Mental Patient Rights

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"Understandably, Doctors believe that the very broad powers which they possess in matters of mental illness are necessary in the interests of the patient."

Ken Buckley. "All About Citizen's Rights", 1976.

However, in our view the provisions of Section 109 Mental Health Act of New South Wales, dealing with Electro-Convulsive Therapy, Electro-Narcosis Therapy and Insulin Schock, appear to be inadequate for the protection of the civil rights of mental patients.

Under these provisions, an involuntary mental patient may be subjected to such procedures when, in the opinion of a single person authorised to make such decisions, it is *reasonable and proper* to do so. And this is so *even in the case where the patient has not given consent.* Further, by section 110 (3) the patient is precluded from bringing any legal action "in respect of any damage or loss suffered ... as a result of" any such procedures being used.

Without wishing to express an opinion on the general effectiveness of ECT as a therapeutic procedure, about which there must remain considerable doubt, nevertheless, we believe that it represents a serious violation of bodily and mental integrity which if done without consent and outside of medical practise would form the basis for a very substantial recovery in money damages – and would also form the basis for a serious criminal prosecution.

That a patient is detained involuntarily should not, in our view, deprive that patient of such fundamental rights as those of bodily and mental integrity; that is the right *not* to be subjected to procedures of this type.

The Mental Health Review Committee, the Edwards Committee, has submitted proposals to the Health Commission for reforming the Act. With regard to the provisions of S109 relating to ECT, they have suggested some modifications. While in agreement with the view that the use of ECT "raises significant questions of civil liberties", the Edwards Committee commented: "We continue to believe that ECT administered involuntarily is justified morally and therapeutically in some limited number of cases ... and allowing appropriate safeguards". We do not believe that the Committee's own criteria are likely to be met. We do not believe that their proposals ensure that "appropriate safeguards" will exist, thus the procedure is unlikely to be confined to "a limited number of cases".

The Edwards Committee has recommended the use of ECT in mental institutions *whether or not an involuntary patient consents* so long as the medical superintendent so directs; and where the patient *does not actively object*, the direction may be made by two members of the staff of the institution. The criteria for the decision to use ECT remains the same – if it

is deemed *reasonable and proper* to do so, it may be applied. We believe this to be tantamount to no protection whatsoever from possible misuse in addition to making possible the routine application of coercive treatment of a potentially dangerous nature.

Our criticism of the proposed changes can be supported by parts of the Edwards Committee commentary. They note that "the decision to give ECT must be taken by the superintendent or two doctors. Generally the decision will be taken by two doctors." Now the decision must be that the use of ECT is *reasonable and proper* in the particular instance. But as the Edwards Committee notes, "ECT is a fairly standard treatment for severe depression (one of the most common mental illnesses)" It is our belief that the decision to use ECT is likely to be a routine formality: medical staff in mental institutions must generally believe it to be a reasonable and proper procedure or it would not be so commonly used at present.

Thus the Edwards Committee reforms will not effectively ensure a thorough consideration of ECT procedures. We are buttressed in this belief by a further comment by the Committee. In speaking of experimental procedures, they noted that "Of course in practice the medical convention of non-interference in the therapeutic discretion of other practitioners would generally mean that a superintendent would allow experimental or unusual procecures, even over his misgivings."

We believe that a mental patient, just as a patient in any hospital, ought to have a general right to his bodily and mental integrity – the right to be left alone, free from physical assault and invasion of mental privacy.

We do not believe that an involuntarily detained patient should lose the general right to refuse treatment. If the patient is alleged to be a danger to self, then that is a risk that that individual ought to be allowed to face with regard to specific forms of proffered treatment. If the patient is alleged to be a danger to others – which is extremely difficult to predict – then *detention* may possibly be justified, but coercive treatment is not justified.

Our concern is heightened by the proposal of the Edwards Committee to broaden the scope of the use of ECT to allow it to be used coercively upon forensic patients transferred from the criminal justice system who may not even be technically mentally ill within the terms of the Mental Health Act.

Further misgivings exist with regard to the use of ECT on voluntary patients who have consented. We question whether consent to such procedures can really be *informed* consent when it is not clear what the internal effects of the procedure are; it is also the case that consent given where the possibility exists of being made an involuntary patient should consent not be forthcoming may not really be consent.

We believe that the government should not implement the reforms regarding ECT suggested by the Edwards Committee, and that further use of ECT should be made the subject of a special and urgent inquiry

Since this comment was written the NSW Government have set up a limited enquiry into the use of ECT. A report on this and further developments will appear in the next issue. Ed.