LEGISLATIVE ASSEMBLY FOR THE
AUSTRALIAN CAPITAL TERRITORY

REPORT ON THE

INQUIRY INTO

THE MENTAL WELFARE AND

CRIMES (AMENDMENT) EXPOSURE DRAFT BILLS

REPORT NO. 5

OF

THE STANDING COMMITTEE ON SOCIAL POLICY

April 1994

RESOLUTION OF APPOINTMENT

The following general purpose standing committees be established to inquire into and report on matters referred to it by the Assembly or matters that are considered by the committee to be of concern to the community ...

... a Standing Committee on Social Policy to consider matters related to health, hospitals, nursing homes, welfare, employment, housing, social security, the ageing, people with disabilities, the family, Aboriginal people, youth affairs, the status of women, multicultural affairs, industrial relations, occupational health and safety, education, the arts, sport and recreation.

Minutes of Proceedings, 2nd Assembly, 27 March 1992.

COMMITTEE MEMBERSHIP

Ms Annette Ellis (Chair)

Mr Michael Moore (Deputy Chair) *(from 16 March 1993)*

Mrs Kate Carnell

Mr Greg Cornwell

Mrs Ellnor Grassby

Ms Helen Szuty *(to 16 March 1993)*

Secretaries: Mr Kim Bond *(to 4 March 1994)*

Mr Russell Keith *(from 4 March 1994)*

PREFACE

Developing mental welfare legislation is a complex task. Providing for individual and community needs in relation to persons who are sometimes not able to competently make decisions about their own welfare or who, for their own or the community's protection, may require involuntary detention for a period raises complex human rights questions. This complexity is reflected in the title of the 1990 review of mental health legislation in the ACT, *Balancing Rights*.

The rights of the individual must be protected. Such rights include the right to the best available mental health care; to be treated with humanity and respect, including the observance of the human rights that all people are to enjoy; to be protected from all forms of exploitation, abuse and discrimination; and, particularly when decisions are being made without the consent of the person, to a fair hearing and the due process of law.

It is also important that the administration of the system of providing treatment and care is done in the most 'user friendly' manner possible to ensure no increase to any distress or trauma to the patient while, at the same time, ensuring the rigorous enforcement of rights and due process.

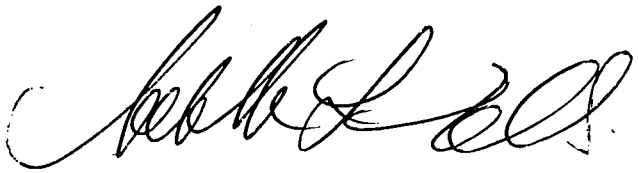
The system also has to be able to cater for everyone within the wide spectrum of people with a mental dysfunction, without inappropriately categorising or treating different people together. The system has to meet the needs of those who can manage their illness but require help with treatment, those who periodically require help in managing their illness, those who lack the capacity to look after their own welfare, those who are a danger to themselves or the community, and those who do not have a treatable mental illness but suffer from a psychological disorder that necessitates them requiring care. In doing this the system must have definitions that are narrow enough to prevent inappropriate treatment or care and broad and flexible enough to ensure that the system is able to cope with people who do not fall within any single neat definition.

The system also has to be able to cater for the needs of the family and carers of people with a mental dysfunction and the needs of the community.

The area of mental health legislation which the Committee examined forms a vital part of the framework of legislation, rules, and policies through which mental health services are delivered.

All of these points and more were raised in the large body of evidence received by the Committee. This report reflects the Committee's consideration of the issues raised in respect of the proposed Bills and makes recommendations on how the Bills may be amended to address concerns expressed.

There is no easy solution to all of these issues. That the committee was able to produce an unanimous report does not reflect a singularity of opinion on the issues raised by the legislation but is born out of the common view that measures must be taken immediately to improve the mental health regime in the ACT in terms of both legislation and services for people with a mental dysfunction. The recommendations of the Committee indicate a way forward for the ongoing development of mental health legislation in the ACT.



Annette Ellis MLA
Chair
20 April 1994

TABLE OF CONTENTS

SUMMARY OF RECOMMENDATIONS

Recommendation 1

4.7. The Committee recommends that the word "treatment" be deleted from clause 26H (c) of the draft Mental Health (Treatment and Care) Bill (clause 25 (c) of the draft Mental Welfare Bill).

Recommendation 2

4.9. The Committee recommends that sections 26 to 26H in the draft Mental Health (Treatment and Care) Bill be replaced with the original section 25 of the draft Mental Welfare Bill, with the addition of a clause specifying that an order for psychiatric treatment may only be given in relation to a person with a psychiatric illness.

Recommendation 3

6.9. The Committee recommends that the ACT Assembly enact as soon as possible legislation in terms of the amended draft Mental Health (Treatment and Care) Bill and Crimes (Amendment) Bill as interim legislation with a sunset clause effective 24 months from the commencement of the legislation, with provision for a 24 months' extension by a disallowable instrument from the Minister.

Recommendation 4

6.11. The Committee recommends that the draft Mental Health (Treatment and Care) Bill re renamed the Mental Dysfunction (Treatment and Care) Bill.

Recommendation 5

6.18. The Committee recommends that the Government continue to address the need for services for people with a mental dysfunction as a matter of urgency, noting particularly the need for more acute beds for people with a mental illness and services for children and adolescents requiring psychiatric intervention.

Recommendation 6

6.19. The Committee recommends that, for the duration of the proposed interim mental health legislation, a formal monitoring mechanism be established whereby the Government reports to the Standing Committee on Social Policy every six months on the need for and provision of services, including legal services, for people with a mental dysfunction.

1. INTRODUCTION

1.1. On 14 September 1993, the Standing Committee on Social Policy received the following reference from the ACT Legislative Assembly:

> *That orders of the day, Nos 39 and 40, Executive business, relating to the Mental Welfare Bill Exposure Draft and the Crimes (Amendment) Bill Exposure Draft, be referred to the Standing Committee on Social Policy for inquiry and report by 16 December 1993.*[1]

1.2. The reference followed a process of consultation undertaken by the Attorney General's Department and ACT Health on the exposure drafts which had drawn considerable response from the community and from professionals associated with mental health and related services.

1.3. The Committee met briefly on 15 September 1993 to put in train the process of the inquiry. Public advertisements calling for submissions were placed in the Canberra Times on Saturday 18 September 1993 and in community newspapers during the following week. The closing date advertised for submissions was 22 October 1993.

1.4. On 27 October 1994, the Committee received a private briefing from officials from the Chief Minister's Department, ACT Health and the Department of the Attorney General. The Committee was informed of the background to the drafting of the Bills and was briefed on the Government's responses to the 1992 report of the Mental Health Review Committee entitled *Balancing Rights*.

1.5. In the process of the briefing, ACT Health and the Attorney General's Department agreed to forward to the Committee the submissions they had received on the Bills during their consultation process.

1.6. The Committee received 30 submissions, with a further 32 being forwarded from the Attorney General's Department and 17 from ACT Health, giving a total of 79 submissions. Of this total, 22 were duplicated, giving a total of 57 distinct submissions on the exposure drafts. (Lists of the submissions received are at Appendices 1 to 3 inclusive.)

---

1 *Minutes of Proceedings*, 2nd Assembly, 14 September 1993.

1.7. In order to further explore what were clearly matters of some concern to the community, public hearings were held on Thursday 4 and Friday 5 November 1993 and were attended by 23 individuals, representing 14 organisations. A full list of individuals and organisations appearing before the Committee is in Appendix 4. Following the public hearings, further information was received from the Chief Minister's Department, including the report of the Interagency Working Group on Mental Dysfunction.

1.8. The Committee commenced the process of reviewing the large volume of evidence presented in submissions and during the public hearings and came to the conclusion that it could not discharge its reference by 16 December 1993. The Committee sought and was granted an extension of its reporting date by the Assembly on 9 December 1993, when it was agreed that the Committee could report:

> *by the last sitting day of April 1994.*[2]

1.9. This arrangement gave the Committee until 21 April 1994 to complete its work.

---

2 *Minutes of Proceedings*, 2nd Assembly, 9 December 1993.

2. DISCUSSION OF THE MAJOR ISSUES ARISING FROM THE EVIDENCE

2.1. The volume of written material received by the Committee demonstrated a high level of community concern about the draft Bills. The range of views presented to the Committee led it to believe that there is a degree of polarisation of opinion as to what the draft Bills should encompass.

2.2. Most submissions were from professionals working with, for example, people with mental illnesses or intellectual disabilities. They included lawyers, psychiatrists and psychiatric nurses. A lesser number were from groups advocating on behalf of such people, including self-help organisations for the mentally ill and groups of concerned citizens. The minority were from those caring directly for family members.

2.3. Flowing from the range of views expressed in evidence, the Committee was faced with the task of sifting the principal issues out of the general evidence and addressing them in turn. The members recognised that any such separation could be seen to be arbitrary: however, the complexity of the evidence was a compelling factor in favour of such an approach.

2.4. Another factor was the observation that many arguments appeared to recur across submissions and during the public hearings: by looking for such consistent matters, the Committee was able to focus on what it agreed were the major issues and to consider each on its merits. What follows, therefore is a the presentation of a series of key arguments, accompanied by the principal points for and against each, providing insight into the basic debates canvassed in the evidence.

The definition of "mental dysfunction" is too broad.

2.5. This concern was expressed in over a third of the written submissions and formed the basis of many consequent issues. As one carer put it:

> *The general confusion arising from the use of the terms 'dysfunctional' and 'mentally ill' should be resolved so that there is legislation dealing specifically with the mentally ill rather than a conglomeration of neurotic and other conditions. The inclusion of the intellectually handicapped under mental health legislation is entirely erroneous.*[3]

2.6. It was argued that the broad definition had the effect of including a range of clinical phenomena with different causes under the same heading, contrary to what is considered "best practice" in other jurisdictions.

2.7. The overall effect of using such a definition would be one of "net-widening", meaning that more people will become involved with the mental health system, thus stretching its resources, without effectively resolving the central issue of ensuring that there is access to a range of treatment options.

2.8. Turning to broader concerns, one submission pointed out that:

> *UN Principle 4*[4] [of the Resolution on the protection of persons with mental illness and the improvement of mental health care] *requires that a determination of Mental Illness be made in accordance with internationally accepted standards. This could be achieved either by reference to a legislated definition or by reference to an international medical standard ...*[5]

2.9. This point was supported in a number of submissions, which reinforced the idea that international obligations require a definition of mental illness in laws affecting the treatment of the mentally ill.

2.10. More parochially, it was also pointed out that a broad definition of mental dysfunction could be seen to be inconsistent with recent legislative developments interstate. Such an outcome could be at odds with the objectives of the National Mental Health Plan, in which the ACT Government is an active participant, which include ensuring consistent mental health legislation across Australia.

---

3 Mrs Pat Linford, Submission to the Inquiry, 3 October 1993, p.4.

4 "Principle 4 Determination of mental illness 1. A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards ...." United Nations General Assembly resolution on the protection of persons with mental illness and the improvement of mental health care, adopted 17 December 1991.

5 Mental Health Action Group, Submission to the Inquiry, 27 August 1993, p.8.

2.11. A number of submissions took a different view of the broad definition, arguing that narrow professionally administered definitions allow those within professions to claim that a person with a mental dysfunction does not fit neatly into usual medical or legal categories. Having fallen outside their notional jurisdiction, it becomes very easy to "pass the buck". It is argued that the result is that those in need of attention fall between the definitional gaps used by professionals and out of the safety net of services which may be able to assist them.

> [The wide definition of mental dysfunction is included because] *there is a strongly perceived need to have a Tribunal in the ACT with the responsibilities and powers to ensure that people with disabilities have access to the services they need. Problems in the past have not arisen for persons who fall into accepted categories eg. mental health or intellectual disability but for those who do not fit neatly into these categories and therefore fall between the gaps in the system ... it is difficult for key agencies in the criminal justice system (police, the courts) to get a determination as to what disability a person is suffering from and what services are available to help that person, therefore a wide initial gateway is necessary ...*[6]

2.12. In essence, it is argued that the broad definition of mental dysfunction ensures that what is termed the right to treatment is observed.

The powers of the proposed Mental Welfare Tribunal are too broad.

2.13. As is demonstrated above, the broad definition of mental dysfunction and the role of the proposed Tribunal are closely linked within the draft Bills. Hence, a similar number of submissions raised concerns about the broad powers of the Tribunal to those concerned by the broad definition of mental dysfunction.

2.14. The essence of the arguments put in a number of submissions was that the Tribunal is a heavy handed way of imposing a solution to definitional and operational differences between professional groups:

> *The* [Mental Welfare Bill] ... *does not make its scope honestly apparent. The Tribunal may make determinations which bind any part of the Health and Welfare system. This is not apparent from a reading of the bill and many services are not aware of it. This glossing over will simply relocate arguments about responsibility to another place rather than resolve those arguments.*[7]

---

6 Mr John McGinness (ACT Attorney General's Department) in correspondence to Mr David Plant, 27 October 1993, p.4.

7 Dr Stephen Rosenman, Submission to the Inquiry, 26 October 1993, p.1.

2.15. The issue was most apparent when considering who has responsibility for the care of those who commit criminal acts, whose behaviour is problematic within mainstream society, but who are not mentally ill according to any internationally accepted clinical definition:

> [The Attorney General] *has been quoted as saying that lawyers like the* [Mental Welfare] *bill. I am not surprised. Lawyers have shown that they do not know what a clinically defined mental illness is. If this Bill becomes law, it will provide the courts with a very convenient way of dealing with people with behavioural problems.*[8]

2.16. Others made the point that the establishment of a Tribunal is not a solution to problems of coordination between existing services or to gaps in service provision. One submission made the point that widening the definition of mental dysfunction and establishing the Tribunal would be useful in ensuring that a greater number in need received attention, and that it followed that:

> *... once the Tribunal is set up ... the numbers of people suffering from mental illness in the ACT will become apparent, and the lack of places for these people will become even more apparent.*[9]

2.17. Turning to other concerns, professional medical groups claimed that the Tribunal's functions have the potential to seriously prejudice accepted ethical practices for medical practitioners in the mental welfare arena:

> *... professional staff will be required to provide services to a range of people unlikely to benefit* [from such treatment] *... will be forced into "custodial" rather than therapeutic relationships with clients ...* [and] *will be compromised in their ability to provide services to those who might genuinely benefit from them ...*[10]

2.18. Within the legal arena, it was argued that the powers of the Tribunal to curtail liberty are very great for an inferior court wherein the rules of evidence do not apply:

---

8 Ms Mary Cooper, Canberra Schizophrenia fellowship, Submission to the Inquiry, 7 September 1993, p.2.

9 Ms Vanessa Sargeant, Youth Affairs Network of the ACT, Submission to the Inquiry, 23 August 1993, p.1.

10 Mr D Kirk, Australian and New Zealand College of Mental Health Nurses, Submission to the Inquiry, 7 September 1993, p.3.

> *... this is a Tribunal of considerable power ...* [which] *effectively has the power to deny liberty for substantial periods. ... There is, in our view, no sound policy reason why the procedural hurdles which ensure fairness, namely the rules of evidence, should not apply ...*[11]

2.19. However, others put the view that the Tribunal's primary function is to ensure that all applications receive an assessment and a decision regarding their disposition. Its determinative powers exist to ensure that no person subject to an application to the Tribunal will be lost to the system or left in limbo, and that any deprivation of liberty occurs only after due process has been observed.

2.20. Pursuing the point further, the fears that the Tribunal will make unusual or ill-informed determinations appear to be based on:

> *... a presumption that ... if you establish a Tribunal, then no matter who you put on that Tribunal, they will act in an irresponsible and capricious manner and they will willy-nilly commit people for care who do not need it.*[12]

2.21. The proposed composition of the Tribunal, chaired by a Magistrate and drawing membership from the mental health professions and the community, would militate against such fears becoming a reality.

2.22. Further, it was pointed out that formal proceedings adhering to the rules of evidence may be discomforting to a range of people with mental dysfunction[13], which may prejudice their ability to present their position in the best possible light or may indeed have effects directly counter to therapeutic aims.

The Mental Welfare Bill should specify a clear pathway for voluntary treatment.

2.23. If a primary aim of the Bill is to ensure the right to treatment in the least restrictive mode, then it should contain a clear pathway for voluntary treatment. However, as one witness put it:

---

11 Legal Aid Office (ACT), Submission to the Inquiry, 1 October 1993, p.4.

12 Mr Ken Crispin, Director of Public Prosecutions, *Transcript of evidence to the Public Hearing*, 4 November 1993, p.91.

13 Mr D Kirk, op. cit., p.2.

> *Under the proposed Balancing Rights regime, they can knock on the door of the hospital and they have a right to be assessed. Under the* [Mental Welfare] *bill they have to go to the Tribunal, get an order and the order has to say, "Okay, this person must be assessed," and then they get assessed.*[14]

2.24. Ease of access to assessment and treatment is particularly important for those seeking repeat admission for mental illness.[15] An accepted and publicly accessible pathway ensures that those with an insight into their condition are admitted to treatment in the most humane manner possible. It also serves to alleviate the frustration of those seeking assistance voluntarily and to reduce the stigma attached to seeking treatment by making voluntary admission the norm.

2.25. However, it may be argued that the pathway for enforceable voluntary treatment is implicit within the Bill: it simply involves applying to the Tribunal for an assessment, thus providing access to treatment with a measure of protection not otherwise available[16]. It should also be noted that the Bill does not affect a person's right to seek mental health treatment by the same means as they would seek any other health treatment, and that avenues of complaint exist under the *Health Complaints Act 1993* if such treatment is refused.

2.26. Also, making the pathway explicit could well be interpreted as an act of discrimination which may serve to institutionalise voluntary treatment rather than moving it into the mainstream of medical and welfare service delivery, which are key aims of the National Mental Health Plan[17].

---

14 Mr Nicholas Seddon, *Transcript of the Public Hearing*, 4 November 1993, p.15.

15 Ms Mary Cooper, op. cit., p.2.

16 Mr John McGinness, op. cit., pp.10. and 12.

17 Australian Health Ministers, *National Mental Health Policy*, AGPS, April 1992, p.17.

The current system of services available to the mentally dysfunctional in the ACT is not adequate and will be overloaded should the Bills be enacted in their current form.

2.27. It was argued in a number of submissions that the combination of a broad definition of mental dysfunction and the sweeping powers of the Tribunal will necessarily result in an increase in dispositions to existing services. The possibility for overloading current facilities was referred to at paragraph 2.16. above and was reiterated in submissions from a number of agencies currently working with the mentally ill:

> *We would like members of the Assembly to understand the extreme pressures on beds in the psychiatry ward at the* [Woden Valley Hospital]. ... *Mental health services are already quite severely under resourced and this legislation does not take into account our limited facilities.*[18]

2.28. The May 1993 report of the Interagency Working Group on Mental Dysfunction identified eleven gaps in service delivery for those with mental dysfunction:

> *Lack of:*
>
> *A. appropriate and effective community facilities and services*
>
> *B. secure treatment facilities for medium to longer term mentally ill*
>
> *C. services for children and adolescents requiring psychiatric intervention*
>
> *D. services for young children requiring psychological intervention*
>
> *E. services for mentally dysfunctional people to meet the needs of Aboriginal Peoples and Torres Strait Islanders*
>
> *F. accommodation options for intellectually disabled*
>
> *G. emergency back up system*
>
> *H. acute beds for people with a mental illness*
>
> *I. services for mothers with small children*
>
> *J. appropriate facilities for inebriates*
>
> *K services for babies and young children.* [19]

---

18 Registrars of Psychiatry, Submission to the Inquiry, 25 August 1993, p.1.

19 Interagency Working Group on Mental Dysfunction, *Final Report*, 1993, p.1.

2.29. When forwarding the Working Group's Report, the Chief Minister included a progress report of 3 February 1994 indicating the action the Government had taken to address these gaps. While some work had been initiated to address most of the gaps and resources were provided to address A, G and J in the 1993-94 ACT Budget, major gaps identified for some time (for example gap H – the need for acute beds, and gap C – psychiatric services for children and adolescents) remain outstanding and will require considerable resourcing to be addressed effectively. The pressure on acute beds was noted at paragraph 2.27. above. The need for services for young people was raised by *Balancing Rights* in 1990:

> *The absence of specifically tailored services and facilities in the ACT for young people with psychiatric illness was identified as an issue many years ago. ...*
>
> *The* [ACT Mental Health Review Committee] *considered that the highest priority should be accorded to resolving issues relating to services for children and young people ... and secure facilities for dangerously mentally dysfunctional people ...*[20]

2.30. It was argued that the ACT does not have, at present, a suitable mix of services as proposed in the *National Mental Health Plan*[21]. The significant gaps in service delivery outlined above would need to be filled within a short time frame for the legislation to be effective in its current form.

2.31. Implicit in a number of submissions was the inference that the coordination of mental welfare services in the ACT is problematic. As noted at paragraph 2.14. above, the Bills would address this matter through the powers of the Tribunal without resolving the underlying issues.

---

20 ACT Mental Health Review Committee, *Balancing Rights*, 1990, pp.142 and 135.

21 Australian Health Ministers, op. cit., pp.20-21.

2.32. It must be noted, however, that the work of the Interagency Working Group on Mental Dysfunction and the 1993-94 ACT Budget initiatives demonstrate a high level of commitment by the ACT Government to addressing the issues of service coordination and adequacy. Further, concerns that the new legislation will overload existing facilities appear to be based on the assumption that the Tribunal will refer the majority of its cases to existing mental health facilities for treatment and overlooks the fact that the Tribunal is empowered to make dispositions across a range of services, thus spreading the load. Addressing the matter directly to mental health services, the Attorney General's Department stated that they:

> ... *do not believe that the* [Mental Welfare] *Bill will have the effect of adding significantly to your client group, although there may be some marginal increment as a result of improved access for people that the system has inadequately responded to in the past.*[22]

2.33. Indeed, it can be argued that since the degree of unmet need is not clearly known, it should not form the basis for restricting the development of new legislative approaches.

2.34. Further, it is entirely possible that the process of implementing the legislation will shed light on areas which require greater resources or more efficient coordination. With particular regard to coordination:

> *The consultative process contemplated* [under the Bills] *would normally render it very difficult for an agency to avoid its service obligations. Indeed the functioning of the Tribunal is likely to encourage the evolution of a much more responsive and comprehensive system of service delivery ...*[23]

The Office of the Community Advocate and the Legal Aid Office (ACT) are not resourced sufficiently to undertake the additional duties which may arise from the Bills.

2.35. Submissions noted that the Community Advocate would acquire statutory roles under the Bills which, while laudable, could not be adequately carried out given the current levels of staffing.

---

22 Mr Gavan Cashman, ACT Attorney General's Department, Correspondence to Ms Prue Wilson, ACT Mental Health Services, 24 September 1993, p.2.

23 Ibid., p.8.

2.36. When this matter was raised with the Community Advocate during public hearings, she was confident that the needs of the Office for resources to carry out its duties would be addressed.[24]

2.37. With regard to the Legal Aid Commission, the Law Society pointed out that the Commission currently serviced the legal needs of many mentally dysfunctional clients[25]. It is therefore reasonable to expect that an active Tribunal would result in an additional workload for the Commission, one which it is not equipped to handle.

The process of application to the Tribunal is open to vexatious abuse.

2.38. Many of the submissions raised the concern that a lack of adequate definition within the application process could well draw a range of applications focusing on people whose behaviour is eccentric but whose activities are not essentially harmful, dangerous or illegal:

> ... *we would prefer to see ... an outline* [in the Mental Welfare Bill] ... *of the matters which should be contained in a statutory declaration* [to the Tribunal] *including any prior diagnosis, any violent behaviour observed by the deponent, any behaviour suggesting harm to the particular subject.*[26]

2.39. Also, an application process with insufficient regulation could well see the Tribunal expending considerable time and resources "weeding out" unwarranted applications rather than focusing on substantial cases.

2.40. On the other hand, a complex application process will inhibit people seeking assistance for matters associated with mental dysfunction, possibly reinforcing the social stigma already attached to mental dysfunction.

A pre-hearing conference system would alleviate many of the concerns relating to the powers of the Tribunal.

2.41. During the public hearings the Chief Magistrate outlined an experimental pre-hearing conference system currently being used to assist the Magistrate's Court with applications under the existing Mental Health Act 1983:

---

24 Ms Heather McGregor, Community Advocate, *Transcript of the Public Hearing*, 4 November 1993, p.84.

25 ACT Law Society, Submission to the Inquiry, 1 December 1993, p.1.

26 Legal Aid Office(ACT), op.cit., pp.6-7.]

> *... at this stage, the pre-hearing conference ... is a very loose thing, and we do not want to be too prescriptive about it, but the basic idea ... is to try and find out what the application* [under the Mental Health Act 1983] *is all about, try and make sure that all the information and solutions that might be available have been explored, and also the doctors often attend. The person, depending on their state, might also attend, the prescribed representative and the representative from Legal Aid attend, and in a large number of cases, solutions are arrived at by that process.*[27]

2.42. Adding a stage prior to a hearing of the Tribunal gives all parties a forum to consider the consequences of an application as well as an opportunity to re-assess the situation and call upon additional advice. It appears likely that strategies for managing the original situation will emerge from the pre-hearing stage without the need for formal intervention and its attendant stigma.

2.43. However, it can also be argued that adding another layer to the process does not essentially change its nature. The pre-hearing conference could not be seen, for example, as a substitute for a defined pathway for voluntary admission for treatment.

The Bills should make explicit the right of those subject to an assessment to have the right to a second medical opinion.

2.44. This point was stated a number of times in the submission of the ACT Mental Health Advisory Council and was repeated in other submissions. The Council was concerned that the proceedings of the Tribunal make explicit that a second medical opinion could be obtained before a treatment order was determined.[28]

2.45. Ensuring that second opinions are readily accessible to those before the Tribunal could serve to bolster the integrity of the procedures outlined within the Bills. It recognises the rights of those before the Tribunal and could serve to alleviate community concern that the Tribunal might make ill-informed dispositions.

---

27 Mr Ron Cahill, ACT Chief Magistrate, Transcript of the Public Hearing, 5 November 1993, p.142.

28 Ms Libby Steeper, ACT Mental Health Advisory Council, Submission to the Inquiry, 26 October 1993, pp.10-11.

2.46. It should be noted that the Bill does require that all persons admitted to or treated at a mental welfare facility are informed of his or her right to a second opinion and a person's right to give evidence at a proceeding of the Tribunal would include the right to submit a second medical opinion.

The summary powers extended to the Police by the Bills are unprecedented and dangerous.

2.47. The ACT Mental Health Action group raised a number of serious objections in relation to the powers accorded to Police officers under the Bills. The powers of Police officers to apprehend, subject to an application to the Tribunal, are very broadly defined and open to considerable abuse.[29] They may well leave Police open to accusations of prejudice should they apprehend people whose behaviour is eccentric but whose activities are not essentially harmful, dangerous or illegal.

2.48. They may also lead to accusations of negligence if the Police fail to act where a danger to the community is perceived or later identified: this places Police in a position of double jeopardy.

2.49. The Law Society placed these concerns within the wider context, asserting that the proposed legislation fails completely to address:

> *... the lack of appropriate institutional facilities in the Territory for the care, supervision and treatment of people suffering mental dysfunction who offend against the criminal code ... no provision is made to facilitate the education and training of police officers, custodial officers or people involved in the judicial system which would enable them to recognise and deal appropriately with mental dysfunction.*[30]

2.50. Such views must be balanced against the intention of the Bills to act promptly to serve the needs of the mentally dysfunctional and to protect the community. Hence, Police officers need the support of legislation which empowers them to apprehend in instances where they have reason to believe that mental dysfunction is the major factor.

---

29 Mental Health Action Group. op. cit., pp.19-21.

30 ACT Law Society, op.cit., p.3.

***There is considerable potential for an overlap of functions with the guardianship board. The Bills do not make sufficient allowance for minors nor for matters under the* Children's Services Act 1986.**

2.51. These matters of the Bills' effect on related legislation (including the Commonwealth Crimes Act 1914) was raised in a number of submissions, including those of the Legal Aid Office (ACT)[31], the Children's Services Council[32], and the ACT Chief Magistrate[33].

2.52. The Children's Services Council was quite specific in its advice, recommending that section 26 of the Children's Services Act 1986 be strengthened, ensuring the transfer of proceedings from the jurisdiction of the Bills to that of the Act.

2.53. The relationship of the Bills to the Guardianship and Management of Property Tribunal raises a central concern about their scope: that is, should mental health and care and control matters be dealt with under one piece of legislation? Mr Nicholas Seddon (among others) felt that the Mental Welfare Bill glossed over this distinction:

> [Balancing Rights] *recognised that there was a mental health function whereby a psychiatrist can do something about someone's condition and a ... quite separate ... care function when you are dealing with people who do not necessarily have a mental illness but who are incapable of looking after themselves or* [are] *possibly ... a danger to the community. Those two functions were separated in* [Balancing Rights] *and I think that the exposure draft Bill does not sufficiently separate those.*[34]

2.54. The distinction of the mental health and care and protection roles is useful in that it draws attention to the need for a range of systems to deal effectively with mental dysfunction rather than assuming that one system can accommodate all such matters. It also serves to make clear where control is being exercised and distinguishes it from situations where treatment is the primary aim.

---

31 Legal Aid Office (ACT), op. cit., pp.10-11.

32 Ms Dianne Procter, Children's Services Council, Submission to the Inquiry, 27 October 1993, p.2.

33 Mr Ron Cahill, ACT Chief Magistrate, Submission to the Inquiry, 26 October 1993, p.2.

34 Mr Nicholas Seddon, op. cit., p.3.

2.55. Contrary to the position above is the argument that combining the two functions ensures that people receive the combination of care, protection and mental health assistance that they need through one process, rather than through two or more separate processes. This prevents people from failing to receive services that would assist them and from "falling between the cracks" of services.[35]

35 Mr Jon McGinness, op. cit., p.4.

3. FINDINGS IN RELATION TO THE MENTAL WELFARE AND CRIMES (AMENDMENT) EXPOSURE DRAFT BILLS

3.1. The Committee's investigations found that there was support for the general intent of the Mental Welfare and Crimes (Amendment) exposure draft Bills and wide acknowledgment of the need for new, comprehensive mental health and welfare legislation in the ACT. There was also a variety of views on a number of points in relation to the Bills and some consistent themes in criticisms raised.

3.2. The Committee found that there were three major areas of concern in relation to the draft Bills:

- the definitions in the Bills, particularly the blurring of the distinction between treatable illness and behaviour disorders;
- the lack of clarity on the roles and powers of the Tribunal, particularly in its roles of administering treatment and care;
- the need for services to implement the Bills and the inability of current services to meet this need.

3.3. To address these concerns, the Committee considers that the Bills would need to be amended to clarify the different roles of providing treatment for people with treatable illnesses and caring for people with behavioural disorders.

3.4. As outlined in paragraphs 2.5. to 2.26., the main concerns in relation to the draft Bills was their broad brush approach to mental dysfunction without clear, explicit differentiation between mental illness (health problems) and mental disorder (behavioural problems). This lack of differentiation leads to an apparent confusion between the care and treatment roles of the Tribunal.

3.5. The Committee would be loathe to see the application of narrow definitions that would result in people in need failing to receive care or treatment. It also recognises the need for the system to be able to manage those suffering from both a mental illness and a mental disorder. Nevertheless, in order to help clarify the roles of the Tribunal and the different paths of treatment and care through the Bill, members considered that the Bill should include a clear definition of mental illness.

3.6. Members considered that the Bill needed to be amended to indicate clear, distinct pathways through the Tribunal for care and treatment, including voluntary treatment. Through this process, it would be necessary to clarify the Tribunal's powers in relation to ordering treatment and detaining persons and its relationship with the Guardianship and Management of Property Tribunal.

3.7. Although the issue of services for people with a mental dysfunction is not an issue to be addressed within the Bills, the Committee is most concerned that this issue is addressed parallel to the Bills. This issue is further addressed in Chapter 6.

4. AMENDMENTS TO THE MENTAL WELFARE BILL

4.1. The Committee having received evidence in terms of that outlined in Chapter 2., the Committee Chair asked the Attorney General's Department to outline possible ways of addressing concerns raised in relation to the draft Mental Welfare Bill. In response, the Department redrafted the Bill under the name "Mental Health (Treatment and Care) Bill" as a discussion paper for the Committee's consideration.

4.2. The amended draft Bill was restructured to make the pathways through the Bill clearer and modified in a number of areas, including:

- providing for a definition of psychiatric illness;
- making explicit the different treatment orders available for psychiatrically ill and other mentally dysfunctional persons;
- making explicit that a person may apply to the Tribunal on his or her own behalf;
- ensuring the Tribunal is constituted appropriately for the needs of the person applying or referred;
- ensuring the Tribunal takes the views of carers into account when giving treatment orders;
- improving the protections for persons subject to a treatment order for convulsive therapy;
- ensuring a person has access to their lawyer at all times;
- providing for pre-hearing conferences by the Registrar;
- binding the Tribunal to the rules of evidence when exercising certain functions;
- making explicit a person's right to an interpreter;
- ensuring the right of appeal to the Supreme Court on the merits of a Tribunal decision;
- clarifying the role of guardians under the Bill; and
- making explicit the right of voluntary patients to refuse treatment or discharge themselves at any time.

4.3. These amendments largely address most of the major concerns of the Committee in relation to the Bill itself outlined in Chapter 3.

4.4. The inclusion of a definition of psychiatric illness in the Bill and the amendments to provide that only a person shown to be suffering from a psychiatric illness may be given an order for psychiatric treatment address the concern that the Bill lacks a definition of mental illness and fails to distinguish between treatable illness and other forms of mental dysfunction.

4.5. The Committee considers that the draft Mental Health (Treatment and Care) Bill would require some further amendment to adequately address concerns raised by its inquiry.

4.6. Some Members of the Committee were concerned that the Tribunal's power to order "specified treatment"[36] may, despite the limitation on ordering "the administration of a particular drug or the way in which a particular clinical procedure is to be carried out"[37], give the Tribunal a decision making role in an area that is properly the province of the professional who is treating the person. The Committee also considered the reference to "treatment" in a type of order that could be given in regard to other than psychiatrically ill persons was inappropriate.

4.7. The Committee recommends that the word "treatment" be deleted from clause 26H (c) of the draft Mental Health (Treatment and Care) Bill (clause 25 (c) of the draft Mental Welfare Bill).

4.8. Members of the Committee were also concerned that a person should not fall within the jurisdiction of the Tribunal merely as the result of an intellectual disability or merely because of substance abuse.

4.9. The Committee recommends that sections 26 to 26H in the draft Mental Health (Treatment and Care) Bill be replaced with the original section 25 of the draft Mental Welfare Bill, with the addition of a clause specifying that an order for psychiatric treatment may only be given in relation to a person with a psychiatric illness.

---

36 Draft Mental Health (Treatment and Care) Bill, s. 26H (c)

37 ibid, s.28

4.10. The Committee considers that there needs to be special provision for minors in relation to mental health care, as required under the Australian Health Ministers' *Mental Health statement of rights and responsibilities* and the United Nations *Resolution on the protection of persons with mental illness and the improvement of mental health care.* The Committee notes that the Attorney General's Department informed the committee that this issue would be addressed in the next stage of the drafting process and that most of the consequent amendments would be within the *Children's Services Act 1986.*[38]

4.11. The Committee notes that the provisions for psychiatric surgery, although an improvement on the existing provisions, are not entirely consistent with the United Nations Principles endorsed by Health Ministers. The provision for such surgery on persons subject to an order of the Tribunal clearly contravenes Principle 11, and the provision of surgery on those unable to consent on their own behalf on the basis of consent by the Supreme Court arguably contravenes the requirement for consent. The Committee draws these comments to the Government's attention.

4.12. The Committee also notes that the draft Mental Health (Treatment and Care) Bill does not provide an enforceable right to treatment or assessment except by application to the Tribunal on the grounds that a person is significantly at risk or a danger to the community, although a provider unreasonably not providing a service is grounds for complaint under the *Health Complaints Act 1993*[39].

---

38 Mr G. Cashman & Dr C. Mead, Submission to the Inquiry, 2 November 1993, pp.25-6

39 *Health Complaints Act no. 96. 1993*, s. 22.

5. NATIONAL AGENDA — IMPLICATIONS FOR THE A.C.T.

5.1. In 1992, all Australian Health Ministers endorsed the *National Mental Health Policy* and the *National Mental Health Plan.*

5.2. In regard to legislation, the *Policy* states that its objectives are:

- *to ensure that mental health legislation across Australia is consistent and that it affirms the rights contained within the Australian Health Ministers' Statement of rights and responsibilities and the United Nations Resolution on the protection of rights of people with a mental illness; and*
- *to ensure that legislation in other sectors is consistent with the principles set out in the National mental health policy.*[40]

5.3. The *Plan* sets out strategies for implementing the *Policy*. In regard to legislation, it states that within the life of the *Plan* (1993 to 1997) the States and Territories will:

- *develop, as soon as possible, State/Territory legislation consistent with the United Nations Resolution;*
- *ensure, as soon as possible, that all mental health legislation incorporates the principles agreed by Health Ministers in the National Mental Health Statement of Rights and Responsibilities;*
- *identify cross border anomalies by 1 July 1993; and*
- *by 1 July 1995 to have in place administrative and legislative arrangements which facilitate the transfer of people with mental disorders across State/Territory borders.*[41]

5.4. The Australian Health Ministers' Advisory Council's (AHMAC) Working Group on Mental Health has established a sub-committee on legislation which is oversighting the development of "model clauses" to facilitate the development of nationally consistent mental health legislation. Consultants have been engaged to draft model clauses to be presented to the sub-committee by the end of October. The consultants are to work under the guidance of the sub-committee and are to consult with relevant organisations, including State and Territory Attorney General's and Health Minister's Departments. Following consideration by the sub-committee and AHMAC, these model clauses will be submitted to Health Ministers for consideration.

---

40 Australian Health Ministers, op. cit., p.28

41 Australian Health Ministers, *National Mental Health Plan*, AGPS, April 1992, pp.11-12

5.5. The AHMAC Working Group is also doing work on performance indicators by which all jurisdictions' efforts to implement the *Policy* and *Plan* may be monitored in terms of both service provision and legislation.

5.6. The ACT is an active participant in AHMAC and the subcommittees outlined above.

5.7. The Committee considers that it is important that the ACT continues its involvement in the work being done by AHMAC and that the ongoing development of mental health legislation and services in the ACT is coordinated with that work being done at a national level. The Committee also notes that it is uncertain when and if the model clauses being developed by AHMAC will receive endorsement by Health Ministers and that, in any case, the clauses are not likely to be considered by Health Ministers earlier than some time in 1995.

6. RECOMMENDATIONS — INTERIM LEGISLATION & RESOURCES PROVISION & MONITORING

6.1. The Committee considers that steps need to be taken as soon as possible to address the urgent needs the inquiry found; most particularly to provide adequate treatment and care for people with mental disorders without recourse to the criminal justice system. There are two major broad areas of need: new legislation and adequate resources.

Mental Health Legislation

6.2. ACT mental health legislation is in urgent need of change. As pointed out in *Human Rights and Mental Illness* (the Burdekin Report), "the ACT *Mental Health Act of 1983* is the least comprehensive of any mental health legislation in an Australian State or Territory."[42] In particular, the Committee found that the current legislative regime fails to provide for the care of people with behavioural disorders. Such people are instead being dealt with by the criminal justice system.

6.3. The Committee considers that the ACT needs to enact new legislation to deal with the inadequacies of the current regime as soon as possible. It is therefore not acceptable to await the development of national model clauses (see Chapter 5.) before enacting new ACT legislation.

6.4. Given that the amended version of the Mental Welfare Bill prepared for the Committee, the draft Mental Health (Treatment and Care) Bill, implements most of the recommendations of *Balancing Rights*, appears to be generally consistent with the principles agreed to under the *National Mental Health Policy* and *Plan*[43], and has been amended to address concerns raised in evidence given to the Committee, the most expedient way forward would be to enact legislation in terms of that draft Bill.

---

42 Human Rights & Equal Opportunity Commission, *Human Rights & Mental Illness: Report of the National Inquiry into the Rights of People with Mental Illness*, p.123

43 The Committee noted that the provisions relating to psychiatric surgery, although an improvement on the existing legislation, are not entirely consistent with United Nations Principle 11.

6.5. Nevertheless, some Members of the Committee, while agreeing that enacting the draft Mental Health (Treatment and Care) Bill would be, given all the circumstances, the most expedient way to improve the mental health regime in the ACT, remained unhappy with the broad deliberative powers of the Tribunal.

6.6. The Committee also notes the high degree of community concern expressed in the evidence presented to it about various aspects of the operation of the Tribunal. Although the proposed amendments go a long way to addressing these concerns, the Committee believes it will also be necessary to review the Bill in light of its operation.

6.7. The Committee is also mindful of the work being done nationally and believes that it is important that the ACT not be out of step with the rest of the nation. It is essential that any new legislation continue to be reviewed in light of national developments to obtain the maximum benefit from the work being done around Australia in this area and to ensure national consistency.

6.8. To ensure that adequate and timely review of the Bill occurs and in recognition of the work being done to develop nationally consistent legislation, the Committee considers that the Bill should be passed as interim legislation with a sunset clause effective 24 months from the commencement of the legislation. In order to allay fears that a sunset clause may result in a legislative void and to allow the Government some flexibility in the review process, provision should also be made for a 24 months' extension by a disallowable instrument from the Minister.

6.9. The Committee recommends that the ACT Assembly enact as soon as possible legislation in terms of the amended draft Mental Health (Treatment and Care) Bill and Crimes (Amendment) Bill as interim legislation with a sunset clause effective 24 months from the commencement of the legislation, with provision for a 24 months' extension by a disallowable instrument from the Minister.

6.10. The Committee takes note of the fact that the draft Mental Health Bill covers more than simply mental health issues as the term "mental dysfunction" within the Bill covers a range of conditions that are not health conditions, such as behavioural disorders. The Committee considers that the title of the Bill should be amended to reflect more accurately the Bill's function and so as to not add to the current public confusion between mental health conditions and other forms of mental dysfunction.

6.11. The Committee recommends that the draft Mental Health (Treatment and Care) Bill re renamed the Mental Dysfunction (Treatment and Care) Bill.

Resources for Mental Health

6.12. The other area of urgent need found by the Committee was the provision of services for people with a mental dysfunction. Members were concerned that, without the provision of adequate resources, new legislation will fail to help people in need of treatment or care and might even aggravate their situation.

6.13. As outlined in paragraph 2.28., the Interagency Working Group on Mental Dysfunction identified eleven gaps in service delivery for people with a mental dysfunction in May 1993.

6.14. Members note the steps the Government made under the 1993-94 Budget to address these gaps and the commitment shown by the Government in addressing the service needs of people with a mental dysfunction (paragraph 2.32.).

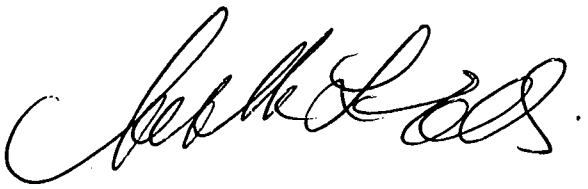
6.15. However, the there are still significant gaps raised by the Working Group that have not yet been adequately addressed and these gaps in service delivery were felt by those giving evidence to the inquiry. More acute beds for people with a mental illness and services to children and adolescents requiring psychiatric intervention are areas of particular need.

6.16. A number of submissions to the inquiry expressed the concern that current services would not be able to meet the demands placed on it by the proposed legislation. The Committee shares these concerns. It is not possible to quantify the effect new legislation will have on demand for services, but it is likely that the legislation will increase the demand for services and change the type of service mix required. An effect of the Bill would also be to make more explicit the demand for particular services.

6.17. It is imperative that new legislation is accompanied by the provision of resources for services for people with a mental dysfunction. In the first instance, this means that the Government must take further steps immediately to meet the needs identified by the Interagency Working Group. It also means that the need for resources must be continually monitored throughout the life of the interim legislation.

6.18. The Committee recommends that the Government continue to address the need for services for people with a mental dysfunction as a matter of urgency, noting particularly the need for more acute beds for people with a mental illness and services for children and adolescents requiring psychiatric intervention.

6.19. The Committee recommends that, for the duration of the proposed interim mental health legislation, a formal monitoring mechanism be established whereby the Government reports to the Standing Committee on Social Policy every six months on the need for and provision of services, including legal services, for people with a mental dysfunction.



Annette Ellis MLA
Chair
20 April 1994

APPENDIX 1: SUBMISSIONS SUBMITTED TO THE COMMITTEE

NUMBER	FROM
1	Ms Pat Linford Carer
2	Ms Linda Crebbin A/g Chief Executive Officer ACT Legal Aid Office
3	Mr Ian Morrison President Canberra Schizophrenia Fellowship
4	Mr David Plant Convenor ACT Mental Health Action Group
5	Mr Allan Anforth Director ACTCOSS
6	Ms Linda O'Donoghue ACT Spokesperson Citizen's Commission on Human Rights
7	Mr Dennis Wilson Chairman Woden Valley Hospital Medical Staff Committee
8	Mr David Kirk President, ACT Branch Australian and New Zealand College of Mental Health Nurses
9	Mr Dorothy Sales Honorary Executive Secretary National Brain Injury Foundation
10	Ms Kristina Nesic Coordinator ACT Youth Accommodation Group
11	Mr Terry Connolly ACT Attorney General
12	Dr Stephen Rosenman Psychiatrist (as a private citizen).
13	Dr Jeffrey Cubis Chairperson Royal Australian and New Zealand College of Psychiatrists

14	Ms Mary McNish Honorary Secretary NSW Council for Civil Liberties
15	Mr Jeff Harmer First Assistant Secretary, Policy Development Division Commonwealth Department of Health, Housing, Local Government and Community Services
16	Ms Libby Steeper Chair ACT Mental Health Advisory Council
17	Mr Laurie O'Sullivan President ACT Council for Civil Liberties
18	Ms Dianne Procter Chair ACT Children's Services Council
19	Brian I'Anson President Mental Health Foundation
20	Justice Terry Higgins Chairman ACT Criminal Law Consultative Committee
21	Mr Gavan Cashman Deputy Law Officer, Administrative Law and Justice Branch ACT Attorney-General's Department Dr Cathy Mead General Manager, Public Health Division ACT Health
22	Ms Judith Upton Chief Social Worker, Mental Health Services ACT Health
23	P A Hohnen, J Houston and J Hemer Ethics Committee ACT Health
24	Ms Betty Butler Private Citizen
25	Ms Sally Petherbridge Regional Director ACT Human Rights Office

26	Mr David Plant Convenor ACT Mental Health Action Group
27	Mr Stephen Hunter Head of the Chief Minister's Division ACT Chief Minister's Department
28	Mr Jon Chesterton Nurse Educator (Mental Health)
29	Mr David Kirk President, ACT Branch Australian and New Zealand College of Mental Health Nurses
30	Mr R J Whitten Executive Director The Law Society of the ACT

APPENDIX 2: SUBMISSIONS FORWARDED BY THE A.C.T. ATTORNEY GENERAL'S DEPARTMENT

NUMBER	FROM
A/G 1	Mr Nicholas Seddon
A/G 2	Mr R J Cahill Chief Magistrate Law Courts of the ACT
A/G 3	Office of the ACT Director of Public Prosecutions
A/G 4	Mr P G Dawson Assistant Commissioner Australian Federal Police
A/G 5	Ms Linda Crebbin A/g Chief Executive Officer ACT Legal Aid Office
A/G 6	Mr Alan Jones Clinical Psychologist, Forensic Service ACT Health
A/G 7	Dr Jeffrey Cubis Chairman The Royal Australian and New Zealand College of Psychiatrists
A/G 8	Mrs Moulder Private Citizen
A/G 9	Director General NSW Attorney General's Department
A/G 10	Ms Lynne Grayson Director, ACT Corrective Services ACT Housing and Community Services Bureau
A/G 11	Mr Richard Young Director, Juvenile Justice Services ACT Housing and Community Services Bureau
A/G 12	Mr Allan Anforth Director ACT Council of Social Service
A/G 13	Mr Alan V Walker Walker Tate & Associates
A/G 14	Ms Mary Cooper President Canberra Schizophrenia Fellowship

A/G 15	Registrars of Psychiatry Woden Valley Hospital
A/G 16	Mr Terry Connolly ACT Attorney-General
A/G 17	Mr Terry Heins Phillip Health Centre
A/G 18	Mr David Kirk President, ACT Branch Australian and New Zealand College of Mental Health Nurses
A/G 19	Ms Judith Upton Chief Social Worker, Mental Health Services ACT Health
A/G 20	Ms Margaret Groube City Mental Health Unit ACT Health
A/G 21	Mr Gavan Cashman Deputy Law Officer, Administrative Law and Justice Branch ACT Attorney-General's Department
A/G 22	Ms Prue Wilson Program Director, Community Mental Health ACT Health
A/G 23	Mr Adam Stankevicius Program Coordinator Citizens Advice Bureau of the ACT Community Information Service
A/G 24	Mrs Jean Ashby Private Citizen
A/G 25	Mr Brian Slarke Victims of Crime Assistance League (ACT) Inc.
A/G 26	Ms Julie Schelb National Industrial Officer Public Sector Union
A/G 27	Ms Julia Ryan Convenor ACT Women's Consultative Council
A/G 28	Dr W E Mickleburgh Private Citizen
A/G 29	Mr Terry Connolly ACT Attorney-General

A/G 30	Mr David Plant Convenor ACT Mental Health Action Group
A/G 31	Mr John McGinness Director, Justice Section ACT Attorney-General's Department
A/G 32	Ms Linda O'Donoghue ACT Spokesperson Citizens' Commission on Human Rights

APPENDIX 3: SUBMISSIONS FORWARDED BY A.C.T. HEALTH

NUMBER	FROM
H 1.	Registrars of Psychiatry Woden Valley Hospital
H 2.	Registrars of Psychiatry Woden Valley Hospital
H 3.	Mrs Jean Ashby Private Citizen
H 4.	Dr Terry Heins Phillip Health Centre
H 5	Dr Terry Heins Phillip Health Centre
H 6.	Dr W E Mickleburgh Private Citizen
H 7	Ms Linda O'Donoghue ACT Spokesperson Citizen's Commission on Human Rights
H 8	Ms Julie Schelb National Industrial Officer Public Sector Union
H 9.	Mr David Plant Convenor ACT Mental Health Action
H 10.	Mr David Plant Convenor ACT Mental Health Action
H 11	Mr Brian Slarke Victims of Crime Assistance League (ACT)
H 12	Mr Brian Slarke Victims of Crime Assistance League (ACT)
H 13	Ms Judith Upton Chief Social Worker, Mental Health Services ACT Health
H 14	Ms Mary Cooper President Canberra Schizophrenia Fellowship

H 15.	Mr David Kirk President, ACT Branch Australian and New Zealand College of Mental Health Nurses
H 16	Ms Vanessa Sargeant Policy and Campaigns Youth Affairs Network of the ACT
H 17	Ms Elaine Robb Employment Services Manager Koomarri Association ACT Inc.

APPENDIX 4: LIST OF WITNESSES

WITNESS	ORGANISATION
Mr Nicholas Seddon	Ex-Chairperson of the ACT Mental Health Review Committee
Mr David Plant	ACT Mental Health Action Group
Ms Pat Daniels	Mental Health Resource
Mr Ian Morrison	Schizophrenia Fellowship
Dr Jeffrey Cubis	Royal College of Psychiatrists
Dr Stephen Rosenman	Psychiatrist
Ms Heather McGregor	ACT Community Advocate
Mr Ken Crispin	Director of Public Prosecutions
Ms Pat Linford	Carer
Mr David Kirk	College of Mental Health Nurses
Ms Helen Briggs	Executive Director, Community Programs
Ms Lynne Grayson	Director , ACT Corrective Services
Mr Ron Cahill	ACT Chief Magistrate
Mr Mark O'Neill	Principal Legal Officer of the Chief Magistrate's Court
Ms Susan Sellick	Chief Magistrate's Research Officer
Mr Phil Thompson	Registrar of the Magistrate's Court
Mr John Ayling	Secretary, Health Department
Mr David Marcus	ACT Health
Mr Chris Hunt	Secretary, Attorney General's Department

Mr Gavan Cashman	Deputy Law Officer, Attorney General's Department
Ms Faye Westwood	Attorney General's Department
Mr John McGinness	Attorney General's Department
Mr Chris Staniforth	Director, Legal Aid Commission