Speech by

BILL FELDMAN

MEMBER FOR CABOOLTURE

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MENTAL HEALTH BILL

Mr FELDMAN (Caboolture—CCAQ) (3.02 p.m.): It is with pleasure that I rise to speak on the Mental Health Bill. Changes to the old Mental Health Act have been necessary for some considerable time. It would be remiss of me, as a former police officer who had to work with the old Act, if I did not say that it needed a complete overhaul. I commend the Minister for doing a job on the old Act.

There are some factors that I need to highlight from the perspective of an operational police officer who had to deal with various aspects of the Bill in the real world. One of the most significant changes that the Bill makes to the current Mental Health Act is the defining of the term "mental illness". The current Act does not contain a definition of "mental illness" whereby one can determine whether a person is or is not suffering a mental illness. As one could well imagine, it is a difficult task to attempt to define mental illness whilst ensuring accurate assessment and treatment, and also ensuring that a person's rights to have a particular belief or opinion do not classify them as being mentally ill.

I remember going over these sorts of things with the troupe of people who gave us a briefing on this legislation. Those people did a wonderful job. It was great to be able to sit down and talk to them in an open manner. I thank the Minister for that opportunity.

The definition provided in this legislation has been determined over a lengthy period by a large range of people through large scale consultations, discussions, submissions, reviews and input from almost all areas of the mental health industry and the community. I notice that the definition refers to international medical standards as per United Nations principles for the protection of persons with mental illness and for the improvement of mental health care. We cannot condone the making into law of principles agreed upon by unelected United Nations committees, but any resolution that such principles are to become binding upon the citizens of this country should be responsive and representative of the Australian public. I believe that in this case they are. However, this is sometimes not the case.

With regard to this Bill, however, I believe that large scale consultation over such a lengthy time has created a balanced and improved outcome with regard to the current Mental Health Act. Having said all this, I point out the greyness of mental health illnesses, and the issues and the subsequent difficulty in classifying someone as mentally ill and requiring treatment or detention in a mental health facility. I am sure that even the definition provided in the Bill now before the House will make some cases difficult to determine in practicality.

The Bill goes further—and I believe this to be an improvement upon the current Act—and defines assessment and treatment criteria. The Bill provides for requests for assessment by an adult who reasonably believes that the person has a mental illness and has observed the person within three days prior to the request. This requires safeguards against false or vexatious requests for assessment, and these are also provided for in the Bill. I believe these to be sufficient to ensure minimal vexatious input against well persons who should be considered to be of sound mind.

Recommendation for assessment is made by a mental health practitioner or a doctor and the recommendation for assessment is valid for seven days. Hence, if an assessment is not made within the seven days, all attempts must be made to ensure assessment of that person at a later date. A request for assessment and a recommendation for assessment must be made by different people. The

procedure requires a health practitioner or ambulance officer to take a person who has an assessment order in force to an authorised mental health facility for assessment.

The police are not involved except at the request of the mental health practitioner or the ambulance officer. The police power to act and aid the practitioner or ambulance officer is provided under section 14(3) of the Police Powers and Responsibilities Act, which states that a police officer is empowered to comply with a request made by a public official. I will deal with that matter a little later.

Despite the person's consent, if necessary, medication can be administered on the way to the mental health facility if it is for the safety of others. A written record must be kept.

A magistrate or justice of the peace is able to make a justice's examination order, which allows an examination of the person to determine if a recommendation for assessment should be made. A police officer may help detain a person for examination. Justice examination orders are also in force for seven days.

Emergency examination provisions are also covered. Emergency examinations by police officers and ambulance officers are provided for in the Bill. I intend to say a little more about this matter at a later stage. If a police or ambulance officer reasonably believes that a person has a mental illness or is at risk of significant physical harm by that person or someone else, they can take that person to an authorised mental health facility for examination to decide if the request for assessment should be made.

Police and ambulance officers—and I am glad to see the QAS mentioned here—are able to make emergency assessment orders. From the making of the order for examination a person cannot be detained for longer than six hours. Psychiatrists make emergency assessment orders and the legislation provides for the patient to be told what is happening throughout the process. If a person is not assessed as having a mental illness, that person is returned by the health officials to where they were collected from or to another reasonable place. If they are assessed as having a mental illness, they are assessed by a psychiatrist and a treatment order is made and involuntary detention can take place. For involuntary assessment, a person must be assessed within a 24-hour period, unless extended, but the extension can be for no more than 72 hours. The Bill provides for an allied person—minors, guardians and attorneys—to be notified of the involuntary assessment or treatment of a patient. These are very good amendments to the old Act.

Before I go any further I must highlight to the Minister the problems that police encounter in the administration of this Bill. I would reasonably have expected that these matters would be cleaned up in the amendments to the old Act. I want to highlight a typical situation which is encountered quite often by police. When I was an operational police officer at Deception Bay we had what we classified as our regular mental health patients. These are people who go off their medication and, unfortunately, the police have to be called.

At Deception Bay we had three regular mental health patients. I will outline the difficulties we had with one particular patient. I will call her Lady X. She was a lady of some 60-odd years and she was a mental health patient. She was a regulated patient on a medical plan and was placed back out in the community. I do not know whether she was assessed as being "on leave", but she was home and she was quite good whilst she was taking her medication.

The problem was that Lady X did not take her medication whilst she was at home and away from the place of safety. This caused a regression in her behaviour. The mental health workers and members of the public would report back to the place of safety and subsequently a warrant to apprehend the errant patient was issued by the registrar of the mental health facility—the place of safety under the old Act. As police, we were required to apprehend the errant patient.

The warrant was generally faxed to the police station nearest to where she resided, which happened to be Deception Bay, and it was up to the police to act. However, owing to the fact that she was not a real danger to herself or to the community—it was just that she was acting oddly and what have you—the police did not treat the matter as something that needed to be done urgently and, of course, the warrant was not given priority. Over probably the next couple of days we would go past in the hope that we would not have to bash down doors or windows—maybe catch her out in the yard gardening or doing something else so that we could just pick her up nice and gently.

For a few days we would hope for that opportunity to arise. Unfortunately, she had been apprehended over a dozen times and had become very, very cunning. She would never put a light on inside the house, she nailed up all the windows and she even used to strip herself naked inside the house because that would cause more problems for us when we had to go in there and get her. She just used to sit there and basically wait for the police to turn up.

Eventually when the warrant reached the top of the priority list and the police were forced to attend the house, we knew that today was the day that we had to act, so we always had a policewoman with us. Unfortunately, policewomen are not always on hand. However, on the day we

made sure that we had a policewoman with us, and we always had an authorised mental health worker available to go with us. Of course, their time is valuable, too. When we turned up, we knew that she was inside because the TV was always on, but she would just refuse to answer the door. We used to check out all the old entrance points of the place and, of course, the windows were nailed shut, the door was nailed shut and there were no keys handy so that we could grab them through a window if we smashed it. So it was a case of having to smash our way in.

Mr Schwarten: One of our houses, too?

Mr FELDMAN: It was probably one of the Minister's department houses, yes. However, the situation reached the stage at which the police finally had to bite the bullet and go in there. Sometimes we used to toss coins. No-one wanted to volunteer for the job, because we knew that once we were inside we would get belted with a broom and a few other things as we were trying to open the door to get back out to get a bit of help. I suppose it was quite amusing, but it is sad in a way that that had to go on. It used to be an unfortunate show for the neighbours: we had a 60 year old woman biting, screaming and belting police, and quite often she was naked. Eventually the keys were located, the doors were opened, the other police could come in and the woman could be detained.

Unfortunately, the police then had to spend the next three to four hours taking her to the closest mental health facility or the one that issued the warrant, and the old Form 16—the authority for detention—had to be filled out. That took a lot of time, and all that generally happened at the place of safety was that this person was given her medication and released. Quite often, she would beat us back to the division. It was a little bit disheartening for the police who spent so much time on the matter.

I was hopeful that the legislation as it relates to this issue would have been changed in the Bill. However, when I spoke to the Minister's staff—and, as I said, they gave the City Country Alliance a very good briefing—I was told that such an issue was still one of those grey areas where we cannot really do too much to increase the ability of either side to rectify that situation. I was hopeful that the Bill might have empowered the ambulance officers in that situation to make that entry, because I think that the women might have been more receptive to an ambulance officer trying to attract her to the door. However, I believe that all the ambulance officers can do is ask to come in, but they cannot actually break in.

Mrs Edmond: They can do that.

Mr FELDMAN: I realise that the ambulance officers can do the initial response, but they cannot actually break into the place. That job is left to the police.

Fortunately, in this Bill clause 117(1) refers to non-compliance with treatment under community category of involuntary treatment order. Subclause (2) of that clause relates to what a doctor is required to do; subclause (3) refers to the written notice or the order to be served on the patient to attend the mental health service on a specific day and time given by the administrator of the health service; subclause (4) refers to the course of action to take should the patient not comply with that written notice or order; and subclause (5) refers to the course of action to be adopted by the police.

Clause 513 deals with the issues of the mental health warrant empowering the police to enter the place and apprehend the patient. Clause 514 deals with the special warrants, that is, the phone, fax and radio copies of the warrant. Clause 515 outlines the procedures before entry which, in effect, are nullified by the provisions of subclause (4) of that clause, which allows the police, in cases of emergency, to break down doors, windows and all of that sort of stuff to get in. Subclause (6) of clause 117 enshrines what happens now, and that is that, once that medication or treatment has been administered, as soon as practicable after the treatment by the administrator, that person is taken back to the place they were taken from or another place specifically requested by them.

I can understand the requirement for the police to be called to assist the public official under the Police Powers and Responsibilities Act and I can see the need to have the police there to effectively force the entry into those places or homes of those errant mental patients. However, I have to ask why, when it is probably as simple as ensuring that that needle can be given, or that medication can be taken, or that small procedural treatment can be implemented, that cannot be done at the person's place rather than having to take them back to that mental health facility. I raised this issue at the briefing. I was hopeful that this Bill would contain a provision that allowed a doctor or a authorised person to deal with those simple medication problems at the person's place rather than being forced to take the person back to the mental health facility. It just seems to the police that when the mental patient actually beats them back to their home, all the police work was for nought and it was just a lot of wasted police time. The police had really just been called upon to babysit that person on a trip to the place of safety.

I understand that ambulance officers do not have the power to make a forced entry into a person's place. However, under this legislation the ambulance will be the first port of call. I know that when the patient then refuses to open the door and there has to be a forced entry, the police have to come in and apply their powers under the Police Powers and Responsibilities Act and under section

515 of the Mental Health Act. Because the police have made the detention, the onus is on the police to transport that person. I ask the Minister: is there a way for the police to actually hand over the patient to the ambulance once they have retrieved the patient?

Mrs Edmond: The ambulance can handle it.

Mr FELDMAN: It is just that I could not see clearly provisions relating to that in the legislation. I saw that when the police actually do the detention, it is still up to the police to have custody of that person. I suppose the ambulance could be used, but a police officer would then have to accompany the ambulance, because they have made the detention.

Mrs Edmond: It would depend on the circumstances, but both can transport them.

Mr FELDMAN: I know that both can transport the person, but I am talking about the situation where the police have actually made the detention. I think that the way in which clause 515 is written—

Mrs Edmond: You can then transfer to the ambulance.

Mr FELDMAN: They can? I could not see that. I will probably have to come and see the Minister—

Mrs Edmond: I will get back to you.

Mr FELDMAN: Perhaps the Minister can address that for me in her reply, because I could not see how that could occur under the Bill. I really look forward to knowing how that transfer can take place, and I know that the police would certainly look forward to that as well. I know that when I used to transport such people, I certainly did not feel all that comfortable having a mental patient in the back who could have a fit or who was perhaps not taking the right medication and I would not have been able to solve the problems. Yet I was the one who was doing the transfer. Police should be more than just babysitters for errant mental health patients who do not take their medication. I was looking for a way in which transport could be organised by a more appropriate authority such as the QAS, which is better equipped to transport patients.

At the briefing I spoke of other operational horror stories. I will not go into them now because I do not have much time left. However, I would like to praise the team the Minister sent to us. Members of that team sat down and went through issues with us. I would personally like to thank the team, because I fired all sorts of questions at them. I had them sweating for a little while, but they did well.

The Mental Health Tribunal is to be abolished and replaced with the Mental Health Court. That is one of the better aspects of this Bill, because I know of the problems that occurred with the tribunal and the distrust in which it was held. Whilst not taking away the powers of inquisition that the tribunal had and aligning it more closely with the wider court system, I believe that is a step in the right direction and I think it should receive wide support.

We will be supporting this Bill. It is long overdue and is well and truly needed. I have seen all sorts of things done throughout my years as a policeman under the name of the Mental Health Act. I have seen people evicted from homes through the misuse of some of the provisions of the Mental Health Act. I have seen so many wrong things occur. It is great to see that the legislation is being amended.

Dr Prenzler will be speaking shortly, and he will be raising some other issues in his speech. But I just pray that the changes that have been made to the Act will have the beneficial effect of delivering a far better mental health service to this State.

In closing, I want to highlight the fact that Caboolture now has a mental health facility with 25 beds. It is a great facility and, because it is so close, there is no more rushing to Brisbane by police or time wasted. I worked with some really great workers at the mental health service in Caboolture. They were on call and on tap whenever we needed them. I want to highlight the good work which they do there. It was a pleasure as a police officer to work with them over the years.