APPENDIX IV

Second 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.

On the other hand, there will be a need for a secure, specialised unit, similar to the closed ward of the present mental hospital, for the longer term care, treatment and rehabilitation of that relatively small proportion of persons whose mental illness makes further involuntary detention necessary for the protection of others. The designation "maximum care hospital" has been suggested for such a facility.

It is recommended that a new Act be framed to replace the present Mental Health Act. 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.

Involuntary admission should apply only to persons suffering from mental illness.

DIVISION I

The treatment and protection of the mentally ill

1. Nothing in this Division should prevent any person requiring treatment for mental illness from being admitted to any hospital with the facilities for his treatment without any formal application, request, order, direction or certificate rendering him liable to be detained under this Division of the proposed Act, or from remaining in any hospital after he has ceased to be liable so to be detained.

2. 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 requires treatment; 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 24 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. Appeals should be to an independent mental health review 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 than once in every 28 days.

If a patient or relative or any other person or persons regard the decision of the mental health review tribunal to be unsatisfactory, there should be provision for the right of appeal to a Court presided over by a Judge. This right of appeal to a Judge should be permitted only once in each calendar year. Such

appeals should be at no cost to the mentally ill person. However, if the appeal is lodged by a relative or some other person or persons and the Judge considers the basis of the appeal to have been frivolous, costs may be ordered against that person or persons.

10. In the case of patients admitted to the maximum care hospital, there should be provision for the Superintendent of the Hospital, on the recommendation of the psychiatrist responsible for his treatment, to permit a patient to be absent from the hospital on trial leave for up to a maximum period of six months. Any extension of trial leave beyond the initial maximum period of six months must be on the recommendation of the mental health review tribunal.

    There should be provision for the cancellation of trial leave and for the return of the patient to the maximum care hospital.

11. There should be provision to permit a member of the Police Force to convey a person who appears to be in need of treatment and protection because of apparent mental illness or of care and protection because of apparent mental handicap 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 from a place of safety to a hospital as an emergency admission; and to accompany and escort those patients who are to be transferred to another hospital recommended as appropriate for extended care because they prove unmanageable in the psychiatric ward of the hospital to which they have been admitted on an emergency order, or in any case after 24 days, if further involuntary detention be considered to be required for the protection of others.

13. 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. The terms "mentally ill offender" and "mentally ill defendant" should be used instead of the present expression "criminal mental defective". Almost all mentally ill offenders can 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.

    Section 77a of the Criminal Law Consolidation Act should be repealed.

    Section 292 of the Criminal Law Consolidation Act should be amended to give a right of appeal from a verdict of insanity. If the accused does not himself raise the plea of insanity, or if he raises any other plea, which, if accepted, would result in a finding of not guilty, he should have a right of appeal against the finding that he is not guilty on the ground of insanity.

14. It is proposed that the managers of psychiatric rehabilitation hostels could be licensed on the grounds that it would be an offence for the manager to accommodate one or more persons, not being members of the proprietor's family, who are on trial leave from the maximum care hospital to which a person has been committed for the protection of others.

DIVISION II

The care and protection of the mentally handicapped

15. The parts of the Act dealing with the mentally handicapped should be a separate and autonomous Division. These parts would be concerned with those mentally handicapped persons who are socially dependent and deemed in need of care and protection. Mental handicap would include intellectual retardation, chronic mental illness, and dementia from whatever cause.

In this Division, no provision 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 Division I of the Act. There should, however, be provision for guardianship and/or custodianship of the mentally handicapped child and adult.

16. There should be a Guardianship Board consisting of persons appointed by the Governor, one at least of whom should be a legal practitioner, one at least of whom should be a medical practitioner experienced in the diagnosis and care of mental handicap, and three other persons of whom one at least should be a woman.

Mentally handicapped persons thought to be in need of care and protection would be referred to the Guardianship Board which would determine whether the person required guardianship and/or custodial care and make appropriate orders.

The persons who may apply to the Guardianship Board for an order should include the person concerned, his spouse, a relative or friend, the Public Trustee or some other person who satisfies the Board that it is appropriate for him to apply.

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 a Court presided over by a Judge. The right of appeal to a Judge should be permitted only once in each calendar year.

18. The Public Trustee is the appropriate Department to be responsible for the control of property of those certified to be unable to manage their affairs.

Any person who is certified by a specialist psychiatrist to be incapable of managing his affairs through mental illness or mental handicap, however occasioned, should be entitled to have the Public Trustee take over the financial management of his estate.

Many cases involving the management of the property of mentally ill or mentally handicapped persons arise out of circumstances such as the gradual incapacity of the aged. In addition to requesting the Public Trustee to take action, provision should also be made for a person who is not incapable of managing his affairs to appoint someone to assume that responsibility in the future. The power should not be invalidated by the subsequent incapacity of the donor.

There should be provision for the reversal of this procedure whereby the application requesting the Public Trustee to take action can be withdrawn on the certificate of a psychiatrist that the person is capable of managing his own affairs.

Where it appears to the Guardianship Board that a person is incapable of managing his affairs through mental handicap, however occasioned, the Board should be empowered to make orders for the financial management of his property and to appoint the Public Trustee to manage the estate of that person. This should not be exhaustive; where the Board considers that such an order would not be proper or would not be in the best interests of the mentally handicapped person, it should be able to make such other orders as it sees fit.