First Report of the Committee to Review and Make Recommendations in Regard to the Mental Health Act 1935-1969

Patients in the Receiving Houses and Mental Hospitals of the State of South Australia fall into several categories:

(1) Patients who suffer from some form of mental illness for which they require treatment.

(2) Patients who require oversight and care.

(3) Patients who, because of disturbed and anti-social conduct, require control for their own good or in the public interest.

Category (1) includes the majority of psychiatric patients. Of those who are admitted to units of the Mental Health Services, 80% already seek treatment voluntarily. Some, because of the nature of their illness, are reluctant to have treatment. Under the present Act, such reluctant patients frequently enter hospital under certificate: but, once in hospital, make rapid progress and are then prepared to stay voluntarily. It must be remembered that many similar psychiatric patients are treated without formality in private hospitals and in the wards of general hospitals.

Category (2) comprises the intellectually retarded and the demented elderly. There is little justification for their certification to closed institutions. The geriatric and severely retarded require nursing care, supervision and rehabilitation; the moderately and mildly retarded pose demands for education and training. The majority of intellectually retarded can live at home and in hostels. Many demented old people are cared for in Nursing Homes. Depending on the severity of the condition, the Mental Hospital at present functions like the ward of a general hospital, a nursing home or a hostel.

Category (3) refers to no one medical classification of patients. The unifying feature is the conduct of the individuals concerned. The person may suffer from a psychiatric illness, be intellectually retarded, or elderly. The person may be an example of psychopathic (sociopathic) personality disorder. Such people may be committed to a mental hospital or to the Hospital for Criminal

Mental Defectives. Cases of psychopathic personality most likely end up in gaol. In this category, then, the psychiatric diagnosis has no relevance. Legal requirements take precedence, and the public interest is of primary concern. Detention and control are demanded, and, for this category, the mental institution is looked upon more as a prison than a hospital.

Depending then on the category into which an individual patient falls, the present mental hospital may be comparable with (a) the psychiatric ward of a general hospital; (b) a nursing home; (c) a hostel; and (d) a prison.

The present agitation regarding the lack of safeguard for a patient's rights and the protection of his civil liberties arises from the fact that, under the present Act, a patient may be involuntarily certified to a mental hospital for a condition which falls into any of these categories.

In considering the task set the Committee to review and make recommendations in regard to the existing Mental Health Act, it is important to bear in mind the current trends in the planning of health services. The implications of these for the future Mental Health Services are contained in two significant reports.

First, in the Report of the Committee of Enquiry into Health Services ("The Bright Report"), one of the governing principles involved in the proposals on mental health in paragraph 8.1 reads as follows:

"Integrating mental health services more closely with other health services in hospitals and community health centres".

In paragraph 8.4 the Committee specifically proposes that:

"No more separate psychiatric hospitals should be built and all future hospital psychiatric services should be developed in conjunction with teaching or base hospitals".

Second, in Chapter 5 on "Mental Health Institutions" in the Report on Hospitals in Australia, prepared by the Hospitals and Health Services Commission for the Australian Government, the following recommendations are made:

"(1) decentralised mental health residential facilities should be provided on the basis of a minimal target of 0.5 beds per 1,000 population over the next 5 years for regions lacking mental health residential facilities.

(2) as part of this decentralisation acute and rehabilitation units should be developed adjacent to or as an integral part of general hospitals".

These trends are being incorporated in the plans for existing and planned general hospitals in South Australia. The Modbury Hospital, the planned Para District Hospital and the proposed new Hospital at Whyalla will all have comprehensive psychiatric units designed on the basis of 0.35 beds per 1,000 with additional day-patient and outpatient facilities. The existing mental hospitals will have new and upgraded facilities, but the ultimate number of beds in these institutions will be determined by the facilities provided elsewhere in the hospital and health services. It is clear that, except in exceptional cases, the old dichotomy by which general hospitals treated only voluntary patients and mental hospitals were the repository for involuntary admissions will not be acceptable in the future. Consideration must therefore be given to the provision of the appropriate legal machinery by which patients, under certain circumstances, can be admitted involuntarily to any hospital with adequate facilities to treat them.

The Mental Health Act Review Committee has met on 11 occasions and, as a result of its review of the Mental Health Act 1935-1969, has reached the conclusion that amendment of the present Act would be quite unsatisfactory and that an entirely new Act is required to meet the changed conditions already referred to.

It is recommended therefore that a new Act be framed to replace the present Mental Health Act and that the following considerations should apply:

1. The proposed Act should be in two divisions and provide for
   (a) the treatment and protection of the mentally ill, and
   (b) the care and protection of the mentally handicapped.
   (Mental handicap will be defined to include both intellectual retardation and dementia.)

2. Involuntary admission should apply only to persons suffering from mental illness. For involuntary admission to be justified, the following criteria would have to be met:

   2.1 The patient shall be suffering from a mental illness that is susceptible to treatment and requires treatment urgently; and

   2.2. Such treatment can be obtained only as a result of admission to and detention in a hospital; and

   2.3 The interests of the health and safety of the patient or the protection of other persons cannot be secured otherwise than by such admission and detention.

3. It should be possible to commit a patient as an emergency admission to any hospital which has the facilities to treat his mental illness on the recommendation of a legally qualified medical practitioner. A patient so admitted should not be able to be detained for longer than 72 hours: and following admission the patient must be examined by a registered psychiatrist within 24 hours.

4. The Hospital authorities should have the power to refuse an emergency admission if the receiving doctor could show good reason why the patient should not be admitted or if the person were considered to be not treatable in that hospital, but nonetheless alternative admission must be arranged by the refusing hospital.

5. All hospital authorities should provide for patients and relatives a clear multi-lingual printed statement describing the facilities and provisions of the psychiatric ward; and included in this a clear statement of the patient's legal rights in relation to hospitalisation.

6. Throughout this period emergency treatment should be provided in accordance with medical requirements and in the patient's interests, if possible but not necessarily with the consent of the patient and/or relatives. Such treatment would exclude experimental procedures and psychosurgery. No patient should compulsorily be detained in a hospital unless treatment likely to improve the patient or prevent deterioration were available.

7. It should be possible for the emergency order to be extended by a further 21 days on the authority of a registered psychiatrist, provided that, if the initial emergency order were signed by a registered psychiatrist, the extension of detention could not be authorised by the same psychiatrist.

8. In the event that a patient proved unmanageable in the psychiatric ward of the hospital to which he had been admitted on an emergency order, or in any case after 28 days, if further involuntary detention were considered to be required for the protection of others, a patient would be transferred to another hospital recommended as appropriate for extended care on the authorisation of two registered psychiatrists, or in the absence of two registered psychiatrists one registered psychiatrist and the medical superintendent of the hospital, provided that, if the initial emergency order were signed by a registered psychiatrist, the order for transfer to another hospital could not be authorised by the same psychiatrist.

9. Throughout the period of involuntary admission there should be provision for regular and frequent review procedures, and the patient should have the right of appeal in relation to detention and treatment. Appeal should be to an independent tribunal including a member of the legal profession, a member of the medical profession (but not of the hospital staff) and one other member of the community. No person should have the right to appeal more often than once in every 28 days.

10. The onus of proof that a person is in need of involuntary admission should lie initially with the person seeking to initiate hospitalisation and is discharged by the opinion of a medical practitioner.

11. There should be provision to permit a member of the Police Force to bring a suspected mentally ill person to a place of safety which may be a hospital, or any other suitable place, the occupier of which is willing temporarily to receive the person, but does not include a Police station unless there is no hospital or other suitable place available. At the place of safety, the patient must be examined by a medical practitioner within 12 hours and might then, if recommended by the medical practitioner, be removed to a hospital willing to admit him.

12. Provision should also be made to permit members of the Police Force to accompany and escort patients in an ambulance to the proper hospital.

13. The parts of the Act dealing with the mentally handicapped should be a separate and autonomous division.

14. In this division, no provisions would be required for involuntary admission of a person found to be mentally handicapped. If there were also evidence of mental illness, the patient would be dealt with under the provisions of the other division of the Act.

15. There should, however, be provision for guardianship and/or custodianship of the mentally handicapped child and adult.

16. A tribunal or board, which should be small, should be established to determine questions of guardianship and custodianship of the intellectually retarded child and adult and of the demented child and adult. Mentally handicapped persons thought to be needing special types of care would be referred to the tribunal which would determine whether the person required guardianship and/or custodial care. Where custodianship was required in relation to the management of financial matters or estates, the tribunal should be able to place control of the person's affairs in the hands of the Public Trustee, and also to have the power to nominate a custodian in whose care the mentally handicapped person could be placed.

17. It would be necessary for provision to be made for the mentally handicapped person or his relatives to have the right to appeal to the appropriate Minister against the decision of the tribunal, both in relation to guardianship and custodianship. Should the Minister's decision be regarded as unsatisfactory by the appellant, provision should be made for the right of appeal to the Family Court. The right of appeal to the Family Court should be permitted only once in each calendar year.

18. There does not appear to be any place in the proposed new Act for the provisions contained in Part III, Division II of the present Mental Health Act concerning criminal mental

defectives. Almost all mentally disordered offenders could be dealt with under other legislation. The only type of case for which provision could be made is one in which a mentally handicapped person committed an offence, was unfit to plead and was unlikely to recover. In such a case, the custodianship provisions of the Act could be invoked to bring such a person under care as he would clearly not be suffering from a mental illness which was susceptible to treatment.

If it is considered that a Bill incorporating these considerations should be prepared, it will be necessary for the Committee to do further work in the following areas:

(1) The role of the Public Trustee and changes in legislation considered desirable in view of the new concepts to be incorporated in the Bill;

(2) The need to explore more completely recent views on indications for guardianship and custodianship;

(3) The desirability of making precise recommendations regarding amendments that should be made to the Criminal Law Consolidation Act and other Acts that are concerned with offenders who may be found to be mentally disordered, and to provide for the proper functioning of the Security Hospital, Northfield, in the health services;

(4) The desirability of writing in safeguards against compulsory treatment of involuntary patients.

It is suggested that a discussion paper setting out the provisions of the proposed Act then be prepared and that a seminar be held with representatives of all groups which have been asked to make submissions to the Committee.

The final document to emerge from the deliberations from the seminar would provide the basis for the Bill to be presented to Parliament.

Dr. W.A. Dibden

16/7/75