AJJ-13

COMMISSION OF INQUIRY

INTO

THE CARE AND TREATMENT OF PATIENTS IN THE PSYCHIATRIC UNIT OF THE TOWNSVILLE GENERAL HOSPITAL

BETWEEN

2nd MARCH, 1975 and 20th FEBRUARY, 1988

REPORT

Volume I: Summary of Findings, Recommendations and Commissioner's Report

FEBRUARY, 1991

SUMMARY OF FINDINGS

1. In the period March, 1975 to February, 1987, during which time Dr. Lindsay exercised effective control of Ward 10B either as the Director of the unit or whilst engaged by the Townsville Hospitals Board as a consultant and in the period February, 1987 to May, 1987, during which time Dr. Cant was in charge of the ward, the care and treatment of patients was, in many respects, negligent, unsafe, unethical and unlawful.

2. Dr. Lindsay was a committed adherent to social therapy in psychiatry as the preferable treatment option for all forms of mental illness and under his direction and influence Ward 10B was developed as a therapeutic community which was integrated with and predominantly influenced by the processes of family therapy.

3. The treatment philosophy embraced by Dr. Lindsay was based on the resocialisation of the mentally ill person and this, according to the philosophy, could be more effectively achieved only by changing the course of the whole range of inter-personal relationships to which the patient had become subject.

4. At least from 1950 and progressively, Dr. Lindsay was heavily influenced in his professional development by the work of Maxwell Jones and T.F. Main and by others who later sought to modify therapeutic community principles in a variety of ways in order to develop what was perceived by each to be the preferred treatment modality in the practice of psychiatry.

5. In the case of Dr. Lindsay, his preferred treatment strategy involved integrating the principles and practice of the therapeutic community with the practice of family therapy.

6. The fundamental and principal component of this strategy was that mental illness was the product of the social environment and of disturbed social relationships and the successful resocialisation of the "identified patient" required treatment not only of that person but also of the others who together constituted the framework of that environment and of those relationships.

7. This principle required that in the treatment of the inpatient or day patient in Ward 10B it was essential that family members and others in relationship to the "identified patient" become involved in the processes of the treatment module in an integral way. Such persons were as much in need of "treatment" as the person or family member who required admission to the hospital for treatment.

8. Dr. Lindsay was particularly anxious at the time of his appointment to the Townsville General Hospital in 1975 to develop therapeutic community ideas and his own modification of them in a general hospital setting in which there would be included patients who would be regulated and subject to detention under the Mental Health Services legislation.

9. Ward 10B was developed to service a wide population catchment in North Queensland and it was therefore envisaged that its patients would be those suffering from the various forms of mental illness including many who would require acute hospital care.

10. All of the patients who were cared for and treated in Ward 10B were subjected to the same basic treatment and to the discipline of the daily ward programme which was designed to reflect the principles embraced by Dr. Lindsay, irrespective of the nature and extent of their illness.

11. It was a direct consequence of the introduction and development by Dr. Lindsay of his preferred treatment modality that in respect of many patients their care and treatment was negligent, unsafe, unethical and unlawful during the periods when the ward operated subject to his influence and that of Dr. Cant.

12. Dr. Lindsay in his role as Director was firmly authoritarian, intransigent in his id rude and abrasive in his dealing with many patients, their relatives and some staff uncooperative and demanding in his dealings with officialdom within the hospi including his professional colleagues and nursing staff.

13. The rigidity of the ward processes to which all patients and their relatives had to sub was fixed firmly in place and never became the subject of critical analysis and assessm by others within the hospital environment because of the dominant personality of Lindsay and his persuasive influence upon his senior medical, nursing and paramedi staff who became his committed and dedicated but uncritical followers.

14. The literature in psychiatry had at least from 1975 questioned the logic and the propri of using therapeutic community principles in the treatment of acutely psychotic patie and had sought to limit the proper application of them and to confine that applicati to specific settings within highly specialised units.

15. Dr. Lindsay either ignored or was unaware of the content of the literature nor did ever consider the modification of his treatment module or subject it or his own professio mind, style and manner to a process of self analysis. Nor was he or it subject to a effective peer review.

16. In 1973, when Ward 10B was established under the influence of Dr. Urquhart, the th Director of Psychiatric Services, and Dr. Atkinson, the Department of Health's Psychiat Supervisor for North Queensland, the intention to develop the new unit as a therapeu community was made clear by the report of Dr. Atkinson to the Townsville Hospit Board dated 18th July, 1973 entitled "Principles of a Therapeutic Community".

17. Dr. Lindsay, then a relatively well known adherent to the principles of social therapy psychiatry and, in particular, to the therapeutic community, was known to Dr. Urquha the Director of Psychiatric Services, and/or his deputy, Dr. Connell, and to Dr. Atkinsc all of whom favoured Dr. Lindsay's appointment as the Director of a newly establish therapeutic community in Ward 10B.

18. Shortly after his appointment as the Director, Dr. Lindsay, on 22nd September, 197 made known in writing to Dr. Cole, the Medical Superintendent of the hospital, t details of the treatment plan which he proposed to implement.

19. This treatment plan was based on five steps:—

(a) Symptomatic Relief;

(b) Re-Socialisation;

(c) Occupation;

(d) Freedom;

(e) Return to the Community.

This theme is included in the document Appendix XXIII and in a later version of i Appendix XXI, and it is examined more fully in Chapter 9.5. In summary, the resoc alisation of the patient within the therapeutic community by means of the ward process of group and psychotherapy was the core feature of the treatment and the other matter in particular, the use of medication, were ancillary to it. It is doubtful that Dr. Cole an the Board ever fully understood the ramifications of what was involved.

20. The assessment meeting, as a part of the process for admission to the ward, was a undisciplined and unprofessional process in which a proper diagnostic formulation wa considered irrelevant and in which candidates for admission and their relatives wer subjected to interrogation about a broad range of subject matter, some of which involve details of the patients' relationships and which was always conducted in the presence c ward staff and other persons awaiting admission and their relatives, who in turn wer subjected to the same process.

21. In the course of the assessment process, relatives were sometimes identified as being in need of "treatment" themselves and encouraged to accept admission together with the "identified" patient.

22. The assessment meeting was regarded as an essential part of this ward's rigid rituals and unless a patient was regulated and detained, any person seeking admission to the ward via Accident and Emergency Department (A & E) was sent away and told to report to the next assessment meeting which was held daily at 8.30 a.m., Monday to Friday. Some returned, some did not.

23. A proper and competent mental state examination of a patient was rarely, if ever, carried out. To diagnose was said to "label" people. Diagnosis of the mental illness was therefore regarded as anti-therapeutic and such diagnoses as were made were frequently identified as involving "severe family pathology".

24. This anti-diagnostic philosophy heavily impacted upon the treatment plan for the patient or intended patient. All patients in the ward or day hospital were subjected to the discipline of the ward's daily programme and irrespective of the character of their illness or their state of health on any day, each patient was subjected to precisely the same compulsory process of ward and smaller group meetings. All, irrespective of their state of health, were the victims of their inter-personal relationships. All, therefore, needed re-socialisation. Therefore, all were to be subject to the dominance of the same treatment strategy. As Dr. Cant wrote:—

> *"The unit wove family, group and social therapies into a dominant therapeutic fabric; the biological model appeared invisible."*

25. Therefore, the proper use of anti-psychotic medication in the treatment of mental illness was displaced by the institution of social therapies designed to redress the root cause of the illness, namely, the disordered social relationship from whence the "identified" patient had come.

26. Medication was required only for "symptomatic relief", that is, the behavioural manifestations of the psychosis had to be suppressed with appropriate medication not for the purpose of treating the psychosis or other illness but to more easily permit the resocialisation of the patient. Disturbed behaviour, or what was perceived to be such, was disruptive of the community and inimical to its processes. Therefore, such behaviour had to be subdued by the use of drugs including barbiturates.

27. The ward meeting and the group meeting were established as the most influential of the several ward structures involved in the care and treatment of patients.

28. These meetings were seen to reflect the democratisation of the decision making process in respect of matters relevant to the patients' treatment and lifestyle both within the hospital and outside of it and hence they were an essential component of this therapeutic community. These meetings, especially the ward meeting—a meeting of the whole ward community—were attended with some degree of formality with the appointment of the chairperson, the secretary, the moving of motions, voting and the counting and recording of votes.

29. Group therapy was conducted in groups not diagnostically based but structured on social criteria, young singles, young marrieds, etc.

30. Relatives were urged and encouraged to attend "group". They, too, were in need of treatment. They, too, had to address the same disordered social environment of which they and the patient were a part and which had caused and/or contributed to the mental illness of the "patient".

31. The strict requirement that relatives attend "group" was a continual source of contention and the processes of group therapy more than any other single feature of the ward's treatment programme provided for the disharmony and the acrimonious and, at times, abusive dialogue between patients and relatives on the one hand and medical and nursing staff on the other.

32. Group therapy, in the case of a majority of patients, particularly for those who were acutely psychotic, was not only useless but harmful and contra-indicated, given their state of mental ill-health.

33. Confrontation was an essential feature of the therapy and both patient and relative, whatever the state of health of the patient, were subjected to it. It was frequently characterised by aggressive and provocative verbal abuse and, at times, potentially dangerous physical exchanges.

34. Requests by patients and/or relatives for consultation with the Director or a registrar to discuss the progress of the patient, his/her treatment and prognosis were invariably refused with the response to bring the matter up "in group", inevitably in the presence of other patients and relatives.

35. Any request by a patient in relation to his treatment, e.g. for a change of medication or a reduction in dose had to be taken to the group by way of a note "to group" for its decision, as did requests for weekend leave, for discharge, to draw money from the bank, to go to the dentist, to have treatment for a physical ailment or to go shopping.

36. Both the ward and group meetings took decisions pursuant to motions moved and voted upon on a variety of matters relevant to the patient's care and treatment, such as to chemically restrain him/her, to have him/her transferred to Mosman Hall or to increase or decrease medication, to change the medication regime or to have a patient placed in seclusion.

37. These group based decisions which affected patient care were acted upon, sometimes immediately in the course of the meeting at which the vote was taken. Other decisions were taken to the staff meeting at midday and were influential in determining the course of treatment, such as the medication which was to be given to the patient.

38. Group decisions were influential not only in the admission of a patient but also in relation to his/her discharge and not infrequently a patient, concerning whom the group had inappropriately decided was fit for discharge, was permitted to discharge himself/herself "against medical advice".

39. "Discharge against medical advice" was a regular occurrence and more often than not was the product not of a stubborn refusal of a patient to accept treatment but of a decision by the patient taken in or subject to the influence of a group discussion and/or decision.

40. Some patients were permitted discharge when the circumstances clearly justified their detention by regulatory order for their own safety.

41. Group therapy, which had to be endured by all on each day, was the very antithesis of confidentiality and its confrontational characteristic, which was an essential feature of it, was destructive and harmful and frequently exacerbated the illness in those who were schizophrenic or suffering manic depressive psychosis.

42. The treatment of any patient involved the process of communalism—another essential feature of the therapeutic community—and accordingly any one patient had the right, indeed the duty, to involve himself/herself in the treatment of any other patient.

43. Psychotropic medication, including the extensive and regular prescription of Sodium Amytal, was used not for the treatment of illness but for sedation and for the control of disturbed behaviour which was sometimes the symptomatic manifestation of the psychosis but not infrequently was the result of intoxicated behaviour from the administration of the drugs themselves, particularly of the barbiturate.

44. Large doses of psychotropic medication were often administered inappropriately as were large doses of barbiturates.

45. Sodium Amytal should never be used in the treatment of psychiatric illness. The opinion of experienced and highly regarded specialists that Sodium Amytal has no place in

psychiatry is undoubtedly correct. Its use was regularly prescribed for numerous patients in Ward 10B.

46. Chemical restraint of a patient is sometimes necessary in a psychiatric unit to control violently aggressive and disturbed behaviour which is dangerous or potentially so. In Ward 10B it was frequently used to resolve relatively minor problems, to deal with a lack of co-operation or compliance because of insolence or for abuse of staff, for what was simply noisy behaviour and, at times, as a punishment and consequential upon a group decision.

47. Chemical restraint in Ward 10B was directed to the immediately perceived behavioural problem without proper diagnosis and the commencement of appropriate medium to long term anti-psychotic medication. The inappropriate stimulus of group psychotherapy and the induction of psychotic patients into the group process was often the catalyst for the institution of chemical restraint with the unnecessarily high dosages of drugs including Sodium Amytal. This, not infrequently, by itself induced intoxicated behaviour which was misinterpreted as a further manifestation of the psychosis. Hence the administration of further and sometimes larger dosages to continue the restraint which in some cases was life-threatening.

48. Prescriptions were invariably written on a sliding scale in respect of Chlorpromazine, Haloperidol, Thioridazine and Sodium Amytal.

49. This process vested in nursing staff a wide ranging discretion as to the choice of drug to be used and the dosage. In some instances, psychotropic medication with a lower and upper limit was prescribed p.r.n. Other prescriptions were written with a lower and upper limit per 24 hours. In the result, dosages were administered either at set times or at other times, depending upon the nurse's assessment of and in order to control the patient's behaviour.

50. In cases where the prescription of a medication p.r.n. is acceptable practice, the indications for the dose p.r.n. should be made clear, the intervals between doses strictly specified, the maximum total dose permissible in a given period clearly laid down and it should be written such that it cancels itself after a specified period. These requirements were never followed.

51. In the result the form of prescription writing imposed upon nursing staff an undue measure of responsibility and at the same time represented an abrogation of responsibility by medical staff.

52. Modecate was often prescribed in a manner inconsistent with its character as a depot injection, e.g., on a daily or second daily basis.

53. Anti-depressant medication was rarely, if ever, prescribed by Dr. Lindsay and medical staff. The use of E.C.T. for appropriate cases was a rarity.

54. The sliding scale method of prescribing psychotropic medication and Sodium Amytal was a negligent and unsafe practice.

55. The use of Sodium Amytal and the manner in which it was prescribed and the doses in which it was administered, were excessive and dangerous and, as such, its use was negligent and unsafe.

56. The administration of very large doses of phenothiazines, in conjunction with Sodium Amytal, was an extremely dangerous practice and, as such, was negligent and unsafe.

57. In the cases of the several patients identified in the report, the use of drugs in their care and treatment, at times with dosages which were potentially lethal, was negligent and unsafe.

58. The use of the various neuroleptics, in particular, the excessive use of Thioridazine in certain cases, was negligent and unsafe.

59. In the cases where Modecate was misused, the care and treatment of the patient v negligent and unsafe.

60. Modified insulin therapy was conducted and supervised by doctors inexperienced in use in a manner which was positively dangerous. It represented care and treatment wh was negligent and unsafe.

61. Chemical restraint, in the case of certain patients identified in the ward, some of wh suffered respiratory and/or cardiac arrest and who required to be resuscitated in Intensive Care Unit of the hospital, was negligent and unsafe.

62. The scant regard for the need for proper diagnosis and the failure to institute a pro treatment plan taken together with the compulsory submission of all patients to gr therapy, was a model of treatment which was intrinsically negligent and unsafe.

63. The fundamental treatment strategy of the ward with its heavy emphasis on psychother including confrontation, and the inappropriate medication practices produced a v atmosphere which was infected by rude, abrasive and aggressive verbal abuse exchanges which frequently spilled over into physical violence. Patients were freque manhandled by staff and/or other patients and some paramedical staff who had provo a violent response from a patient for unacceptable reasons.

64. Relatives of patients were never educated in or ever able to understand the ward proce The unorthodox patient/doctor and staff relationships which developed were divisive frustrating for relatives who were frequently dealt with rudely and with harsh and abra language. To be told that they were the cause of their relative's illness only serve make matters worse.

65. The Commission, through its investigative process, identified 65 patients of Ward who had died in circumstances which justified close investigation. In several cases care and treatment of patients who later died was negligent and in the case of sev these patients it was necessary to consider whether the negligence was of such a d as to provide evidence of criminal negligence.

66. P1 and P2 died because the treatment of them in Ward 10B was negligent and un

67. P116, P85, P113, P33, P32, P118, all of whom committed suicide, were cared fo treated in Ward 10B in a manner which was negligent and unsafe.

68. Many other patients, who are identified in the report, were treated in a manner v was negligent and unsafe. These were patients not included amongst the deaths.

69. The process whereby P66 was permitted to leave the hospital in the care of O Graham McKie on 25th December, 1975 exposed her to the risk of moral and ph danger and accordingly was negligent and unsafe.

70. The conduct of Dr. Lindsay and Dr. Cant in the instances specified in Chapter 17 report was unethical in their care and treatment.

71. The emphasis placed by Dr. Lindsay and Dr. Cant upon the need for the remo confidentiality as a characteristic of the patient/doctor relationship, not only assessment meeting but generally, was unethical.

72. The refusal by doctors to consult with patients, when requested, on a one to one and confidentially was unethical.

73. The attempted intrusion by ward, nursing and paramedical staff into the private bu of P3 in respect of which she had given instructions to her solicitor, was unethica

74. Certain patients were unlawfully assaulted.

75. There are numerous instances recorded, both in patients' files and in the evidence patients were manhandled with the use of force by doctors, nurses, other staff and patients, either for the purpose of administering medication or for effecting the se

of a patient or for what was perceived to be some justifiable therapeutic purpose. In my opinion, these instances constitute cases of unlawful assault.

76. The seclusion of a patient was frequently unlawful in that it was effected contrary to express requirements of Regulation 57 of the Mental Health Services Regulations.

77. Doctors and nurses generally paid lip service only to the requirements of Regulation 57 when effecting the seclusion of patients.

78. From its commencement, complaints about the ward and its operation were made to the hospital administration and the Division of Psychiatric Services. These complaints were made by members of the public, patients and their relatives, parliamentary representatives, members of the A.W.U., members of the police service, psychiatrists in training, resident medical officers and other specialist consultants to the hospital.

79. These complaints included complaints about lack of security, absconders, the treatment of patients and relatives by medical and nursing staff, the processes of group therapy, the medication practices of the ward, the failure and/or refusal of medical staff to adequately respond to the concerns of those working in A&E or in other sections of the hospital.

80. Complaints from patients and their relatives became intensive in 1986 and their concerns were made public by Mr. McElligott, MLA, the elected representative for a Townsville based electorate. These complaints were, in substance, the same complaints about the ward's treatment policies which had been brought to the attention of the hospital administration and the Director of Psychiatric Services by Dr. Scott-Young, MLA, the elected representative for another Townsville based electorate in early 1982/1983.

81. By 1983, CRAPPIT (the Committee for the Rotation and Placement of Psychiatrists in Training) had effectively withdrawn accreditation to Ward 10B as a suitable training ground for specialist psychiatrists.

82. Neither the hospital administration nor the Director of Psychiatric Services, Drs. Urquhart and Tucker, took any action to effectively investigate the various concerns which were dismissed with bureaucratic nonchalance and indifference.

83. Rather, the hospital administration and the Division of Psychiatric Services responded to the complainants with only an aggressive display of support for Dr. Lindsay and the ward practices.

84. In 1982, Dr. Urquhart prepared a letter for the then Minister for Health which asserted that the therapeutic community in the psychiatric unit at the Townsville General Hospital was a "place of excellence".

85. In 1986, the Hospital Manager, in collaboration with the Chairman of the Board and after "investigation" by the Medical and Nursing Superintendents, responded to Mr. McElligott, MLA alleging that "relatives and friends are faced with the awesome truth that they may be a contributing factor to the patient's illness" and that they "react in a defensive way to placate their own conscience". At the same time, Mr. McElligott, MLA was rebuked for raising the issue publicly.

86. At no time prior to December, 1987, and then only because of chaos in the ward, which was generated by the staff's active and passive resistance to the changes promoted by Dr. Schioldann-Nielsen, did the Board or the Hospital Executive or the Director of Psychiatric Services examine, investigate or meaningfully assess the quality of the care and treatment given in the ward.

87. Had they done so, the totally deficient and wholly unacceptable treatment modality would have been exposed, together with details of the negligent, unsafe, unethical and unlawful practices which attended the care and treatment of mentally ill persons, many of whom were acutely psychotic and severely disturbed.

88. The Hospitals Board and its Executive failed hopelessly to address the many deficiencies which were so readily recognisable in the care and treatment of patients in Ward 10B.

89. Those who occupied the position of Director of Psychiatric Services during the rele period, Drs. Urquhart and Tucker, maintained at the public hearing of the Commi the same defensive stance which they adopted in their official position which was o considerable status and influence. This can only be seen to have been based up narrow and mindless urge to ensure professional solidarity in the defence of a profess colleague.

90. Their failure and/or refusal to take decisive investigative action and to critically a the care and treatment given to the patients and to provide an effective overview a satisfactory degree of quality control represented a dereliction of duty and a failu demonstrate the required measure of professional and official competence and responsib

91. At the public hearing, each sought to condone and approve of what had been a substanc deficient, unacceptable, negligent, unsafe, unethical and unlawful treatment regime.

92. Dr. Lindsay, at all material times, enjoyed the unswerving loyalty and support of lea figures among the medical and nursing staff—Drs. Cant, Allen, Saltzer, Rooney and ot and Mr. Readman, Srs. Hill, Davis, Burnett and Frain, as well as paramedical s particularly, Ms Lambert, Ms Craig and Mr. Weber.

93. Those nursing staff, like Srs. Burnett and Frain, and paramedical staff, like Ms Lamb who were appointed therapists or co-therapists, were extremely influential in determi the form of the care and treatment given to patients. It was of greater significance t regarded as a therapist than as a nurse or a psychologist. The position of therapist one of considerable power and influence.

94. The directorship of Dr. Schioldann-Nielsen from May, 1987 to February, 1988 wa short duration but, nevertheless, extremely significant. He set about dismantling therapeutic community and the ward practices which had been developed since 19 He was only partly successful.

95. His efforts were frustrated and undermined by the active and passive resistance of th who stood to lose most from a change in treatment modality such as Dr. Cant, Burnett and Frain and Ms Lambert.

96. Dr. Schioldann-Nielsen was intent upon reducing the influence of social therapy in care and treatment of patients which henceforth was to be based on a more medica and psychologically oriented approach. Group therapy was prohibited. Sliding sc prescriptions for medication were proscribed and the use of Sodium Amytal was bann

97. Dr. Schioldann-Nielsen's efforts to change the manner and style of treatment was suppor by the Board and the Medical Superintendent but they were ineffective in addressing problems which confronted Dr. Schioldann-Nielsen. The nursing staff who were int on resisting Dr. Schioldann-Nielsen's reforms enjoyed the support of the Nursi Superintendent.

98. Dr. Schioldann-Nielsen enjoyed the support of Drs. Richards, Green and Spencer a with their assistance was able to maintain an acceptable level of care and treatment the patients in spite of the orchestrated resistance to his reform programme.

99. In February, 1988 he resigned, frustrated and disillusioned, but by then he had unwitting achieved what had seemed impossible to achieve in the period March, 1975 to Ma 1987—the intervention of the Hospitals Board but, more importantly, of the Director Psychiatric Services, Dr. Tucker, who, in the course of a two day visit, saw the "eviden of practices which would be unacceptable in modern General Hospital Psychiatric Units

100. The last vestiges of the therapeutic community of Ward 10B and of Dr. Lindsay treatment modality were finally removed by the Task Force headed by Dr. Westmo and Mr. Rosenthal in 1988 who restored the unit to a treatment style characterised b professional, acceptable, clinical practices at medical, nursing and paramedical levels.

101. The psychiatric unit at Townsville General Hospital is now under the leadership of Professor James and Dr. John Allan. It enjoys a very favourable reputation and the standard of patient care and treatment in the unit is of a high standard.

102. Regrettably, in the public mind, the unit, which is still referred to as Ward 10B, is synonymous with substandard care and treatment of the mentally ill.

103. There is insufficient evidence to prosecute any person in respect of the assaults referred to in Chapter 19 of the report.

104. There is insufficient evidence to prosecute any person in respect of the death of the persons referred to in Chapter 19 of the report.

105. The prosecution for breaches of s.59 of the Mental Health Services Act and of Regulation 57 of the Mental Health Services Regulations are now barred by the effluxion of time.

106. Exhibit 315 should be referred to the Attorney-General for his consideration as to whether it constitutes a breach of s.127 of the Criminal Code.

107. There is insufficient evidence to prosecute Mr. McKie in relation to the evidence given by R32 in relation to P66.

108. Those cases in which there is sufficient evidence to prosecute or to take disciplinary proceedings are identified in a supplementary report.

RECOMMENDATIONS

1. That the Honourable the Attorney-General examine and consider the desirability of amending the criminal law in relation to assault to take account of those circumstances in which it may be necessary to subject mentally ill patients to non-consensual treatment.

2. That the Honourable the Minister for Health, in consultation with the Honourable the Attorney-General, and as part of the process recommended in paragraph 1 consider the lawfulness of the administration of non-consensual treatment to patients who are lawfully detained in a hospital pursuant to the Mental Health Services Act.

3. That the Honourable the Minister for Health re-examine the provisions of Regulation 57 of the Mental Health Services Regulations and the definition of "seclusion" therein in the light of Chapter 18.2 of the report.

4. That the Honourable the Minister for Health take such steps as he may be advised to ensure that the provisions of the Mental Health Services Regulations are properly administered and complied with in all psychiatric hospitals and units.

5. That the Honourable the Minister for Health ensure that all persons who are "associated with the treatment of patients in a hospital" have drawn to their attention the provisions of ss.57-61 of the Mental Health Services Act.

6. That the Honourable the Minister for Health refer Exhibit 315 to the Honourable the Attorney-General for his consideration of the question whether it involves a breach of s.127 of the Criminal Code.

7. That the Honourable the Minister for Health consider for submission to the Governor in Council the question whether, and if so, to what extent, the treatment of mentally ill patients by the use of therapeutic community related principles should be "proscribed" pursuant to s.53 of the Mental Health Services Act.

8. That the Honourable the Minister for Health take such steps as he may be advised to ensure that the provision of the Mental Health Services Act and Regulations relating to official visitors is made to function in an efficient and effective manner.

9. That the Honourable the Minister for Health ensure the establishment of an effective quality assurance programme in the provision of mental health services in the State hospital system and to that end, investigate the feasibility of establishing a Mental Illness Review Committee (M.I.R.C.) of the kind referred to in Chapter 20.19 of this report, or a similar body which would operate independently of the Director of Psychiatric Services.

10. That consistent with the Government's Capital Works Programme the psychiatric unit at Townsville General Hospital be re-established and re-named and that it receive the resources and the support necessary to maintain in the long term the high standard of medical and nursing care and treatment which is now being provided in the unit.