HUMAN RIGHTS COMMISSION

REPORT NO. 2

PROPOSED A.C.T. MENTAL HEALTH ORDINANCE 1981

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29 October 1982

The Hon. N. A. Brown, Q. C. , M.P.
Acting Attorney-General
Parliament House
Canberra, A.C.T. 2600

Dear Minister,

Pursuant to paragraph 9(1)(a) and sub-section 16(1) of the *Human Rights Commission Act* 1981 this report is presented to you following the Human Rights Commission's examination of the proposed A.C.T. Mental Health Ordinance.

Yours sincerely,

Chairman
for and on behalf of the
Human Rights Commission

Members of the Human Rights Commission

Chairman

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THE FUNCTIONS OF THE COMMISSION

Section 9 of the *Human Rights Commission Act* 1981 reads: 9. (1)

The functions of the Commission are —

(a) to examine enactments, and (when requested to do so by the Minister) proposed enactments, for the purpose of ascertaining whether the enactments or proposed enactments are, or would be, inconsistent with or contrary to any human rights, and to report to the Minister the results of any such examination;

(b) to inquire into any act or practice that may be inconsistent with or contrary to any human right, and —

(i) where the Commission considers it appropriate to do so — endeavour to effect a settlement of the matters that gave rise to the inquiry; and

(ii) where the Commission is of the opinion that the act or practice is inconsistent with or contrary to any human right, and the Commission has not considered it appropriate to endeavour to effect a settlement of the matters that gave rise to the inquiry or has endeavoured without success to effect a settlement of those matters — to report to the Minister the results of its inquiry and of any endeavours it has made to effect such a settlement;

(c) on its own initiative or when requested by the Minister, to report to the Minister as to the laws that should be made by the Parliament, or action that should be taken by the Commonwealth, on matters relating to human rights;

(d) when requested by the Minister, to report to the Minister as to the action (if any) that, in the opinion of the Commission, needs to be taken by Australia in order to comply with the provisions of the Covenant, of the Declarations or of any relevant international instrument;

(e) on its own initiative or when requested by the Minister, to examine any relevant international instrument for the purpose of ascertaining whether there are any inconsistencies between that instrument and the Covenant, the Declarations or any other relevant international instrument, and to report to the Minister for the results of any such examination;

(f) to promote an understanding and acceptance, and the public discussion, of human rights in Australia and the external Territories;

(g) to undertake research and educational programs, and other programs, on behalf of the Commonwealth for the purpose of promoting human rights and to co-ordinate any such programs undertaken by any other persons or authorities on behalf of the Commonwealth;

(h) to perform —

(i) any functions conferred on the Commission by any other enactment;

(ii) any functions conferred on the Commission pursuant to any arrangement in force under section 11; and

(iii) any functions conferred on the Commission by any State Act or Northern Territory enactment, being functions that are declared by the Minister, by notice published in the Gazette, to be complementary to other functions of the Commission; and

(j) to do anything incidental or conducive to the performance of any of the preceding functions.

(2) The Commission shall not —

(a) regard an enactment or proposed enactment as being inconsistent with or contrary to any human right for the purpose of paragraph (1) (a) or (b) by reason of a provision of the enactment or proposed enactment that is included solely for the purpose of securing

adequate advancement of particular persons or groups of persons in order to enable them to enjoy or exercise human rights equally with other persons; or

(b) regard an act or practice as being inconsistent with or contrary to any human right for the purpose of paragraph (1) (a) or (b) where the act or practice is done or engaged in solely for the purpose referred to in paragraph (a).

(3) For the purpose of the performance of its functions, the Commission may work with and consult appropriate non-governmental organizations.

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1. INTRODUCTION

(a) Background

1. The Human Rights Commission has examined the proposed Mental Health Ordinance for the A.C.T. as requested in the Attorney-General's letter of 21 June 1982 (text at Appendix 1).

2. The proposed Ordinance, which represents the result of a decade of draft proposals and community discussion, has nevertheless proved to be extremely controversial. An earlier inquiry by the Standing Committee on Welfare of the A. C. T. House of Assembly received twenty-nine written submissions representing a wide variety of views ranging from those urging immediate implementation to those requesting total redrafting. A summary of these submissions was made available to the Commission.

3. By June 1982, when the proposed Ordinance was referred to the Commission, two main areas of disagreement remained. One involved a definition which bracketed the intellectually handicapped with the mentally ill. The other related to the civil liberties aspects of the proposed legislation. Both of these areas fall within the mandate of the Human Rights Commission.

(b) Human Rights

4. Human rights are defined in the *Human Rights Commission Act* 1981 as the rights and freedoms recognised in the International Covenant on Civil and Political Rights (ICCPR) and in the Declarations of the Rights of the Child, on the Rights of Mentally Retarded Persons and on the Rights of Disabled Persons. This review is thus focused on the rights defined in these documents. Articles of particular relevance to the proposed Mental Health Ordinance are set out in Appendixes 2 to 4.

5. The Declaration on the Rights of Disabled Persons provides that disabled persons 'have the same fundamental rights as their fellow-citizens of the same age' (paragraph 3). This means that the fundamental rights of those who are mentally ill should not be reduced or modified simply on the ground of mental illness.

(c) Consultations

6. In inquiring into the proposed Ordinance the Commission has held discussions with the Capital Territory Health Commission, the Australian Federal Police and a range of groups and organisations representing the mentally ill, the mentally handicapped and those who have to deal with the mentally disturbed in their day-to-day work. A draft report on the Ordinance was circulated to some 150 individuals and organisations for comment. A list of those who responded is attached at Appendix 5 and the major points raised by the commentators are summarised at Appendix 6. In addition, the proposed Ordinance was discussed by a group during a consultation which the Commission held with twenty-seven A. C.T. non-government organisations on 29 September 1982.

7. It is hardly to be expected that proposals fully satisfactory to all interests could be devised. Nevertheless, the Commission believes that if the proposals recommended in this report are adopted, none of the groups consulted would retain any basic objections, and that the A.C.T. groups who have to live with the existing highly

unsatisfactory situation all appear to be prepared to accept the Ordinance, thus revised. The Commission thanks most warmly all those organisations and individuals who assisted its inquiries. It also thanks the staff involved, and particularly its principal project officer, Dr Helen Ware.

8:. , The Commission emphasises that the tentative redrafts it circulated for discussion and which it has included in this report are designed to elucidate the problems. They are not attempts at final drafting, but are intended to indicate as precisely as possible the object and function of each proposal.

II. REVIEW OF THE PROPOSED MENTAL HEALTH ORDINANCE

(a) Significant Issues

9. Following consideration of the draft Mental Health Ordinance (excerpted in Appendix 7) by the A.C.T. House of Assembly, changes were proposed to the Ordinance. These are contained in a letter dated 1 June 1982 from the Health Commission to the Secretary of the Attorney-General's Department (Appendix 8). The Human Rights Commission has considered the draft Ordinance as if it incorporates those changes.

10. The Mental Health Ordinance is essentially designed to provide a means for placing mentally disordered persons in the care of mental health authorities. These mechanisms of control are designed to be distinct from, and in large part an alternative to, the procedures associated with the criminal law. However, from a human rights point of view the mental health procedures should in no case accord less protection than is available to persons charged with criminal offences or held in detention. This point has been well made by the European Court of Human Rights.' Both the ICCPR and the Declaration on the Rights of Disabled Persons are relevant. There are fundamental safeguards provided by the ICCPR, especially by Articles 9 and 14, to ensure that the person detained knows and understands the reason for the detention; that there is a fair hearing at an early date and opportunity for review; and that there is provision for representation of a person detained. Such safeguards must be fully incorporated into the Mental Health Ordinance.

11. The Commission recognises that, from the start, the proposed Ordinance has incorporated several valuable protections of human rights. Following the public debates of earlier this year, several further safeguards, such as the 72 hour limit upon emergency procedures, will be incorporated. The Commission welcomes these built-in protections, and notes that in some cases they have been misunderstood, being seen as measures to restrict freedom rather than protect it. Accordingly, the Commission has concluded that its primary task is to endeavour to carry out some relatively fine tuning in order to ensure that the provisions of the ICCPR and paragraphs 3 and 4 of the Declaration on the Rights of Disabled Persons are fully implemented.

12. The Ordinance has to deal with three groups of persons:

(a) those who are mentally dysfunctional to varying degrees but still capable of making decisions on their own behalf;
(b) those who are mentally dysfunctional to the point where they are incapable of making decisions;
(c) those who are incorrectly considered to be mentally dysfunctional.

It is necessary to ensure that the rights of all three groups are fully protected.

13. Complex questions are involved, and in most cases two or more rights may be in conflict. Arguments for more rather than less protection of the disabled person tend to be based upon Article 25 of the Universal Declaration of Human Rights (1948) and the International Covenant on Economic, Social and Cultural Rights (which Australia has ratified) which state that everyone has the right to an adequate standard of living for himself and his family, including food, clothing, housing and medical care and necessary social services.

See *Wintwerp V. The Netherlands (1979)* 2 EHRR 387

14. However, the Declaration and the Covenant do not address the issue of an individual's right to refuse medical treatment. The civil rights case is exemplified by the requirement in the ICCPR that every individual is to enjoy, without discrimination, the right to life; to liberty and security of person; to freedom from arbitrary arrest; to freedom from torture or cruel, inhuman or degrading treatment or punishment; and to freedom from medical or scientific experimentation without his free consent (Articles 2, 6, 9, 8 and 7 respectively).

15. Some consider that individuals should in the end be forced to accept medical care for their own good; others maintain that the right of autonomy extends to include the insane, even if injuries follow. After prolonged consideration of the issues involved and of the provisions of the relevant international instruments, the Commission takes a middle view, believing that conflicting rights have to be weighed and that neither extreme paternalism nor an extreme *laissez-faire* position is appropriate. In other words, there are some situations where the State should intervene to protect the individual from himself/herself, but such situations are very rare. The recommendations made by the Commission are based on the propositions that:

(a) the fact that a person wishes to commit suicide is not in itself evidence of mental illness;

(b) a sane person should not be prevented from committing suicide by the compulsory provisions of the Ordinance;

(c) it is permissible to restrain persons who are mentally ill from committing suicide or from self-mutilation because the likelihood is that they would not have chosen this course of action in the absence of the mental illness;

(d) in order to prevent serious harm to other people, it is permissible to restrain all persons — whether mentally ill or not — although the measures of restraint can with advantage be different for the mentally ill: this is in effect one of the main purposes of the Mental Health Ordinance;

(e) because of the seriousness of the invasion of liberty involved in restraint and compulsory treatment, this can only be justified in extreme cases and for limited periods of time under multiple safeguards. Except in these extreme cases, paternalistic arguments of intervening for the individual's own good should not prevail;

(f) whilst it may be highly distressing for relatives, friends and the community to watch the individual suffer, compulsory intervention at an early stage to relieve that distress should not, in the Commission's view, be permitted.

The statement in (b) does not require a policeman or bystander seeing someone about to jump off a cliff to determine their mental state before intervening. Clearly intervention should come first.

16. The central human rights issues which are raised by the proposed Mental Health Ordinance in its revised form (see paragraph 10 above) are:

(a) to which persons the Ordinance should apply, involving primarily the definitions to be used;

(b) what safeguards should surround the emergency procedures and the making of treatment orders;

(c) when, if at all, the special procedures of convulsive therapy and psychiatric surgery should be allowed without informed consent.

17. Owing to the basic structure of the Ordinance it is more meaningful to consider issues (a) and (b) together. Indeed, many of the misunderstandings associated with the Ordinance have resulted from not recognising that it is designed to define *limited* groups of persons in respect of whom treatment orders can be issued.

(b) Definitions, Safeguards and Treatment Orders

18. The central provision of the draft Ordinance is section 27. Having in mind the need both to protect civil liberties and to avoid discrimination against mentally retarded persons, the Commission believes in overall tightening of the provisions of section 27 to be desirable. This would minimise the possibility of unwarranted restraints without reducing the availability of treatment orders where they are urgently and genuinely needed.

19. Proposed section 27, which lays down the requirements for the making of treatment orders, reads as follows:

> 27. Where, on an application for a treatment order made under this Part, the Court is satisfied that —
>
> (a) the person in relation to whom the application is made is suffering from mental dysfunction;
>
> (b) by reason of that mental dysfunction —
>
> (i) the person has engaged, or is likely to engage, in behaviour that has resulted or is likely to result in harm to himself or to another person;
>
> or
>
> (ii) the person is in a state of social breakdown; and
>
> (c) the person has refused, or is not likely voluntarily, to undergo, or to co-operate in, adequate treatment for the mental dysfunction,
>
> the Court may make a treatment order in respect of the person.

20. The Ordinance thus provides that three conditions must be complied with before a person may become the subject of a treatment order:

(a) mental dysfunction;
(b) harmful behaviour *or* social breakdown;
(c) refusal of treatment.

21. *(i) Mental Dysfunction.* Mental dysfunction in the draft Ordinance is defined thus:

> 'Mental dysfunction' means a disturbance or defect to a disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation, emotion or of some other mental function.

This definition does not specify the degree of disablement involved, and contains a final catch-all phrase. It is thus capable of extremely broad interpretation, although it needs to be kept in mind that it is only operative in conjunction with harmful behaviour or social breakdown and refusal of treatment. In the Commission's view — and it understands this to be the intention — the definition should not cover the mentally retarded unless they are likely to harm themselves or others or are in a state of social breakdown.

22. In the official World Health Organisation (WHO) definition adopted for the International Year of Disabled Persons (IYDP) in Australia:

> • . . a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

Clearly, this covers almost all degrees of restriction, however slight, and hence the term 'disabling degree' requires qualification. The Commission therefore proposes that:

> **(1) The definition of mental dysfunction should be amended to make it clear that the disturbance or defect must be severely disabling and to omit the imprecise reference to 'some other mental function'.**[2]

Inclusion in the proposed definition of the final catch-all phrase makes it circular, as does the standard 'mentally ill person means a person who owing to mental illness requires care . . .'[3] It also removes any requirement to specify the form of mental dysfunction involved, which could make it extremely difficult for the individual concerned to deny that he or she is suffering from mental dysfunction.

23. (ii) *Harmful Behaviour.* Similarly, in respect of the second proposed condition,' the Commission considers it would be preferable to qualify the degree of harm required before an order could issue. This would remove from the ambit of treatment orders mentally retarded persons who are not violent or in a state of social breakdown. The Commission therefore recommends that:

> (2) **Sub-paragraph (bXi) should be revised so that the second pre-condition for treatment without informed consent would require:**
>
> **(a) a *high degree of probability* (rather than simply a likelihood) that the person will engage in the behaviour; and**
>
> **(b) behaviour that will result in *death or serious harm* (rather than harm).**

Thus this provision would only cover grievous violence towards others or oneself, and attempted suicide. It would not cover self-neglect nor the pursuit of a life-style inimical to the individual's long-term welfare.

24. Some concern has been expressed that the requirement that 'the person has engaged . . . in behaviour' is unduly vague as to time-frame and would cover acts performed years previously. The Commission proposes that:

> (3) **The redrafting should tighten up this provision to make it clear that it refers only to current behaviour at the time of application for a treatment order and that only reasonably recent past history should be taken into account.**

25. (iii) *Social Breakdown.* The Commission has had the greatest difficulty in reaching a conclusion as to the desirability of including a social breakdown clause in the Ordinance.' Finally it was a majority decision that the inclusion of a tightened-up social breakdown clause would constitute a humane welfare provision for the cases specified, while not unduly infringing the rights of the individual to respect and to liberty of person. Such a clause would allow treatment to be given to persons suffering from severe schizophrenia or depression or senile dementia without resorting to a stretching of sub-paragraph (b)(i) relating to violence. The majority would see the provision operating, with paragraph (a), only where there was clear inability to maintain minimal physical functioning.

26. One important reason for the inclusion of a social breakdown clause is the fact that some individuals who are apparently mentally ill are unknowingly suffering from readily identifiable physical illnesses which result in mental symptoms. A

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[2] The Commission notes that in this and the following paragraphs its proposals for change are intended to illustrate succinctly the objectives it has in mind. They are not to be regarded as precise drafting proposals. See also paragraph 8 above.

[3] See, for example, the definition in section 5 of the South Australian Mental Health Act, 1976-1977.

[4] Sub-paragraph 27(b)(i) of the draft Ordinance: see paragraph 19 above.

[5] Sub-paragraph 27(b)(ii) in the draft Ordinance, quoted at paragraph 19 above.

treatment order would allow the discovery of such physical illness. Indeed, a thorough examination for physical illness should be a right of all persons under treatment orders.

27. If the social breakdown clause were to be omitted, many of the individuals involved would most probably be imprisoned under A .C.T. vagrancy legislation, which is far from representing an enlightened way of dealing with persons who are mentally ill, intellectually handicapped or chronically depressed to the point where they cannot secure the necessities of life.

28 The minority of the Commission believe that the proposed social breakdown clause should be struck out so that only violent forms of behaviour causing or highly likely to cause death or serious harm would be covered. Their view is that any breakdown clause could lead to individuals being given treatment without consent and that this violates their liberty of person. Having no social breakdown clause would also avoid any possible abuses of the legislation as a form of social control against 'no-hopers', derelicts and other social outcasts.

29. The Commission is of the view that in any definition of social breakdown the grounds for interference need to be especially strong and to be based upon verifiable facts rather than subjective judgments. This could be achieved by *coupling* sub-paragraphs (a) and (b) in the definition', rather than having them as alternatives, and by equating the harm to the person involved with that in sub-paragraph (i), the violence clause (see paragraph 23 above).

30. To this end, the Commission suggests amendment of the proposed definition of the term 'social breakdown' which appears in sub-paragraph (b)(ii) to make it clear that:

> **(4) Social breakdown. . . require(s) proof of incapacity to obtain and use the goods and services essential to the support of life; and to make the decisions and take the actions essential to an autonomous life. The degree of incapacity should result in the person being in a state of severe distress or physical, material or emotional deprivation such as, with a high degree of probability, will cause death or long-term and serious harm to the person.**

31. (iv) *Consent.* Paragraph (c) of proposed section 27[7] requires that the third condition to be fulfilled before a treatment order can be issued is that 'the person has refused, *or is not likely voluntarily* [Commission's italics], to undergo, or to co-operate in, adequate treatment . . . This involves a subjective assessment of a person's likely state, which the Commission believes should not be made. The Commission therefore recommends that the paragraph should be redrafted to remove the subjective element 'not likely' and that the proposed section 36 be tightened to ensure that all treatment orders are reviewed at least annually after the initial order by the Supreme Court.' This could be done by making it clear that:

> (5) (a) **Each individual must be asked whether he or she is willing to consent to treatment.**
>
> **(b) A treatment order should only be issued when there has been —**
>
> - **a clear refusal of treatment;**
> - **repeated postponement of treatment, which amounts to refusal; or**
> - **refusal to comply with a course of treatment**
>
> **and that any order made by the Supreme Court should not exceed 12 months.**

[6] The proposed definition — in section 4 of the draft Ordinance — is quoted at Appendix 7.

[7] Quoted at paragraph 19 above.

[8] For further discussion of the importance of informed consent, see paragraphs 35-41 below.

[9] See sub-section 36(31 of the proposed Ordinance.

32. (v) *Freedom of Opinion.* There are, particularly in controversial cases, risks in assessing the degree of aberration a person has. To avoid confusion between the protestor and the mentally dysfunctional, the Commission believes –

> **(6) A freedom of opinion provision based on section 4 of the Northern Territory Mental Health Act should be included.**

Section 4(ii) of that Act provides that:

> (ii) A person shall not be considered to be a mentally ill person by reason only that he expresses or refuses or fails to express a particular political, anarchic, religious, irreligious, legal, illegal, moral, or immoral opinion or engages in or refuses or fails to engage in a particular political, anarchic, religious, irreligious, legal, illegal, moral or immoral activity.

Whilst a less wordy version would be preferable, its central points should be incorporated in the Ordinance. The Commission understands that a similar provision, which also covers sexual preference, has been recommended for inclusion in the New South Wales legislation, which is now under revision.

33. Whilst in a perfect world, or even possibly in twentieth century Australia, such a provision should not be necessary, the ICCPR provides for special protection for political and religious freedom and freedom of expression. The insertion of a provision such as the Northern Territory already has would be consonant with the ICCPR and would demonstrably provide protection to persons with unorthodox views protesting in the national capital. Further, the Commission is aware of at least one instance in which there was considerable pressure to commit an individual under the mental health legislation because of his dramatic way of stating his political views. We consider the clause would be a desirable reassurance to those concerned with civil liberties in an age of protest.

34. It has been suggested that the freedom of opinion clause might also make it clear that intellectual handicap does not in itself constitute mental dysfunction. It is the Commission's view that such an amendment is on balance undesirable: legally, the intellectually handicapped will not come within the purview of the Ordinance unless all three of the conditions are fulfilled. Excluding them would leave them with nowhere to go but prison if violent behaviour made it impossible for them to remain where they were, and it is the Commission's view that this would be a disadvantage for them. It should be noted that the proposed tightening up of the definition of mental dysfunction will exclude the mildly intellectually handicapped. For the severely intellectually handicapped, laying down strict criteria for treatment without consent appears to be the best course.

(c) Treatment without Consent

35. *(i) Convulsive Therapy (ECT).* Section 45 of the draft Ordinance provides that electro-convulsive therapy (defined as a procedure for the induction of an epileptiform convulsion) may only be administered with the consent of the person concerned or, if the person is subject to a treatment order, when the Director has applied for and a court has approved the treatment. The court may only approve if satisfied that the therapy will result in a substantial benefit to the person, that no other treatment will result in the same degree of benefit and that the person is, by reason of mental dysfunction, incapable of making for himself a decision whether or not to undergo the therapy. A capable person may refuse and that refusal will prevent the treatment being given.

36. The Commission has discussed a number of alternatives for administration of electro-convulsive therapy without the consent of a person detained under a treatment order. The alternatives are that:

(a) The treatment should *not* be allowed in any circumstance.

(b) The treatment should *only* be allowed under the same protections as provided for psychiatric surgery in the draft Ordinance.

(c) The treatment should be allowed under the conditions set out in the draft Ordinance but with added provisos that the court should ensure that electro-convulsive therapy does not become a standard practice and that it should obtain a second opinion from an independent specialist medical practitioner before approving the treatment.

37. The Commission favours option (c), provided there is careful control and review of the practice in the interests of patients, that voluntary consent is given in the presence of an independent third party [10] and that the treatment is given only where there is no other form of treatment reasonably available that is likely to result in the same degree of benefit to the person.

38. The Commission considers, given the public concern over ECT treatment, that the court should be fully satisfied that strict medical, legal and ethical requirements have been met. It therefore recommends that:

> (7) Section **45 of the proposed Ordinance should be amended to provide that electro-convulsive therapy should only be administered without consent if, in addition to the safeguards there provided, the court is required to obtain an opinion from an independent specialist medical practitioner as to the desirability of the treatment.**

39. (ii) *Psychiatric Surgery.* Part VII of the Ordinance places controls on all psychiatric surgery. Psychiatric surgery is defined as surgery, other than neurosurgery, which alters the function of the brain for the purpose of treating mental dysfunction. For all potential subjects of psychiatric surgery, the main controls included in the draft Ordinance are that:

(a) The patient must consent in writing.

(b) A committee of specialists (section 49) must consider and recommend the surgery.

(c) The Director must approve.

It is important to note that because of the seriousness of psychiatric surgery, consent is required whether or not the person is under a treatment order. Provided the person is capable, refusal to consent will prevent the treatment being given. It is *only* where the person is incapable of consenting in writing to the surgery that the court may allow a medical practitioner to process an application through the specialist committee to the Director, and then only provided it is satisfied the person will benefit from the surgery and that there is no effective alternative.

40. The Commission is equally divided on the issue of psychiatric surgery for those incapable of giving consent. One group within the Commission accepts the treatment as potentially helpful in rare cases and as a treatment of last resort. The other group considers psychiatric surgery a treatment so severe that allowing it to be administered without consent could be held to constitute 'cruel, inhuman or degrading treatment or punishment' in terms of Article 7 of the ICCPR. This group notes that the scientific basis for the efficacy of such treatment is not yet fully accepted.

[10] See recommendation 8. at paragraph 41 below.

II Section 55 of the proposed Ordinance.

(8) Consent to ECT[12] or psychiatric surgery should be in writing in the presence of an independent third party, e.g. a chaplain or social worker.

As further protections the Commission recommends inclusion in section 55 of an additional requirement to the effect that:

(9) The court must be satisfied that psychiatric surgery is a treatment of last resort, to be used only when it is clear that less drastic alternatives have failed or will not succeed;

and inclusion of an additional safeguard in the form of a requirement that:

(10) The court, in determining whether the surgery is for the benefit of the individual, should not take into account the interests of the broader community.

41. However, the Commission is agreed that *if* the Ordinance is to provide for psychiatric surgery, the procedure provided for in the draft Ordinance already offers very full protection both to volunteers and to those who are incapable of giving consent. However, it considers that the following additional safeguards should be added:

42. (iii) *The Patient's Friend.* Persons who are the subject of emergency procedures and treatment orders are by that fact likely to be disordered, incapable in some ways, and alarmed, excitable, disturbed and frightened. In these circumstances, it seems essential that there be access to at least one person not identified with the authorities (departmental, professional and legal) nor perceived by the patient to have any interest other than that of the patient.

43. Under section 29(1) of the proposed Ordinance, the court may direct an application for a treatment order to be served on another person to protect the interests of the patient. Further, under section 33, a prescribed relative *may* be present at the hearing of an application if this is requested by the patient, and under section 34 the court may direct that an appropriate person be informed of any order it makes.

44. While these provisions are helpful, the Commission believes broader arrangements should be made to provide for a 'patient's friend' where the individual either does not have prescribed relatives resident in Canberra or in Australia or does not have prescribable relatives whom he or she wishes to trust. A need for (and a right to) such a person is recognised in the Declaration on the Rights of Mentally Retarded Persons (paragraph 5: `. . . a qualified guardian. . . to protect [the patient's] well-being and interests'). The practice of recognising a 'friend' has long been customary in court proceedings involving minors and other types of persons likely to find it difficult to defend their own interests.

45. The most harassing time would be when emergency procedures are enforced. Therefore the medical health officer or medical practitioner should be required, before detention if practicable, but in any case as soon as possible after detention, to identify and notify the patient's friend and to arrange for the friend to be present as soon as possible. It also seems essential that the friend be notified of an application for a treatment order, and attending the hearing.

46. All this suggests that every patient should have the right to nominate a 'prescribed friend' who may stand in all the positions where 'prescribed relative' is named in the draft Ordinance. A problem will remain where the patient is not able to nominate a 'prescribed friend'. One obvious case is where the patient does not have a good grasp of English. A 'prescribed friend' who has to be nominated on behalf of the individual should be able to speak the first language of the patient, be acceptable to the patient and be able and available to provide assistance.

[12] See also paragraph 37 above.

47. The Commission suggests that:

(11) The definition of 'prescribed relative' in section 4 should be extended to include a 'prescribed friend' who would need to be notified at the stages and in the circumstances mentioned in paragraphs 44-46 above and when changes were being made in treatment arrangements.

48. (iv) A *Court Observer*. In the making of treatment orders, some concern has been expressed that the court may in effect become a rubber stamp, particularly as it is to be closed on such occasions. Magistrates are not experts in mental dysfunction and will have to rely heavily upon the testimony of expert witnesses, and these may have a natural preference for treatment.

49. Proposed section 32, which entitles the individual to legal representation, gives some protection at a court hearing, as does section 33(e), which envisages the presence of the 'prescribed friend'. The Commission considers, however, that opening the court but requiring that no person should be named — as recommended by the A. C. T. House of Assembly — may be unsuitable, given the degree of distress likely to be experienced by some individuals if subject to a full formal court procedure.

50. Accordingly, the Commission suggests, in addition to the protections in sections 32 and 33, that:

(12) It would be appropriate to provide for an independent observer to have the right to be present in the court, to watch over not only the rights of the individuals concerned but also the way in which the court functions in general and handles human rights issues balancing between civil liberties and welfare considerations. To this end, the Ordinance should provide that a representative of an independent agency or, if necessary, of the Human Rights Commission be amongst those specified in section 33 as entitled to be present at the hearing of an application for a treatment order.

51. (v) A *Statement of Rights.* As a further protection, the Commission recommends that:

(13) Each individual taken in under the emergency procedures in respect of whom a treatment order is then sought should be provided with a printed statement of rights under the Ordinance in an understood language. The statement of rights should be available on request to the general public.

Experience with the provision of a statement of rights under the South Australian Mental Health Act, 1976-1977 has shown that it serves to allay fears and to inform patients how they can appeal.

52. (vi) *Use of Psychotropic Drugs.* The Commission has received a number of submissions to the effect that the Ordinance should regulate the administration of psychotropic drugs and inhumane physical treatments contrary to Articles 7 and 10 of the ICCPR. Whilst drug regimes may on occasions be abused, there appears to be no obvious practical way of regulating their use. It is, however, suggested that the Ordinance should impose a duty of care similar to the provision in Section 9(cc) of the South Australian Mental Health Act, 1976-1977. Thus the Commission recommends that:

(14) The Director and the Health Commission should be placed under a statutory obligation to minimise restrictions upon the liberty of patients, and interference with their rights, dignity and self-respect, so far as is consistent with the proper protection and care of the patients themselves and with the protection of the public.

III. RELATED ISSUES

53. No piece of legislation can reasonably be viewed entirely in a vacuum divorced from other legal provisions. In the course of its inquiries into the Mental Health Ordinance the Commission's attention has been drawn to a number of associated human rights issues which would require changes in other areas of the law. These include:

(a) the repressive nature of vagrancy law in the A.C. T.;
(b) the need for modern provisions for Guardianship for mentally retarded adults in the A.C.T.;
(c) the position of minors who are mentally dysfunctional;
(d) the position of those mental health patients who will still need to be transferred between the A.C.T. and the States; and
(e) the fate of residents of the A.C.T. who are found not guilty on the grounds of insanity.

54. The Commission has already decided to contract out a study of possible guardianship provisions for the A.C.T. as a part of its research program.

55. There are two other areas for co-ordination, although not directly involving legal issues. One concerns the Health Commission's power to license private mental health facilities. There is currently a move towards standardised accreditation for such institutions and it would be unfortunate if no provision were made for the A.C.T. to be part of this movement. There might also be a denial of the mentally retarded person's right to education (paragraph 2 of the Declaration) if the licensing requirements were to be exclusively medical and to ignore the educational requirements of such persons. The other concerns the need for co-ordination between the police and the Health Commission in handling violent or potentially violent individuals who are mentally dysfunctional and in handling cases of social breakdown.

IV. RECOMMENDATIONS

(1) The definition of mental dysfunction should be amended to make it clear that the disturbance or defect must be *severely* disabling and to omit the imprecise reference to 'some other mental function' (paragraph 22).

(2) Sub-paragraph (b)(i) should be revised so that the second pre-condition for treatment without informed consent would require:

(a) a *high degree of probability* (rather than simply a likelihood) that the person will engage in the behaviour; and

(b) behaviour that will result in *death or serious harm* (rather than harm) (paragraph 23).

(3) The redrafting should tighten up this provision to make it clear that the provision refers only to current behaviour at the time of application for a treatment order and that only reasonably recent past history should be taken into account (paragraph 24).

(4) Social breakdown should be defined to require proof of incapacity to obtain and use the goods and services essential to the support of life; *and* to make the decisions and take the actions essential to an autonomous life. The degree of incapacity should result in the person *being in a state* of severe distress or physical, material or emotional deprivation *such as, with a high degree of probability, will cause death or long-term and serious harm to the person* (paragraph 30).

(5) (a) Each individual must be asked whether he or she is willing to consent to treatment.

(b) A treatment order should only be issued when there has been —

- a clear refusal of treatment;
- repeated postponement of treatment, which amounts to refusal; or
- refusal to comply with a course of treatment

and that any order made by the Supreme Court should not exceed 12 months (paragraph 31).

(6) A freedom of opinion provision based on section 4 of the Northern Territory Mental Health Act should be included (paragraph 32).

(7) Section 45 of the proposed Ordinance should be amended to provide that electro-convulsive therapy should only be administered without consent if, in addition to the safeguards there provided, the court is required to obtain an opinion from an independent specialist medical practitioner as to the desirability of the treatment (paragraph 38).

(8) Consent to ECT or psychiatric surgery should be in writing in the presence of an independent third party, e.g. a chaplain or social worker (paragraphs 37 and 41).

(9) The court must be satisfied that psychiatric surgery is a treatment of last resort,

to be used only when it is clear that less drastic alternatives have failed or will not succeed (paragraph 41).

(10) The court, in determining whether the surgery is for the benefit of the individual, should not take into account the interests of the broader community (paragraph 41).

(11) The definition of 'prescribed relative' in section 4 should be extended to include a 'prescribed friend' who would need to be notified at the stages and in the circumstances mentioned in paragraphs ill 16 above and when changes were being made in treatment arrangements (paragraph 47).

(12) It would be appropriate to provide for an independent observer to have the right to be present in the court, to watch over not only the rights of the individuals concerned but also the way in which the court functions in general and handles human rights issues balancing between civil liberties and welfare considerations. To this end, the Ordinance should provide that a representative of an independent agency or, if necessary, of the Human Rights Commission be amongst those specified in section 33 as entitled to be present (paragraph 50).

(13) Each individual taken in under the emergency procedures in respect of whom a treatment order is then sought should be provided with a printed statement of rights under the Ordinance in an understood language. The statement of rights should be available on request to the general public (paragraph 51).

(14) The Director and the Health Commission should be placed under a statutory obligation to minimise restrictions upon the liberty of patients, and interference with their rights, dignity and self-respect, so far as is consistent with the proper protection and care of the patients themselves and with the protection of the public (paragraph 52).

APPENDIX 1

Correspondence with the Attorney-General

2 March 1982

Senator the Hon. Peter Durack, Q.C.
Attorney-General
Parliament House
Canberra, A.C. T. 2600

Dear Attorney-General,

The Commission has received a number of complaints from organisations and individuals in the A.C.T. relating to the provisions of the draft Mental Health Ordinance 1981 which is to apply in the Australian Capital Territory.

In the normal course, the Commission would have followed up the complaint pursuant to section 9(1)(b) of the Act. However, it is doubtful whether a draft Ordinance falls within the definition of an 'act or practice' and in any case paragraph 9(1)(a) provides that the Commission may examine proposed enactments in effect only when requested to do so by the Minister.

The draft Mental Health Ordinance appears to raise a number of general human rights issues, as for example in connection with the provisions on emergency detention and treatment orders. It also raises a problem of special relevance in its definition of 'mental dysfunction' because of the annexure of the Declaration on the Rights of Mentally Retarded Persons to the Human Rights Commission Act.

The Commission is of the view that there could be advantage in an examination of the provisions of the draft Ordinance before it is enacted. It accordingly would be grateful if you felt able to request it to examine the Ordinance for the purpose of ascertaining whether it would be inconsistent with or contrary to any human rights and to report to you the results of its examination.

Yours sincerely,

P.H. Bailey
Deputy Chairman

Attorney-General
Parliament House
Canberra, A. C.T. 2600

21 June 1982

Mr P. H. Bailey, 0.B. E.
Deputy Chairman of the
Human Rights Commission
P.O. Box 629
Canberra City, A . C . T. 2601

Dear Mr Bailey,

I refer again to your letter of 2 March 1982 seeking a request from me to the Human Rights Commission to examine the draft Mental Health Ordinance for the Australian Capital Territory pursuant to section 9(1) (a) of the Human Rights Commission Act 1981.

I have approved your proposal and pursuant to section 9(1) (a) of the Human Rights Commission Act I now request the Human Rights Commission to examine the proposed Mental Health Ordinance for the Australian Capital Territory for the purpose of ascertaining whether that proposed Ordinance would be inconsistent with or contrary to any human rights as defined in the Act, and to report to me the results of that examination.

In view of the urgent need for the new Ordinance, I should be grateful if the Commission would examine the proposed Ordinance as a matter of priority and report to me as soon as possible thereafter.

The Minister for Health has advised that officers of the Capital Territory Health Commission will be available to make submissions to the Commission either in relation to the proposed Ordinance or to the practical situation for which the proposed Ordinance is designed.

Yours sincerely,

Peter Durack

APPENDIX 2

International Covenant on Civil and Political Rights

(Relevant Articles)

Article 7

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

Article 9

1. Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such pfocedures as are established by law.

4. Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.

5. Anyone who has been the victim of unlawful arrest or detention shall have an enforceable right to compensation.

Article 10

1. All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

Article 12

1. Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence.

2. Everyone shall be free to leave any country, including his own.

3. The above-mentioned rights shall not be subject to any restrictions except those which are provided by law, are necessary to protect national security, public order *(ordre public),* public health or morals or the rights and freedoms of others, and are consistent with the other rights recognized in the present Covenant.

Article 14

1 All persons shall be equal before the courts and tribunals. In the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law. The Press and the public may be excluded from all or part of a trial for reasons of morals, public order *(ordre public)* or national security in a democratic society, or when the interests of the private lives of the parties so requires, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice; but any judgment rendered in a criminal case or in a suit at law shall be made public except

where the interests of juvenile persons otherwise requires or the proceedings concern matrimonial disputes or the guardianship of children.

2. Everyone charged with a criminal offence shall have the right to be presumed innocent until proved guilty according to law.

3. In the determination of any criminal charge against him, everyone shall be entitled to the following minimum guarantees, in full equality:

(a) To be informed promptly and in detail in a language which he understands of the nature and cause of the charge against him;

(b) To have adequate time and facilities for the preparation of his defence and to communicate with counsel of his own choosing;

(c) To be tried without undue delay;

(d) To be tried in his presence, and to defend himself in person or through legal assistance of his own choosing, to be informed, if he does not have legal assistance, of this right; and to have legal assistance assigned to him, in any case where the interests of justice so require and without payment by him in any such case if he does not have sufficient means to pay for it;

(e) To examine, or have examined, the witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;

(f) To have the free assistance of an interpreter if he cannot understand or speak the language used in court;

(g) Not to be compelled to testify against himself or to confess guilt.

4. In the case of juvenile persons, the procedure shall be such as will take account of their age and the desirability of promoting their rehabilitation.

5. Everyone convicted of a crime shall have the right to his conviction and sentence being reviewed by a higher tribunal according to law.

6 When a person has by a final decision been convicted of a criminal offence and when subsequently his conviction has been reversed or he has been pardoned on the ground that a new or newly discovered fact shows conclusively that there has been a miscarriage of justice, the person who has suffered punishment as a result of such conviction shall be compensated according to law, unless it is proved that the non-disclosure of the unknown fact in time is wholly or partly attributable to him.

7. No one shall be liable to be tried or punished again for an offence for which he has already been finally convicted or acquitted in accordance with the law and penal procedure of each country.

Article 17

1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.

2. Everyone has the right to the protection of the law against such interference or attacks.

Article 18

1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice,

and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

2. No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.

3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

Article 19

1. Everyone shall have the right to hold opinions without interference.

2. Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.

3. The exercise of the rights provided for in paragraph 2 of this article carries with it special duties and responsibilities. It may therefore be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:

(a) For respect of the rights or reputations of others;

(b) For the protection of national security or of public order *(ordre public)*, or of public health or morals.

APPENDIX 3

Declaration on the Rights of Mentally Retarded Persons

(Relevant Paragraphs)

1. The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.

2. The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

4. Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.

5. The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.

6. The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.

7. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.

APPENDIX 4

Declaration on the Rights of Disabled Persons

(Relevant Paragraphs)

2. Disabled persons shall enjoy all the rights set forth in this Declaration. These rights shall be granted to all disabled persons without any exception whatsoever and without distinction or discrimination on the basis of race, colour, sex, language, religion, political or other opinions, national or social origin, state of wealth, birth or any other situation applying either to the disabled person himself or herself or to his or her family.

3. Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible.

4. Disabled persons have the same civil and political rights as other human beings; paragraph 7 of the Declaration on the Rights of Mentally Retarded Persons applies to any possible limitation or suppression of those rights for mentally disabled persons.

11. Disabled persons shall be able to avail themselves of qualified legal aid when such aid proves indispensible for the protection of their persons and property. If judicial proceedings are instituted against them, the legal procedure applied shall take their physical and mental condition fully into account.

12. Organizations of disabled persons may be usefully consulted in all matters regardint the rights of disabled persons.

13. Disabled persons, their families and communities shall be fully informed, by all appropriate means, of the rights contained in this Declaration.

APPENDIX 5

List of Private Individuals and Organisations Responding to the Human Rights Commission

Australian Association for the Mentally Retarded
A.C.T. Council of Social Services
Australian National University Counselling Centre
Sir Charles Bright
Christian Science Committee on Publication
Citizen's Committee on Human Rights
Committee on Mental Health Advocacy
Council for Civil Liberties
Ms Robin Creyke
Warwick Everson
Handicapped Citizens' Association A.C.T.
Professor Robert Hayes
Mr Paul Kaufmann
Mr Philip McNamara
Mr Ivan Potas
Schizophrenia Fellowship
Dr Donald Scott-Orr
Dr John Snowdon
Thomas Cahill Cottage

APPENDIX 6

Major Points Raised in Comments to the Human Rights Commission

Introduction

Following reference to the Commission of the proposed Mental Health Ordinance, the Commission had discussions with the Capital Territory Health Commission and some of the principal groups who had expressed interest and concern over the Ordinance. It then prepared a discussion paper which it circulated early in September 1982 to some 150 interested organisations and individuals for comment. It received valuable contributions from a substantial number of individuals and organisations, and expresses its appreciation for the time and effort they put into responding both in writing and in person. The Ordinance was also discussed by a group formed during a consultation the Commission held on 29 September with representatives of thirty A. C. T. non-government organisations with concerns in the human rights field.

It is not possible to do justice in the report itself to the many valuable points raised during the process of consultation. However, it seems important to place them on the record, and the following notes summarise the main points raised.

General

Many of the commentators noted that the draft Ordinance, without the amendments proposed or identified for discussion by the Commission, already represented a significant advance in terms of clearly defining the persons who would come under the Ordinance and in protecting their rights. Nevertheless, there was concern on the points noted in the following paragraphs.

Mental Dysfunction and the Intellectually Handicapped

Many comments were made on the situation of the intellectually handicapped under the Ordinance. One view was that it was discriminatory to bracket the mentally ill and the intellectually handicapped in one piece of legislation. Another view was that to have a separate Ordinance for intellectually handicapped persons deemed to be incapable of giving informed consent would be even more discriminatory. Those who included the severely intellectually handicapped within their comments tended to favour a single Ordinance, provided its terms limited its application to those genuinely incapable of giving informed consent to treatment. Some saw the tightening of the definition (by referring to *severe* disability) proposed by the Commission as substantially meeting the problem.

Whilst no one considered the definition of mental dysfunction to be ideal, equally no one proposed an alternative that appeared on examination to be preferable to the proposed change, although one commentator put forward the definitions used in fifty American States.

Social Breakdown

The inclusion of a social breakdown clause was strongly debated. Those who opposed it feared undue interference in the lives of 'no-hopers' and drop-outs. Those who favoured it saw the alternatives as being the vagrancy laws or the complete physical breakdown of the individual.

Civil Liberties

Civil liberties concerns mainly focused upon tightening up the Ordinance to ensure that a very restricted category of persons would be covered and that their liberties would be fully protected. There was considerable support for a provision, as in the Northern Territory Act, specifying that some behaviours would not, in themselves, constitute evidence of mental dysfunction. Suggestions of criteria which should *not* be applied included religion, political opinion and sexual preference, including pedophilia. Several case studies from elsewhere in Australia were submitted from which it appeared that individuals' unpopular opinions, or behaviour more appropriate to another culture, had unduly influenced the diagnosis and treatment of mental illness.

Other civil liberties concerns related to:

(a) proposal that the hearings of applications for treatment orders be held in a closed court;
(b) the provisions for restrictions upon communications by persons under treatment orders;
(c) the need for individuals to be provided with a statement of their rights in their own language;
(d) the degree of harm appropriate to the definition of risk to the individual and the community;
(e) the extent to which past behaviour should be taken into account in the determination of mental dysfunction;
(f) the need for legal aid;
(g) problems associated with the application of the 'user pays' principle to the mentally ill;
(h) a possible specification of the right to appear before the court in an unmedicated state;
(i) the right of individuals to choose the form of treatment, including unconventional folk remedies, the power of religion or no treatment at all.

Several submissions stressed that mentally dysfunctional individuals should not be placed in a worse position *vis-a-vis* their rights than persons charged with or convicted of criminal offences.

ECT, Psychosurgery and Drugs

The Commission received numerous comments on the roles of ECT, psychosurgery and psychoactive drugs. There is evidently considerable public concern related to the use of all of these treatments. It should be noted that whilst public concern over ECT and psychosurgery has received the most media attention, those who have personally been treated for mental dysfunction are often equally concerned about the problems associated with treatment with psychoactive drugs. There is questioning as to the effectiveness of all three forms of treatment and as to the most appropriate course of action where individuals have reached the point of mental dysfunction where they are incapable of giving informed consent to treatment.

One point upon which commentators were agreed was that records on the treatments used and their effects should be kept in such a way as to allow monitoring of their use and effectiveness. There was also general agreement that *if* there is to be psychosurgery in the absence of informed consent, the protections afforded in the draft Ordinance represent a reasonable protection of the rights of the individual.

Another common concern was that informed consent should be fully informed and freely given, with recognition of the special pressures upon individuals receiving treatment for mental dysfunction within a residential institution. It was also stressed

that the possibility of physical illness should always be fully investigated with a physical and pathological examination.

Privacy

Commentators were concerned that the privacy of individuals who might come under treatment orders should be respected, but also that information about the workings of the Ordinance should be made public to allow for informal discussion of its efficacy. It was noted that in some contexts there is a special stigma associated with involuntary treatment which could be avoided if the names and personal details of persons under treatment orders were not made public.

Guardianship and Advocacy

Many submissions pressed for adequate guardianship and advocacy provisions for the mentally ill and the intellectually handicapped. The only division of opinion was as to how the desired provisions could most effectively be achieved. Migrants, persons approaching senility, and minors were also pointed out as groups with additional needs for a patient's friend or advocate.

Related Legal Issues

A number of points were raised concerning related legal issues, notably vagrancy legislation, the question of governor's pleasure prisoners and mentally dysfunctional prisoners in general, and the powers of the police. Several submissions pointed out that the draft Mental Health Ordinance covered only a very restricted area of mental health and made no provision for a right to treatment or the other positive rights now recognised in some American bills of rights for mental patients.

APPENDIX 7

AUSTRALIAN CAPITAL TERRITORY

Mental Health Ordinance 1981

[Relevant Sections]

No. of 1981

I, THE GOVERNOR-GENERAL of the Commonwealth of Australia, acting with the advice of the Federal Executive Council, hereby make the following Ordinance under the *Seat of Government (Administration) Act* 1910.

Dated 1981.

Governor-General

By His Excellency's Command,

Minister of State for Health

An Ordinance relating to mental health

PART I — PRELIMINARY

Short title

1. This Ordinance may be cited as the *Mental Health Ordinance* 1981.

Commencement

2. (1) This Part (other than section 3) and Part II shall come into operation on the date on which this Ordinance is notified in the *Gazette*.

(2) The remaining provisions of this Ordinance shall come into operation on such date as if fixed, or on such respective dates as are fixed, by the Minister of State for the Capital Territory by notice published in the *Gazette*.

Repeal

3. (1) Parts **I**to VI (inclusive), Part IX and sections 170 to 180 (inclusive) of, and the Schedules to, the Lunacy Act of 1898 of the State of New South Wales shall cease to be in force in the Territory.

(2) The Inebriates Act, 1900 of the State of New South Wales and the Inebriates (Amendment) Act, 1909 of that State shall cease to have effect in the Territory.

(3) The *Inebriates Ordinance* 1938 and the *Lunacy Ordinance* 1938 are repealed.

Interpretation

4. In this Ordinance, unless the contrary intention appears—

"Chairman" means —

(a) the Chairman of the Commission; or

(b) if a person is acting as Chairman of the Commission — the person so acting;

"Commission" means the Capital Territory Health Commission;

"Council" means the Mental Health Advisory Council established by Part III;

"convulsive therapy" means a procedure for the induction of an epileptiform convulsion in a person;

"Court" means the Court of Petty Sessions;

"Director" means —

(a) the Director of Mental Health Services; or

(b) if a person is acting as the Director of Mental Health Services by virtue of an appointment under section 10— the person so acting;

"medical practitioner" means a person registered as a medical practitioner under the *Medical Practitioners Registration Ordinance* 1930;

"member" means a member of the Council;

"mental dysfunction" means a disturbance or defect, to a disabling degree, of perception, comprehension, reasoning, learning, judgment, memory, motivation, emotion or of some other mental function;

"Mental Health Officer" means a person appointed to be a Mental Health Officer under section 12;

"neurosurgery" means surgery on the brain of a person for the purpose of treating a pathological condition of the physical structure of the brain;

"prescribed relative", in relation to a person, means a spouse, parent, guardian, grandparent, uncle, aunt, brother, sister, half-brother, half-sister, cousin, child or adopted child (being a child or adopted child of or above the age of 18 years) of the person;

"psychiatric surgery" means surgery on the brain of a person, other than neurosurgery, for the purpose of treating mental dysfunction by altering a function of the brain;

"social breakdown", in relation to a person, means the condition in which the person's capacity to —

(a) obtain and use the goods and services essential to the support of life; or

(b) make the decisions, and take the actions, essential to an autonomous life,

is so impaired as to cause the person to suffer severe distress or deprivation;

"treatment order" means an order made by the Court under section 27, or that order as varied and in force from time to time.

PART II — ADMINISTRATION

Director of Mental Health Services

5. There shall be a Director of Mental Health Services.

Appointment of Director

6. (1) The Director shall be appointed by the Commission.

(2) Subject to this Ordinance, a person appointed under sub-section (1) holds office for such period, not exceeding 5 years, as is specified in the instrument of his appointment.

(3) A person appointed under sub-section (1) holds office on such terms and conditions with respect to matters not provided for by this Ordinance as the Commission determines, and is eligible for re-appointment.

(4) A person who has attained the age of 65 years shall not be appointed or re-appointed as the Director, and a person shall not be appointed or re-appointed as the Director for a period that extends beyond the date on which he will attain the age of 65 years.

Eligibility for appointment as Director

7. A person is not eligible to be appointed or hold office as the Director unless he is a medical practitioner who is entitled to practise as a psychiatrist.

Resignation

8. A person may resign the office of Director by writing signed by him and delivered to the Chairman.

Removal from office

9. (1) The Commission may remove a person from office as Director for mis-behaviour or physical or mental incapacity.

(2) If a person holding office as Director —

(a) becomes bankrupt, applies to take the benefit of a law for the relief of bankrupt insolvent debtors, compounds with his creditors or makes an assignment of his remuneration for their benefit; or

(b) ceases to be eligible to hold that office,

the Commission shall remove him from office.

(6) If at a meeting of the Council, the Chairman of the Council is not present, the Deputy Chairman of the Council shall preside at the meeting.

(7) Questions arising at a meeting of the Council shall be determined by a majority of the votes of the members present and voting.

(8) The member presiding at a meeting of the Council has a deliberative vote only.

Disclosure of pecuniary interest

20. (1) A member who has a direct or indirect pecuniary interest in a matter being considered or about to be considered by the Council shall, as soon as possible after the relevant facts have come to his knowledge, disclose the nature of his interest at a meeting of the Council.

(2) A disclosure under sub-section (1) shall be recorded in the minutes of the meeting of the Council and the member shall not, unless the Minister or the Council otherwise determines —

(a) be present during any deliberation of the Council with respect to that matter; or

(b) take part in any decision of the Council with respect to that matter.

(3) For the purpose of the making of a determination by the Council under sub-section (2) in relation to a member who has made a disclosure under sub-section (1), a member who has a direct or indirect precuniary interest in the matter to which the disclosure relates shall not —

(a) be present during any deliberation of the Council for the purpose of making the determination; or

(b) take part in the making by the Council of the determination.

(4) Where a member fails, without reasonable excuse, to comply with the requirements of this section, the Chairman shall terminate the appointment of the member.

PART IV — EMERGENCY PROCEDURES

Emergency detention

21. (1) Where a medical practitioner or an authorized Mental Health Officer has reasonable grounds for believing that —

(a) a person is suffering mental dysfunction;

(b) the condition of the person gives rise to an immediate and substantial risk of harm to the person or to another person; and

(c) the person will not accept treatment which the medical practitioner or Mental Health Officer reasonably believes necessary to avert that risk,

the medical practitioner or Mental Health Officer may take the person to premises of the Commission.

(2) A medical practitioner or an authorized Mental Health Officer may, for the purposes of taking a person to premises of the Commission in pursuance of sub-section (1), enter any premises by force, if necessary, and with such assistance as he thinks necessary, if there are reasonable grounds for believing that the person is at those premises.

(3) Where a person is taken to premises of the Commission under sub-section (1), the Director may, subject to this Part, detain the person at those premises and while the person is so detained —

(a) keep the person in such custody at those premises as the Director thinks appropriate in the circumstances;

(b) subject the person to such restraint as is reasonable and necessary to prevent the person from doing harm to himself or to any other person;

(c) cause the person to be examined by a medical practitioner; and

(d) cause to be administered to the person such treatment (if any) as is necessary to prevent the person from doing harm to himself or to any other person.

(4) In this section, "authorized Mental Health Officer" means a Mental Health Officer who is authorized in writing by the Director for the purposes of this section.

Application for treatment order in respect of detained person

22. Where the Director is satisfied that an application should be made for a treatment order in respect of a person detained under section 21, the Director shall cause an application for a treatment order in respect of that person to be made as soon as practicable.

Release of person from emergency detention

23. A person who is detained under section 21 shall be released from that detention if —

(a) the Court makes an order under section 24 that the person be released from that detention;

(b) a treatment order is made under Part V in relation to the person; or

(c) the Director is satisfied that there are no longer any reasonable grounds for believing that the person is likely to do harm to himself or to any other person.

Court may order release of person

24. The Court may, on application by a person detained under section 21 or by a prescribed relative of the person, if it is satisfied that —

(a) an application for a treatment order in respect of the person has not been made; and

(b) there are no longer any reasonable grounds for believing that the person is likely to do harm to himself or to any other person,

order that the person be released from that detention.

Communications by detained persons

25. (1) A person who is detained under section 21 is entitled, upon making a request to the Director or to another person performing duties in connection with the detention of the person, to be provided with facilities for preparing a written communication and for enclosing that written communication in a sealed envelope.

(2) Where a person who is detained under section 21 delivers to the Director, or to another person performing duties in connection with the detention of the person, a sealed envelope addressed to any person, the Director shall cause the sealed envelope to be forwarded, without delay, to that last-mentioned person at the address appearing on the envelope.

(3) Subject to sub-sections (1) and (2), the Director shall, as far as is reasonably practicable, afford to a person who is detained under section 21, reasonable opportunities to communicate with other persons.

PART V — TREATMENT ORDERS

This Part not to affect operation of Part VII

26. Nothing in this Part affects the operation of Part VII.

Treatment order

27. Where, on an application for a treatment order made under this Part, the Court is satisfied that —

(a) the person in relation to whom the application is made is suffering from mental dysfunction;

(b) by reason of that mental dysfunction —

(i) the person has engaged, or is likely to engage, in behaviour that has resulted or is likely to result in harm to himself or to another person; or

(ii) the person is in a state of social breakdown; and

(c) the person has refused, or is not likely voluntarily, to undergo, or to co-operate in, adequate treatment for the mental dysfunction,

the Court may make a treatment order in respect of the person.

Application for treatment order

28. (1) An application for a treatment order shall be made jointly by a medical practitioner and a Mental Health Officer.

(2) An application for a treatment order shall specify the grounds on which the order is sought.

(3) The parties to an application for a treatment order are —

(a) the applicants;

(b) the Director;

(c) the person in respect of whom the order is sought; and

(d) any person upon whom the application has been served in pursuance of directions given under sub-section 29 (2).

Service of application

29. (1) An application for a treatment order shall be served by the applicants on each of the other parties to the application.

(2) Where —

(a) an application for a treatment order has been served on the person in respect of whom the order is sought; and

(b) the Court is of the opinion that it is desirable, for the proper protection of the interests of the person, that the application be served on some other person,

the Court may give such directions as it thinks fit with respect to the service of the application on that other person.

(3) An application for a treatment order shall be served on a person —

(a) by delivering a copy of the application to him personally; or

(b) by leaving a copy of the application at the last known or usual place of residence of the person with some other person who is apparently resident at the place and apparently of or over the age of 16 years.

(4) The Director shall cause notice in writing of the date on which, and the time and place at which, an application for a treatment order will be heard to be given to the person in respect of whom the order is sought not less than 24 hours before the time specified in the notice.

(5) Evidence of service of an application under this section may be given by affidavit.

Restriction of applicants

30. A person may not join in making an application for a treatment order if —

(a) the making of the order would be likely to result in financial gain to the person, otherwise than by way of reasonable fees charged in the ordinary course of the practice of his profession; or

(b) the person is a prescribed relative of the person in respect of whom the order is sought.

Person in custody of Director to be present at hearing

31. (1) Where an application is made for a treatment order in respect of a person who is in the custody of the Director, the Director shall cause the person to be present

during the hearing of the application unless the Court is satisfied that in the circumstances the presence of the person during the hearing would not be practicable.

(2) For the purpose of performing his obligation under sub-section (1), the Director may employ such assistance as he thinks necessary.

Representation

32. Where an application is made for a treatment order, the person in respect of whom the order is sought is entitled to be represented at the hearing of the application by a barrister or solicitor or by any other person.

Persons entitled to be present at hearing

33. A person is not entitled to be present in a room in which an application for a treatment order is being heard unless he is —

(a) the Magistrate constituting the court;
(b) a member of the staff of the Court;
(c) a party to the application;
(d) a person representing a party to the application;
(e) a person who is a prescribed relative of the person in respect of whom the ordef is sought and whose presence is requested by that last-mentioned person;
(f) a person who is giving evidence;
(g) an officer of the Court; or
(h) a person who is present with the leave of the Court.

Requirements of treatment order

34. (1) A treatment order shall direct —

(a) that the person in respect of whom the order is made remain in the custody of the Director of premises specified in the order throughout the period for which the order has effect; or
(b) that the person attend, in accordance with the directions of the Director, at the place specified in the order for the purpose of undergoing treqment.

(2) Subject to this Ordinance, a treatment order shall specify —

(a) the period during which the order is to have effect;
(b) where the order includes a direction referred to in paragraph (1) (a) —
  (i) the extent (if any) to which the person to whom the order relates may be subjected to restraint, other than confinement, while the order remains in force; and
  (ii) the extent (if any) to which communication by the person with other persons, other than by means of written communication, may be restricted while the order remains in force; and
(c) where the order includes a direction referred to in paragraph (1) (b) — the maximum frequency with which the person may be directed to attend at the premises specified in the order.

(3) Where the Court makes a treatment order that includes a direction referred to in paragraph (1) (a), the Court may, in the treatment order, give to the Director such directions (if any) as it thinks necessary to ensure that a responsible person, being a relative or friend of, or a person having an interest in the welfare of, the person to whom the order relates, is informed of the making of the order and of the premises at which the person is kept.

Treatment of persons under treatment orders

35. Where a treatment order is in force in relation to a person, the Director is authorized to administer, or cause to be administered, to that person such treatment for the mental dysfunction suffered by that person as the Director thinks necessary, other than —

(a) treatment that produces, or is likely to produce, an irreversible physical lesion;

(b) convulsive therapy;

(c) treatment that has, or is likely to have, the effect of subjecting the person to whom it is administered to undue distress or deprivation, having regard to the benefit likely to result from the administration of the treatment; or

(d) treatment involving a therapeutic procedure the effects of which have not been demonstrated clinically.

Period of effect of treatment order

36. (1) The Court shall not specify in a treatment order, for the purpose of paragraph 34(2) (a), a period exceeding 28 days.

(2) The Supreme Court may, on application made jointly by a medical practitioner and a Mental Health Officer at any time before the expiration of the period specified in a treatment order for the purposes of paragraph 34 (2) (a), extend that period for such further period, being a period of not more than 6 months commencing on the expiration of the first-mentioned period, as it thinks fit.

(3) Where the Supreme Court has extended the period of a treatment order for a further period under sub-section (2), the Supreme Court may, on application made jointly by a medical practitioner and a Mental Health Officer before the expiration of that further period, extend that further period for such period, commencing on the expiration of that further period, as it thinks fit.

(4) Where an application is made under sub-section (2) or (3), the Supreme Court shall not extend the period specified in a treatment order for the purposes of paragraph 34 (2) (a) unless the application is supported by the evidence of a medical practitioner who is not an applicant for the extension.

Custodial treatment order — powers of Director

37. (1) This section applies to a treatment order that directs that the person to whom the order relates remain in the custody of the Director throughout the period for which the order has effect.

(2) Subject to this section, where a treatment order to which this section applies is in force in relation to a person —

(a) the Director, a medical practitioner or a Mental Health Officer is authorized to take the person to premises specified in the order;

(b) the Director is authorized to keep the person in such custody at those premises as he thinks appropriate for the period during which the order has effect; and

(c) the Director is authorized to subject the person to such restraint as is reasonable and necessary to prevent the person from doing harm to himself or to any other person or to permit treatment to be administered to the person.

(3) For the purpose of the exercise of the authority conferred by paragraph (2) (a), the Director, a medical practitioner or a Mental Health Officer is authorized to

enter, by force if necessary, and with such assistance as he thinks necessary, any premises if there are reasonable grounds for believing that the person to whom a treatment order relates is on those premises.

(4) A treatment order does not authorize the removal of a person from custody in which that person is held under any law in force in the Territory.

(5) Where a court, by an order or warrant, commits a person who is confined in pursuance of a treatment order to the custody of a person other than the Director, the Director shall, on the production of the order or warrant, deliver the person to a person acting in the execution of that order or warrant.

Non-custodial treatment order — powers of Director

38. (1) This section applies to a treatment order other than a treatment order to which section 37 applies.

(2) Where a treatment order to which this section applies is in force in relation to a person the Director is authorized to give to that person directions with respect to the attendance of the person at the place specified in the order for the purpose of treatment.

Explanation of treatment to be given

39. (1) Where the Court makes a treatment order under this Part, the Director or the medical practitioner who is to administer treatment to the person in respect of whom the order is made shall, before that treatment is administered, explain to the person the nature and the effects, including the side-effects (if any), of the treatment.

(2) Where, in the opinion of the Director or medical practitioner, a person would be unable to understand an explanation given for the purpose of sub-section (1), the Director or medical practitioner may give the explanation required by that sub-section to a prescribed relative of the person.

Variation and discharge of treatment orders

40. (1) The Court may, at any time, vary a treatment order, other than by extending the period specified in a treatment order for the purposes of paragraph 34 (2) (a), or discharge a treatment order.

(2) Subject to sub-section (3), an application for variation or discharge of a treatment order may be made by the person to whom the treatment order relates, by a prescribed relative of that person or by a medical practitioner.

(3) An application for variation of a treatment order shall be made jointly by a medical practitioner and a Mental Health Officer if the variation sought by the application includes —

(a) where the order includes a direction referred to in paragraph 34 (1) (b) — an increase in the frequency with which the person may be directed to attend at premises specified in the order; or

(b) the substitution for a direction referred to in paragraph 34 (1) (b) of a direction referred to in paragraph 34(1) (a).

(4) Where an application is made under sub-section (3), the Court shall not vary a treatment order unless the application is supported by the evidence of a medical practitioner who is not an applicant for the variation of the treatment order.

Confinement not to be excessive

41. A person in the custody of the Director in accordance with a treatment order shall not be subject to confinement in excess of what is reasonable and necessary —

(a) to prevent the person from doing harm to himself or to another person; or

(b) to ensure that the person remains in the custody of the Director in accordance with the treatment order.

Restraint not to be excessive

42. (1) A person in the custody of the Director in accordance with a treatment order that does not specify the extent to which the person may be subjected to restraint shall not be subjected to restraint (other than confinement) except to the extent that restraint is reasonable and necessary —

(a) to prevent harm to the person or to another person; or

(b) to permit treatment to be administered to the person.

(2) A person referred to in sub-section (1) shall not be subjected to restraint (other than confinement) for more than a single period, being a period not exceeding 48 hours.

Restriction of communication

43. (1) Subject to this Ordinance, where —

(a) a person is in the custody of the Director in accordance with a treatment order;

(b) the treatment order authorizes the imposition of restrictions on communication between the person to whom the order relates and other persons; and

(c) there are reasonable grounds for believing that it is desirable, in the interests of the effective treatment of the person, that communication between that person and other persons be restricted,

the Director may, subject to the order, impose such restrictions upon communication by that person with other persons as are reasonable and necessary to ensure the effectiveness of that treatment.

(2) Subject to sub-section (3), where restrictions are imposed in pursuance of sub-section (1), the Director shall, as soon as is practicable, cause a medical practitioner to explain to the person to whom those restrictions relate —

(a) the nature of the restrictions;

(b) the period during which the restrictions will remain in effect; and

(c) the reasons for the imposition of the restrictions.

(3) Where, in the opinion of the Director or a medical practitioner, a person would be unable to understand an explanation given for the purpose of sub-section (2), a medical practitioner shall give the explanation required by that sub-section to a prescribed relative of the person.

(4) Restrictions imposed under sub-section (1) cease to have effect at the expiration of a period of 7 days, but nothing in this sub-section prevents the imposition of further restrictions immediately after the previous restrictions cease to have effect.

Written communication

44. (1) A person in the custody of the Director in accordance with a treatment order is entitled, upon making a request to the Director or to another person performing duties in connection with the custody of the person, to be provided with

facilities for preparing a written communication and for enclosing that written communication in a sealed envelope.

(2) Where a person in the custody of the Director in accordance with a treatment order delivers to the Director, or to another person performing duties in connection with the custody of the person, a sealed envelope addressed to any person, the Director shall cause the sealed envelope to be forwarded, without delay, to that last-mentioned person at the address appearing on the envelope.

PART VI — CONVULSIVE THERAPY

Restrictions on use of convulsive therapy

45. (1) A medical practitioner shall not administer, or authorize the administration of, convulsive therapy to a person, other than a person in respect of whom a treatment order is in force, unless —

(a) the person has, by instrument in writing signed by him, consented to the administration of the therapy and has not, whether orally or in writing, withdrawn his consent; and

(b) convulsive therapy has not been administered to the person on 10 or more occasions since that consent was given.

Penalty: $500.

(2) The Director or a medical practitioner shall not administer, or authorize the administration of, convulsive therapy to a person in respect of whom a treatment order is in force unless —

(a) the Court, on application by the Director or medical practitioner, has approved the administration of convulsive therapy to the person; and

(b) convulsive therapy has not been administered to the person on 10 or more occasions since the Court so approved the administration of convulsive therapy to the person.

Penalty: $500

(3) The Court shall not give its approval under sub-section (2) for the administration of convulsive therapy to a person unless the Court is satisfied that —

(a) the administration of the therapy will result in a substantial benefit to the person;

(b) there is no other form of treatment reasonably available that is likely to result in the same degree of benefit to the person; and

(c) the person —

(i) is capable of weighing for himself the considerations involved in a decision whether to consent to the administration of the therapy and has, by writing signed by him, consented to the administration of the therapy and has not, whether orally or in writing, withdrawn his consent; or

(ii) is, by reason of mental dysfunction, incapable of weighing for himself the considerations involved in a decision whether to consent to the administration of the therapy.

Administration of convulsive therapy to be recorded

46. (1) The Director or a medical practitioner who administers, or authorizes the administration of, convulsive therapy shall make a record of that administration or authorization, as the case may be, and shall deliver that record to a person

employed by the person or authority responsible for the conduct of the hospital at which the therapy is, or is to be, administered.

(2) A person or authority responsible for the conduct of a hospital shall retain a record delivered in accordance with sub-section (1) for a period not less than 5 years after the date on which the record is so delivered.

Penalty: $250.

PART VII — CONTROL OF PSYCHIATRIC SURGERY

Psychiatric surgery not to be performed except with approval of Director

47. (1) Subject to this Part, a medical practitioner shall not perform psychiatric surgery on a person for, or in connection with, the treatment of mental dysfunction suffered by that person except with the approval of the Director and in accordance with the conditions (if any) to which that approval is subject.

Penalty: $5,000 or imprisonment for 12 months, or both.

(2) A medical practitioner shall not perform psychiatric surgery on a person who —

(a) has signed a statement stating that he consents to an application being made for the approval of the Director for the performance of the surgery; and

(b) at any time thereafter refuses, either orally or in writing, to consent to the performance of the surgery.

Penalty: $5,000 or imprisonment for 12 months, or both.

(3) Psychiatric surgery may be performed on a person in accordance with this Part notwithstanding that a treatment order is in force in relation to the person.

Application for approval

48. An application for the approval of the Director for the performance of psychiatric surgery shall —

(a) be made by the medical practitioner by whom the surgery is to be performed;

(b) be in writing signed by the applicant; and

(c) be delivered to the Director together with —

(i) a statement in writing signed by the person on whom the surgery is to be performed and stating that he consents to the application being made; or

(ii) an order made by the Court under section 55.

Director to submit application to committee

49. (1) Where an application has been made in accordance with section 48 the Director shall, as soon as practicable, submit the application to a committee consisting of —

(a) a psychiatrist;

(b) a neurosurgeon;

(c) a barrister and solicitor;

(d) a psychologist; and

(e) a social worker.

(2) The members of a committee for the purpose of sub-section (1) shall be appointed by the Director.

(3) A member of a committee appointed under this section shall be paid such fees and allowances (if any) as are prescribed.

(4) A person is not eligible to be appointed under sub-section (2) unless he is for the time being a person approved by the Minister for the purpose of this sub-section.

(5) The Minister shall not approve a person for the purpose of sub-section (4) unless he is satisfied that the person, by reason of his training and experience, is a suitable person for appointment to a committee under this section.

(6) The chairman of a committee constituted under this section shall be the member appointed by the Director to be chairman of the committee.

(7) The Director shall submit an application to a committee by delivering a copy of the application to the chairman of the committee.

Committee to report on application

50. (1) Where an application has been submitted to a committee, the committee shall —

(a) consider the application; and

(b) make a report to the Director in relation to the application.

(2) A committee shall, in a report on an application, recommend —

(a) whether the Director should approve of the performance of the surgery to which the application relates; and

(b) if the committee recommends that the Director approve of the performance of that surgery — the conditions (if any) to which that approval should be subject.

Director to act in accordance with report of committee

51. Where a committee has made a report to the Director in relation to an application, the Director shall deal with the application in accordance with the recommendation or recommendations of the committee.

Director may require applicant to produce information and documents

52. (1) The Director may, at the request of a committee, require a medical practitioner who has made an application under section 48 to produce to the Director such information or documents, or both, as the Director specifies.

(2) A requirement under sub-section (1) shall be made in writing and delivered to the person to whom it is directed.

(3) Sub-section (1) does not authorize the Director to require the production of information or documents other than information or documents relevant to the consideration by a committee of an application under section 48.

(4) Where a requirement has been made under sub-section (1), a committee is not required to give further consideration to the application in relation to which the requirement was made until all information and documents specified in the requirement have been produced to the Director.

Meetings of committee

53. (1) Meetings of a committee shall be convened by the chairman of the committee.

(2) Subject to sub-section (3), a question arising at a meeting of a committee shall be decided in accordance with the opinion of a majority of the members of the committee.

(3) A committee shall not recommend that the performance of psychiatric surgery be approved by the Director unless the recommendation is supported by the psychiatrist and neurosurgeon who are members of the committee.

Criteria for approval

54. A committee shall not recommend that the Director approve the performance of psychiatric surgery unless the committee is satisfied —

(a) that there are reasonable grounds for believing that the performance of the surgery will result in substantial benefit to the person on whom it is to be performed; and

(b) that there is no alternative form of treatment reasonably available that will benefit that person to the same degree.

Order by Court

55. Where the Court, on application by a medical practitioner, is satisfied —

(a) that, by reason of mental dysfunction, a person is unfit to sign a statement for the purpose of paragraph 48 (c);

(b) that there are grounds for believing that the person may benefit from psychiatric surgery; and

(c) that it is desirable that an application be made for approval of the performance of that surgery,

the Court may, by order, give leave to the medical practitioner specified in the instrument to make an application for approval of the performance of that surgery.

PART VIII — CONTROL OF PRIVATE MENTAL HEALTH FACILITIES

Interpretation

56. In this Part, "mental health facility" means a hospital, nursing-home, hostel or other institution that ordinarily provides treatment or accommodation for persons suffering mental dysfunction.

Application

57. Nothing in this Part applies to or in relation to a hospital, nursing-home, hostel or other institution conducted by the Commission.

Mental health facilities to be licensed

58. A person who, not being the holder of a licence granted under this Part, conducts a mental health facility, whether as the owner, or employee or agent of the owner, of that mental health facility, is guilty of an offence punishable, on conviction, by a fine not exceeding $1,000.

APPENDIX 8

Letter from Capital Territory Health Commission to Attorney-General's Department

The Secretary
Attorney-General's Department
Administrative Building
Parkes Place
Parkes, A. C .T. 2600

1 June 1982

Attention: Mr E.J. Wright

PROPOSED MENTAL HEALTH ORDINANCE

Reference is made to your memorandum LD17714846 dated 15 December 1981. The A. C .T. House of Assembly has accepted the draft Ordinance in principle subject to a number of amendments most of which have been accepted by the Commission. The draft Ordinance is to be referred to the Human Rights Commission.

2. Amongst other things the House of Assembly's Welfare Committee recommended a review of the penalties in the Ordinance. The Justice Division of your Department will be requested to undertake this review. Attached to this memorandum is a copy of the memorandum to your Department on this and other matters.

3. A letter from Mr Justice Kelly, a copy of which was forwarded to the Capital Territory Health Commission by your Department, indicates that if Parts VII and VIII of the Lunacy Act are to be retained it will also be necessary to retain section 3 of the Act as it defines terms used in those Parts. It is requested that the Ordinance be altered accordingly.

4. Mr Justice Kelly's letter also indicates that questions of considerable difficulty would be raised if Part V of the Act is repealed without replacement. It is therefore requested that the Ordinance be altered so as not to repeal Part V. As a consequence it will be necessary to retain the Lunacy Ordinance 1938 which amends that part of the Act.

5. The definition of 'mental dysfunction' in section 4 of the Ordinance should be altered by substituting 'perceptual interpretation' for 'perception'. The definition of 'prescribed relative' in that section should include de facto spouses.

6. Section 11 should be altered to require that a delegation only be made to a person employed under the Public Service Act 1922 or the Health Commission Ordinance 1975.

7. Section 12 should be altered to provide for the appointment of Mental Health Officers by the Minister not the Commission and consequently also for the termination of appointments by the Minister. Qualifications for Mental Health Officers may be prescribed in the regulations.

8. Sub-section 15(2) should be altered to substitute appointment by the Commission for appointment by the Chairman.

9. Comments on the Ordinance made by an officer of the Law Reform Commission suggest that while sub-section 21(2) permits entry to premises by force if necessary the section does not permit the medical practitioner or authorised Mental Health Officers to use force to take the person to the Commission's premises. Your advice is requested whether sub-section 21(1) permits the use of force if that is necessary to enable the person to be taken to premises of the Commission and the use of such assistance as the medical practitioner or authorised Mental Health Officer thinks necessary.

10. A requirement should be added to sub-section 21(3) that where the Director can reasonably be expected to know of or to be able to ascertain the existence and location of a prescribed relative, friend or barrister and solicitor of a person in respect of whom emergency action has been taken the Director should be required to inform that person that the action has been taken.

11. A requirement should also be added to section 21 that a medical practitioner or authorised Mental Health Officer taking emergency action should record the details of the action, including the identity of the person (where it is possible to ascertain this), the date and time of the action, the reason for the action, whether entry to premises was necessary and any other details that appear to be relevant. This record should be made available to the Director as soon as reasonably practicable after the person has been taken to the premises of the Commission. The Director should be required to record details of all action taken in accordance with sub-section 21(3). The 2 records should be required to be produced by the applicants if application is made for a treatment order. Sub-section 21(3) should be altered to require that the Director shall cause the person to be examined by a medical practitioner as soon as reasonably practicable. Also medical treatment should only be given under paragraph 21(3)(d) where it should not be delayed until after a treatment order is obtained.

12. Section 22 should be altered so that the Director must cause an application to be made as soon as practicable but in any case no longer than 72 hours after the emergency action was taken.

13. Section 23 should be altered so that a person must be released from emergency detention if an application for a treatment order is not made within 72 hours of the emergency action being taken. In addition a person should be released as soon as it is determined that a treatment order application will not be made. Paragraph 23(c) should specify that a person is to be released where the Director is satisfied that there are or are no longer any reasonable grounds.

14. Section 24 should be altered to permit an application to be made by any person whom the Director is required to inform under sub-section 21(3). The section should also be altered to require the Director to render reasonable assistance to a person detained under section 21 to make a verbal or written application for release.

15. Section 25 should be altered to require the Director or other person referred to in sub-section 25(1) to inform the person of his rights under the section and section 24.

16. Sub-section 34(1) should be altered to refer to premises specified by the Director and place specified by the Director in paragraphs (a) and (b) respectively. Sub-paragraph 34(2)(b)(i) should be deleted as this is intended to be at the discretion of the Director. This is regarded as necessary because restraint has a great effect on treatment. Paragraph 34(2)(c) should also be deleted as the frequency of visits is also to be at the discretion of the Director.

17. The A. C . T. House of Assembly has requested that paragraph 35(d) be redrafted to make it clearer though it is difficult to see how this would be done. Mr Justice Kelly has suggested that paragraph 35(d) 'make it plain that the therapeutic procedure must be one the substantially beneficial effect of which has been demonstrated to a degree which makes the procedure acceptable to the majority of practising psychiatrists'. Your advice is requested whether it is possible to draft such a provision and whether this would make things clearer.

18. Sub-sections 36(2) and (3) should be altered so that applications will be made by a psychiatrist and a Mental Health Officer.

19. Mr Justice Kelly has suggested in relation to sub-section 37(4) that consideration be given to a provision 'whereby a person in custody may, when a treatment order in respect of him is made and the treatment cannot be given him at the custodial institution, be removed from custody for treatment at an appropriate institution'. The Custody referred to by the Judge is presumably penal custody or custody on remand where no bail has been granted. This is acceptable to the Commission provided that in each particular case the Commission's facilities are adequate. Your advice is requested whether it is possible to make this alteration.

20. Because of the alteration of sub-section 34(1) a consequential alteration to sub-section 38(2) will be necessary.

21. The Director or the medical practitioner administering treatment should be required to explain to a person to whom a treatment order relates that he is entitled to apply for a variation of an order under sub-section 40(2). Where in the opinion of the Director or a medical practitioner the person would be unable to understand that explanation the Director or medical practitioner should be able to give the explanation to a prescribed relative of the person.

22. Sub-section 42(1) should be altered as a consequence of the deletion of sub-paragraph 34(2)(b)(i). Sub-section 42(2) should be altered to refer to any person subject to a treatment order.

23. Section 44 should be altered to require the Director subject to sub-sections 44(1) and (2) and section 43 and as far as is reasonably practicable to afford to a person subject to a custodial order reasonable opportunities to communicate with other persons. The Director or medical practitioner treating the person should be required to inform the person of this right. When in the opinion of the Director or the medical practitioner the person would be unable to understand that explanation the Director or medical practitioner should be able to give the explanation to a prescribed relative of the person.

24. It has been suggested that the consent referred to in section 45 should be an informed consent made after the procedure is fully explained to the person in circumstances where it is clear that he understands both the treatment and its possible effects. It appears however that it is already implicit in the section that the consent should be an informed one and your advice is requested whether this is so or whether the requirement should be made explicit.

25. Paragraph 49(1)(d) should be altered to refer to a clinical psychologist. It has been decided that the members of these committees should be appointed by the Commission and sub-section 49(2) should be amended accordingly. The Chairman of the Committee should also be appointed under sub-section 49(6) by the Commission. Sub-sections 49(4) and (5) should be deleted.

26. Section 56 should be altered to define 'mental health facility' as a hospital, nursing home, hostel or other institution that ordinarily provides treatment and accommodation or accommodation only for persons suffering mental dysfunction. Recognised hospitals as defined in section 3 of the Health Insurance Act 1973 should be excluded from the definition.

27. Section 62 should be altered so that detailed requirements for conditions of licences may be prescribed by regulation. It is not intended that Part VIII be brought into operation until regulations have been made for this purpose. As well as the matters set out in sub-section 62(1) it should be possible to prescribe other matters relevant to the conditions under which a mental health facility should be permitted to operate. It appears that this change will require a general rephrasing of the sub-section so that regulations may be made prescribing —

- the standard of maintenance of the premises and grounds,
- the standard of maintenance of equipment,
- the numbers of persons to be employed at each type of facility in connection with the treatment and accommodation of patients at that type of facility and the training and experience of these persons,
- staff/patient ratios, and
- any other requirement relevant to the proper administration of a facility.

It should still be possible for the Commission to limit the number of patients at a facility and the current requirement in paragraph 62(1)(b) should continue.

28. In relation to paragraph 62(1)(f) it was agreed with Mr Attridge of your Department that the Commission would raise the question whether the holder of a licence is responsible for 'and fails to comply' with the condition specified in this paragraph where allegedly harmful treatment is in fact administered by a visiting medical practitioner. A visiting medical practitioner should himself be responsible for the treatment he gives but despite this the holder of the licence should have a supervisory responsibility.

29. Sub-section 67(1) should be altered by giving the power to appoint inspectors to the Commission not the Director.

30. Sub-section 68(1) should be amended by deleting 'reasonable'.

31. The power of the Tribunal under section 69 should be extended to reviewing directions given under section 63. It is at present intended that detailed conditions of licences should be prescribed in regulations but your Department has suggested that greater flexibility be given with respect to the conditions of a licence. In addition an officer of the Law Reform Commission in comments on the Ordinance has referred to the draft Child Welfare Ordinance appended to ALRC 18, draft section 122 and the N. T. Education Act, Part VII. Your Department has been asked to advise on the acceptability of the approach adopted in Part VII of the draft Child Welfare Ordinance.

32. The House of Assembly has requested that sub-section 71(3) of the draft Ordinance be deleted. It appears that the deletion of this sub-section would have implications not realised by the Assembly. The request does however raise the question whether costs should be awarded as the result of action taken under this Ordinance or whether each party should bear his own costs. It is requested that sub-section 71(3) be deleted and that the Ordinance provide that no costs should be awarded as a result of action under this Ordinance.

33. Section 73 should be altered to require the report to be prepared and furnished to the Minister by 30 September in each year for the year ending on the preceding 30 June. the report should only be made in relation to treatment orders and not include details of other matters or things.

,Section 74 should be altered to delete the reference to the Lunacy Ordinance - 1938:

35. A provision should be included in the Ordinance which provides that fees prescribed by the new legislation should be moneys of the Commission and not payable into the Consolidated Revenue Fund.

36. Where the advice of your Department has been sought the foregoing instructions indicate the expectations of the Commission that the advice will allow particular proposals to be effected. It is suggested that drafting could proceed on this basis.

S.J. Gisz