WHY SPECIFIC LEGISLATION FOR THE MENTALLY ILL?

It is undoubtedly true that mental illness and its impact on society has attracted much greater attention recently than in the past. In general, this greater attention has produced better-informed and more understanding attitudes towards mental illness. Unfortunately, there have been some notable exceptions. The Cornelia Rau incident and the recent front page photograph in *The West Australian* of a naked man with a history of mental illness taken shortly after he had allegedly killed two of his family members, show the ignorance and stigma that still surrounds the entire subject of mental illness. So, as a person with little previous involvement in the area, it was with some trepidation that I recently agreed to become the President of Western Australia's Mental Health Review Board, the main function of which is to review the status of involuntary patients detained in hospital or being treated on a community treatment order.

There was one issue that I wanted to understand better when I started in this role: why does mental illness attract specific legislation? After all, mental illness is similar to many other illnesses. Mental illness is also commonplace, with one in five Australians experiencing a mental illness at some point in their lives. Further, the vast majority of people with a mental illness either never seek treatment or, if they do seek treatment, are treated as voluntary patients as opposed to involuntary patients. We don't have (or presumably need) a Cancer Act or a Dementia Act, so what is the purpose of the various Mental Health Acts and other similar legislation?

One possible justification is the principle of beneficence. That is, people with some types of mental illness require and will benefit from treatment but might not have the capacity to give informed consent. Therefore, a regime that interferes with a mentally ill person's freedom of choice and personal liberties could be justified if the treatment is likely to be in the person's best interests (ie, without it the person's health, safety, reputation and personal relationships would be at risk).

This explanation is attractive. But only superficially. Many conditions (both physical and mental) can deprive a person of the short or long-term capacity to consent to needed care and treatment. We have devised processes to deal with those situations (and situations involving children) without the restrictions and interference with rights that characterise the way we deal with the mentally ill. Under guardianship and similar legislation, appropriate people or tribunals are routinely authorised to make important decisions for, and give consent on behalf of, people judged incapable of doing so themselves. This includes decisions about where such people will live, what medical treatment they will receive, and whether some form of restraint can be imposed. Although this can also interfere with the rights of the people concerned, it is typically less restrictive than being an involuntary patient. If such a regime of substituted decision-making works for children or people with, for example, dementia or an intellectual disability then why can't it work for people with a mental illness?

A second possible justification for such a restriction on personal liberty relies on the notion that some mentally ill people represent a danger to others. However, the vast majority of mentally ill people pose little or no danger to others. On the other hand, there are many others in the community who do pose such a danger but who don't suffer from a mental illness. Preventing anticipated violence (including domestic violence) is, of course, extremely difficult. However, in this regard there is little that is sufficiently unique about people suffering from a mental illness to justify invoking the kinds of limits on freedom that come with being an involuntary patient.

There may be an argument for legislation specific to certain individuals or categories of people who pose a substantial danger to others, whether because of a mental illness, personality disorder or some other reason. But, such legislation should be enacted only with the most stringent safeguards and only in the most exceptional cases, rather than as a blanket-cover for the mentally ill as a whole. Judicial approval and regular review of any detention would be essential. Several jurisdictions in Australia have already enacted such legislation or are examining the possibility of doing so. A particular focus seems to be individuals who are finishing long prison sentences and who, despite the degree of danger that they are thought to represent to the community, do not fall within the ambit of mental health legislation.

There is nothing new about these thoughts. Others, with far greater experience than I in the field of mental health, have posed and tried to answer such questions. One should not be optimistic that policy makers are likely to see the merits of abolishing legislation specific to the mentally ill. The special status that such legislation confers on the mentally ill is discriminatory in that it singles out the mentally ill in a way that other sections of the community are not and engenders further discrimination. Abolition would, one might hope, go a long way towards ridding mental illness of at least some of the mythology and stigma to which it has long been subject.

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