two main reasons for this. First, there is a general acceptance that this is an area of social interaction (or lack of, depending on one's point of view) best left to the control of the medical profession. Secondly, and probably more to the point, because there is no money to be made in this area of legal practice since persons who most frequently come within operations of legislation such as this Act come from the lowest socio-economic sector—they tend to be working-class, blacks, migrants and women.[4] As we know, the legal profession has hardly been concerned to protect the interests of the working-class and other minority groups.

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[1] 17 Geo. II c. 5 (1744) cited in McClemens and Bennet, "Historical Notes on the Law of Mental Illness in NSW" (1962) 4 *Syd. L. Rev.* 49.

[2] *E.g.* ss 4-6 Lunacy Act 1898 (N.S.W.).

[3] The rationale behind this move was that persons coming under the Act are sick, not criminal.

[4] While no studies appear to have been carried out in this country we may draw some general conclusions from the fact that state-controlled psychiatric institutions are located right inside those communities with largely working-class populations, *e.g.*, Rozelle and Parramatta Hospitals. See Boehringer, "Mental Health: Care or Oppression?" (1977) 2 *Legal Service Bulletin* 321.

The new attitudes of the 1958 Act can best be seen in four main parts: Definitions, admission and detention procedures, property control and management, and treatment.

II DEFINITIONS

Section 4 defines "a mentally ill person" as

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

This definition embodies by reason of the use of term "illness", an interesting philosophic viewpoint. Clearly, if a person is ill then there must be something amiss *within* the person—whatever difficulties or problems the person has are a matter of individual pathology. However, a number of scholars have disputed this understanding of "mental illness".[5]

It follows from such a philosophy that "mentally ill" persons should be dealt with by the medical profession. Such persons are fit subjects for certain diagnostic procedures and treatment regimes. Interestingly, the 1958 Act only requires that a person assessing a "mentally ill person" be a medical practitioner—there is no requirement that such person be a trained psychiatrist. Ostensibly a gynaecologist or any medical specialist would do.

Theory aside, the definition of a "mentally ill person" is still dubious. It is circular and vague and thus might well embrace any number of people who ought never to be caught by the Act. It casts the net wide. We might well wonder, whether we be legal or medical practitioners, just what is meant by these elements of the definition "care", "control", "for his own good", "in the public interest", "incapable of managing himself", not to mention what is "mental illness". We might well ask how to define, and who defines "for his own good", and whether "the public interest" in the context of the Mental Health Act means the same as it does in the context of, say, public law.

A variety of possibilities come to mind in relation to defining "mental illness". Incapacity resulting from a stroke? Alcoholism? Homosexuality? Psychosis? Neurosis? Incapacity arising from old age? Surely this definition needs to be clarified. For it is on the basis of whether or not a person is assessed as being a "mentally ill person" that the rest of the Act comes into effect. The Edwards Committee reviewed the definition in 1974.[6] It proposed amendments that did not affect the definition's philosophy but did reduce its vagueness. Those amendments are yet to be enacted. They are long overdue.

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[5] Szasz, *The Myth of Mental Illness* (1962); Laing, *Sanity, Madness and the Family* (1974); Brown, *Toward a Marxist Psychology* (1974).

[6] Report of N.S.W. Mental Health Act 1958 Review Committee, (The Edwards Committee). Frieberg, "Out of Mind, Out of Sight" (1976) 3 *Monash L. Rev.* 134, 139-140 discusses the American experience in placing medical definitions alongside legal procedures.

III ADMISSION AND DETENTION PROCEDURES

"Voluntary patients" have perfunctory admission and detention procedures set out in section 21 of the Act. "Voluntary patients" are persons who have applied on their own behalf,[7] and persons under the age of eighteen who are admitted upon application made on their behalf by the person in whose care and custody they may be.[8] "Involuntary patients" are those admitted by other persons, contrary to or despite the wishes of the patient concerned. "Involuntary patients" have detailed admission and detention procedures set out in section 12 of the Act. For these patients admission and detention may be effected by a medical practitioner who certifies that such person is mentally ill; the written request of a relative or friend; the police, pursuant to a justice's order; a police officer who certifies that he *believes* such person to be a mentally ill person; or by a welfare officer.

Experience has shown that in a majority of instances either a relative or friend has notified one of the relevant authorities (medical practitioner, police, welfare officer), who then arranges for the admission of the person. Furthermore, studies carried out in Great Britain have shown that family members frequently have highly dubious reasons (often psychological or emotional) for admitting other members to psychiatric institutions.[9] This practice, unhealthy as it is, is encouraged by the psychiatric profession. It can only exacerbate the legal problems surrounding admission; the problems are legion.[10]

Under section 12(4) "as soon as practicable after" a person is admitted [s]he must be examined by two medical practitioners, "separately and apart from each other". If the two recommend that such person be detained for further observation and treatment then such person shall be taken before a magistrate.[11] Apart from the absence of any legislative requirement that the medical practitioners referred to in section 12 need have any training in psychiatry,[12] there is the more pressing problem of the prospective patient's civil liberties. Undeniably, since many persons (the majority?) are administered tranquillising medication upon admission, the validity of any assessment made by medical practitioners following such medication becomes highly suspect. It may be "as soon as practicable", but it is not sound practice. Collaterally, does administration of medication in such circumstances amount to assault or even aggravated assault or, even perhaps, assault occasioning actual bodily harm?

Further, what can the requirement that the medical examinations be conducted "separately and apart from each other" possibly mean when

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[7] Mental Health Act 1958 (N.S.W.) s. 21(1)(a).

[8] *Id.*, s. 21(1)(b).

[9] Gostin, *A Human Condition* (1975) 18.

[10] Tedeschi, "Safeguarding the Mental Patient" *Sydney Morning Herald*, 25 February 1977, 7, discusses whether we should compel committal and treatment at all.

[11] Mental Health Act 1958 (N.S.W.) s. 12(8).

[12] Even if one adopts an anti-psychiatry view, such a fundamental fact is alarming in terms of the underlying philosophy and ideology of this Act.

the two medical practitioners concerned work within the same hospital environment and according to the same terms of reference (that is, the ideology underpinning psychiatry).

Under section 12(8) when it is decided to take a person before a magistrate "due notice" is required to be given to the nearest known relative or friend. What constitutes "due notice" is far from clear. It has been and probably still is common practice in some hospitals to give only a few hours notice, *if any at all*, as the following two cases show:

Case 1. R, a granddaughter, went to visit P in a nursing home on the relevant day and was *only then* informed that P had been transferred to Rozelle Hospital. R arrived at Rozelle Hospital to visit P *at the same time* as the magistrate arrived. R (fluent in English) was mystified by the proceedings, not to mention P (whose language was Polish).

Case 2. F (the only known friend of P) visited P on Wednesday evening and was told by one of the staff doctors that P would be seen by a magistrate. No date or time was indicated. On the following day when F was again visiting P the magistrate arrived unannounced. Taylor C.J. in *Lazarow* v. *Briese*[13] held that these circumstances in combination were sufficient to constitute "due notice". However, this decision was a patently bad one and it leaves the whole problem unresolved. Unfortunately, there is no requirement in section 12(8) that the patient be given notice of the intended procedures, nor is there any such requirement in any other provision of the Act.

Section 12(9) is also untoward. It sets out the role of the magistrate. If it were to fit with the rationale behind the present Act—the need to shift control from the judiciary to the medical profession—then the role would be administrative, the actual admission and detention procedures being carried out by the medical practitioners. However, section 12(9) is drafted in terms contrary to this principle. It is the magistrate who, after due consideration of the medical recommendations, must be "satisfied" that a person is "mentally ill". It is the magistrate who orders his detention or discharge. These are not nominal powers and their effect is Draconian; under section 105 if a patient leaves the mental hospital any police officer and any employee of the hospital may "escort" him back. Obviously, a section 12(9) detention order amounts to virtual imprisonment.

IV MANAGEMENT AND CONTROL OF PATIENT'S PROPERTY

The import of the property control provisions of Part XI is that any person, admitted involuntarily to a mental hospital in New South Wales and subject to a section 12(9) detention order, will have control and management of his property vested in the office of the Protective Commissioner. There are many disturbing implications in the Protective Commissioner's discretion. For example, section 73(1) provides that the Master in the Protective jurisdiction of the Supreme Court *may* pay to the person, after his discharge, all money standing to his credit in his

[13] (1978) Sup. Ct of N.S.W. (unreported).

current account. Since large numbers of people going through these processes are on social security benefits, the possibility of real hardship becomes an actuality. Another example, contained in section 73(3), is that such control and management may continue after a person is discharged. Unfortunately, in New South Wales this particular provision does operate, on the tacit assumption, it seems, that once "mentally ill" always "mentally ill". It is difficult to conceive of any other class of persons in our society who are subjected to such extensive control over their lives, other than perhaps undischarged bankrupts.

V TREATMENT

Any Act dealing with "illness" would be incomplete if it did not provide for treatment. Under the present Act treatment may include such dangerous and already discredited procedures as electro-convulsive therapy ("shock treatment" or E.C.T.)[14] and psychosurgery (presently leucotomy).[15] An involuntary patient may be subjected to any one of these procedures. Since such a person is regarded as being incapable of giving consent, the Act provides that in circumstances where it is considered "necessary" that such procedures be carried out then the consent required is that of an authorised officer.[16] Where E.C.T.'s are considered "necessary" a patient may be subjected to such treatment "notwithstanding that the patient or any other person legally entitled to consent . . . has not consented . . .".[17] Since there is some doubt about whether these procedures, particularly psychosurgical procedures, are therapeutic or experimental, the existing provisions of the Act must give cause for grave misgivings.[18]

VI CONCLUSION

When trying to determine whether proceedings are judicial or administrative, it is a useful rule of thumb to look at the consequences which flow from the determination made. Since serious legal effects flow from a section 12(9) detention order, it is argued that section 12(9) procedures are in fact judicial procedures. Section 14 of the Justices Act 1901 (N.S.W.), as amended, adds weight to this argument:

> Every Stipendiary Magistrate, while sitting in the exercise of his jurisdiction under this or any other Act, shall, except in cases where he is acting ministerially, be deemed to be a Court of Petty Sessions with all powers and authorities incident by law to such a Court.

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[14] Mental Health Act 1958 (N.S.W.) s. 109.

[15] *Id.*, s. 108. The Edwards Committee, note 6 *supra*, recommends that a further five psychosurgical procedures be available—amygdalodotomy, hypothalamotomy, temporal lobectomy, electrode implantation, cingulectomy.

[16] Mental Health Act 1958 (N.S.W.) s. 108.

[17] *Id.*, s. 109(2). I have sat through magistrate's inquiries where patients, in every case women, have been in tears begging the magistrate to order the staff not to give them E.C.T.'s.

[18] See, *e.g.*, Report of the Committee of Inquiry into Psychosurgery (N.S.W.) (1977) 10 ff.

So too does section 3(1) of the Evidence Act 1898 (N.S.W.), as amended: " 'Legal proceeding' means any civil or criminal proceeding or inquiry in which evidence is or may be given, and includes an arbitration". If this argument is accepted then a person taken before a magistrate would be entitled to legal representation, to examine and cross-examine witnesses. Hearsay evidence could be attacked, as could be the admissibility of doctor's written recommendations without the doctor's attendance at inquiries. At present magistrate's inquiries do not extend these rights to people appearing before them and they are "riding roughshod" over civil liberties.

At the time of writing, the Mental Health Act is under review (as it has been since 1972) and a number of recommendations have been made to the Minister of Health.[19] The majority of the recommendations are designed to amend the provisions with respect to property control and treatment programs. The only recommendation made with regard to magistrate's inquiries is that the magistrate should, before proceeding with the matter, satisfy himself (to this date it has always been a male) that "due notice" has been given to the relative or friend. Surely this is not enough? The scope of the Act invites abuse. The property provisions allow real hardship. The powers of treatment are arbitrary. The admission and detention procedures seriously threaten the liberty of persons coming within the reach of the operation of the Act. Clearly there is need for legal representation of persons being taken before magistrates under the Mental Health Act.

[19] The Edwards Committee, note 6 *supra*.