COMMENTARY ON JOHN DAWSON'S PAPER "THE OPERATION OF THE PRESENT CIVIL COMMITTAL PROCESS". by Dr James B Woolridge, psychiatrist.

THE HOSPITAL VIEW.

John Dawson's paper is an accurate description of the civil committal process as I have experienced it operating in New Zealand.

He identifies many of the shortcomings, contradictions and injustices of the process and the concerns of the various groups involved in this process as I have heard them expressed.

As a psychiatrist involved in the care of the mentally ill I believe that the point needs to be made very clearly that there is in fact such an entity as mental illness. Although it may be defined in vague and circular terms in the Mental Health Act, within in the psychiatric profession we are attempting, with some degree of success, to develop satisfactory operational definitions of the various mental disorders including mental illness.

Patients suffering from major mental disorders such as schizophrenia, major affective disorder and various organic disorders are "ill" in a similar sense to patients suffering from pneumonia, diabetes or A.I.D.S.

These mental illnesses give rise to disordered mental functioning which, in turn, may give rise to social deviance and this deviance may well be the precipitant of hospitalisation through committal. While acknowledging that, as mental health professionals, we are involved in a social control process, we must not lose sight of the fact that these individuals are ill, suffer, cause anguish to their families and both require and deserve treatment.

To some degree mental health professionals find themselves in an uncomfortable position when caring for the compulsorily detained mentally ill. We have been trained to help those who seek our help and imposing treatment upon those who do not wish it seldom sits easily with us.

Often, too, we find ourselves at the interface between the civil libertarians and those who would have us exercise more control over the socially deviant. On the one hand we are "the lackeys of the state imposing our malign will upon hapless eccentrics" and on the other hand we let loose upon the community those deviants and public nuisances from whom society deserves to be protected. In spite of the fact that this position causes us some discomfort from time to time it is possibly indicative of a healthy state of affairs inasmuch as both complainants are equally vociferous, the

issue is under ongoing debate - for example here today - and perhaps the balance is not too far from being correct.

Few mental health professionals wish to be involved in the control of social deviance which is not determined by mental illness and few of us believe that committal should be primarily a medical matter.

This paper highlights the concerns of the various groups involved in the committal process. Families are concerned about lack of "follow up" and "support", the police are concerned about the time and resources it takes to process a committal application, doctors who write certificates are concerned about the poor circumstances in which they are written, hospital staff are concerned about the inadequacy of the information contained in the certificates and judges are concerned about the conditions under which they are required to conduct hearings. It would be interesting and doubtless chastening to survey the concerns of those individuals who have been at the sharp end of the process. I would like to be able to say that my impression is that the majority of patients, having recovered from their illness with appropriate treatment, appreciate that compulsory treatment was necessary and that it was carried out with as little offence to human dignity as possible. Unfortunately this is rarely the case.

There are three general types of situation in which coercion may become necessary during the course of treatment. These are -

1. Very short term.
2. In the relatively short-term treatment of an acute illness.
3. In the longer term in the course of a chronic or relapsing illness.

1. <u>VERY SHORT TERM.</u>

Situations can arise where it is necessary to coerce a voluntary patient. For example an angry individual may need to be physically restrained from striking a fellow patient or staff member, or a distraught person may need to be prevented from harming him or herself.

While it is clear that such restraining action is often, perhaps usually, taken without recourse to committal, nursing staff in particular have, at Carrington Hospital, been so sensitised by the Oakley inquiry that they may be reluctant to even place an elderly, restless and demented individual in a "table-top chair" for an hour or so without invoking the full rigmarole of the committal process. Conversely at other hospitals informal patients are regularly secluded for short

periods without having been committed. Committal in such situations may be believed to "protect the hospital and staff" but it is hard to see how it benefits the patient.

There would appear to be a need for some type of formal legal sanction to cover such very short-term situations.

SHORT-TERM.

There is frequently a need to detain people in order to treat an acute disorder. Although figures in John Dawson's paper show that the majority of such patients are discharged from their committed status within a relatively short period of time in fact many of them could be discharged even sooner and it is my opinion that the initial period of detention should be for only one week. Within this time the majority of patients' mental state can be improved with appropriate treatment and a "therapeutic alliance" forged to the extent that treatment can be continued on an informal basis. Some facility needs to be available to extend the period of detention for an extra week if necessary.

At present patients entering hospital under Section 21 are already the subject of a reception order. It requires definitive action on the part of the psychiatrist to discharge such a patient and for a variety of reasons such action may not be taken and the patient may remain committed, with his civil rights in abeyance, for longer than is necessary.

When a patient enters hospital under Section 19 a decision has to be made whether to change the patient's status to informal, simply allow the certificates to "lapse" or whether to go ahead with a hearing with a view to obtaining a reception order. It is easy to "err on the safe side" in cases of doubt and John Dawson has indicated graphically how judges tend to be guided by medical advice and how biased the process is "against" the patient.

Personally I believe that for a patient to be detained compulsorily for a period longer than the order of a couple of weeks the onus should be on the mental health professionals to present a cogent case as to why this is necessary. I would welcome the presence of a patient's advocate. John Dawson asserts that the present process is simply, in the majority of cases, a rubber stamping by the judiciary of a medical decision. I believe strongly that this should be a shared responsibility and that therein lie the most effective safeguards for all parties and particularly for the patient.

3. LONGER TERM IN THE COURSE OF A CHRONIC OR RELAPSING ILLNESS.

It is certainly necessary from time to time to exercise control in the longer term. This may be in order to ensure compliance with medication or in order to facilitate re-admission to hospital should illness recur. The paper points out how traumatic the committal process can be and a reception order certainly makes readmission much simpler, although one wonders if its availability may deter one from fully exploring less restrictive treatment options. I would point out that although some patients are certainly returned to hospital when they refuse to comply with medication this is, in my experience, relatively unusual and in the event of a patient stopping medication which the mental health professional considers to be necessary, one usually waits until the patient becomes ill again before requiring readmission.

The Act requires that the patient be mentally disordered at the time the reception order is made. Much mental illness is, by nature, episodic and the ludicrous situation may arise where staff attempt to get the patient to the judge "while he is still crazy" in order that a reception order be made rather than being able to argue that although the mental disorder may not be immediately apparent today committal is nevertheles appropriate.

It would seem to me that it is particularly desirable when such longer term control is deemed necessary that decisions be genuinely shared by legal and medical personnel and that a patient's advocate be involved. While doctors wish the judiciary to take their recommendations seriously they most certainly do not, in my experience, wish for them simply to endorse a medical decision and to assure the patient of their omniscience and unquestionable goodwill.

MEDICATION AND SECLUSION.

The paper emphasises the prominent role of medication and seclusion in dealing with committed patients. Medication does have a major role to play in the treatment of the acutely mentally ill but there are many other therapeutic factors, whose contribution should be acknowledged, operating

in an acute admission ward. There are therapeutic groups of various types, occupational therapy, family meetings, and one must not forget the "asylum" function of the mental hospital which can protect the patient from the hostile environment in which he has become sick.

Seclusion is used far too often and will probably continue to be used too often until such time as facilities and staff numbers approach realistic levels. Small numbers of staff coping with large numbers of patients in outdated buildings will inevitably have recourse to more restrictive management practices, such as seclusion. This is not to say that we should not, as mental health professionals, be continually monitoring our attitudes, practices and role in the compulsory detention of the socially deviant individual. For just that reason this seminar is most welcome.