



Speech by

DESLEY BOYLE

MEMBER FOR CAIRNS

Hansard 17 May 2000

MENTAL HEALTH BILL

Ms BOYLE (Cairns—ALP) (12.50 p.m.): I am pleased to speak in support of the Mental Health Bill 2000, which is a very important Bill. In bringing in this Bill at the beginning of the new millennium, the Minister has recognised that it is many years overdue. However, it is right and proper that she has taken some time over the past several years to ensure that the Bill put before us was well considered and was the subject of wide consultation.

A particular element of the Bill that deserves recognition is the fact that within it are contained the principles on which it is founded. Too often in this Parliament we become preoccupied with the letter of the law and with writing legislation to control the implementation of the Government's direction, and sometimes in the translation we lose the principles behind legislation. Therefore, I wish to put on record some of the principles on which the Mental Health Bill 2000 is based.

In the development of the legislation particular consideration was given to the treatment of people with mental illness and their rights. All people with a mental illness have the right to receive the best available treatment and care in the least restrictive environment and using the least intrusive means appropriate to their needs and the protection of others. These words may sound simple, yet they signal a different era in the field of mental health and in the treatment of people with mental illness. In the past, they have not necessarily received the best available treatment and no attention has been paid to the extent to which their environment was restricted. In addition, there has been no recognition of their need to maintain their lifestyle within the community.

Another principle underlying the Bill is that these people should be treated with humanity and respect and be protected from exploitation and abuse. Sadly, as a society, and not just as a Parliament, over the previous century we have not recognised the significance of mental illness and the importance of the need for good treatment of it.

Another of the principles is that people with mental illness should live, work and receive treatment, as far as possible, in the community in which they live. That is sensible. It was insensible of mental health professionals who controlled the system in decades past not to recognise that the treatment of these people should not take place in an isolated location and take people away from their daily lives, family, work and social activities only to catapult them back into the community without rehabilitation and without attention being paid to the continuation of their usual lifestyle.

The principles in the Bill seek to ensure, to the greatest extent practicable, that an individual participates in decisions affecting him or her, especially decisions about treatment and the importance of an individual's continued participation in community life. This principle, too, sounds obvious to us in the year 2000, but in the past it has not been the case that individuals have participated in decisions affecting them. Individuals did not even have their treatment programs explained to them or the opportunity to ask questions and to have them answered. The climate in which mental health care has been delivered over the past 50 years in Australia and in other countries is very different from that which this Bill is aiming to set.

Some honourable members may know that, prior to my becoming a member of Parliament, I worked for some 25 years as a psychologist and, in the early years, as a clinical psychologist. I recall very clearly the first day I went to work after moving to Canberra to take up a position as a clinical psychologist at the Royal Canberra Hospital, which involved working primarily in the acute psychiatric

ward. It was a shock to my system, in spite of my academic training. Indeed, any member of the public would have been shocked. In those days, the ward was hidden away and had bars on the windows and locks on the doors. The patients were left to sit in one large day room and were called on only when they had to see doctors for treatment. The treatment was very much drug based and involved the frequent use of ECT, which certainly would not be tolerated today.

The patients were not treated as individuals. The hours during which their families could visit were restricted. Their families were not welcomed and were not informed about what treatment their family member was undergoing. Patients were not consulted or informed about their treatment or what would happen next. The attitude was that they were mentally ill and the psychiatrists in particular knew best and would prescribe the treatment to be carried out. We all hoped that somehow the patients would get better and that they could be thrown back into their lives, hopefully not to return. But of course they frequently did.

The shame attaching to mental illness in society was highlighted by the case of one woman who, I recall, was very severely depressed and also very anxious. She was the wife of a high-ranking public servant in Canberra at that time. Out of a fear that his wife's mental illness would become known publicly and have an effect on his career, he requested the ward staff to allow her to use another surname while a patient in the ward. I am pleased to say that we did not agree to that request. Nonetheless, his visits to his wife were very limited. It seemed to us that he was ashamed and embarrassed and more worried about any effect on his career than about the illness his wife was suffering. However, given the severe level of shame attaching to mental illness in the 1970s in Australia, his actions were perhaps understandable. Thank heavens throughout the eighties and the nineties we have seen the rise of positive mental health and consumer movements. They have contributed to our reaching the position today at which we can offer a very different sort of mental health care.

Sitting suspended from 12.58 p.m. to 2.30 p.m.

Ms BOYLE: There have been a lot of changes in society and attitudes to mental health in the past 20 years that have contributed considerably to the way that this Bill has been drafted. While all of us have recognised that our mental health can be affected by such things as stress, whether within our family and personal lives or within our work lives, this is a way of coming closer to looking at what had been the bogymen, as it were: mental illness.

Unfortunately, right across Australia we have also had to recognise the seriousness of depression, particularly as it has been evidenced through the high youth suicide figures and even the suicide figures of older people in our society. In beginning to face the illness that is depression and how widespread it is across age groups and all sectors of society, we have come closer to recognising the importance of diagnosing mental illness, of treating it as soon as possible and even, where possible, of preventing it in the first place. At the same time we have had a move to empty out the institutions of old; rather than simply resigning people to a very limited, controlled, institutionalised life forever for having evidenced mental illness, we now recognise that their management in the community, wherever possible, is not only their right as human beings but is also going to lead to greater health and better management of their mental illness than if they were kept institutionalised.

Along with this, we have seen moves in departments other than Health, such as Family Services, and in community based organisations to offer counselling, support, rehabilitation and retraining services for those who have suffered disability or illness, including mental illness. At the same time, research into the causes of mental illness has demonstrated that many of those illnesses that we have regarded as psychiatric illnesses, as mental illnesses, are not in fact so. They may present as that and be apparent through changes in behaviour or changes in the ability to communicate with others or to relate to others, but many of them are genetically determined in combination with biochemical factors. I predict that in another 20 or 30 years from now very little of what we now know to be mental illness will be so classified. In fact, we will have found the pattern of physical causation that is behind these very serious illnesses.

While society has changed in its attitudes towards mental illness, unfortunately our system of treatment and management, particularly in psychiatric wards, has not been so responsive. While on the one hand legislation is a part of this resistance to change, so too has been professional habit, professional cultures. One of the things, therefore, that I would like to give recognition to in relation to this Bill is the pressure that it will place upon professional psychiatrists, medical practitioners in general, psychologists, social workers and others to offer their assistance to people with mental illness in different ways to those that have been so much a part of the culture—rather than sitting in airconditioned offices making appointments to suit themselves and offering limited assistance to people where they live and with their families and out in the community. The system is due for a change.

I must give recognition to a number of people and organisations in the Cairns area at the community level who have kept the pressure on conventional treatment services for those with mental

illness. They have asked—demanded even—that there be a different level of communication and explanation with those who do have mental illness. They have fought and sometimes provided support services themselves for those patients as well as for their families.

On this occasion I would like to recognise the leader of the relatives and friends of the mentally ill association in Cairns, Petrina Ferrari, and her colleagues who have provided a halfway house for those who have suffered mental illness and are able to leave hospital but not fully return to independent life in the community. I would also like to give recognition to Anna Delamaine, who has long been an advocate for consumers—for those who have suffered from mental illnesses—being able to speak up and demand their rights, information and communication from the system. I would also like to recognise Robyn Nestor, who is a Queensland Health employee but who thinks outside the square and who is presently working with a number of groups in the Cairns area, in particular the mental health network, to look at how we can better provide support to families and others close to those who suffer from mental illness.

A week or so ago I was particularly pleased when I received a delegation of day patients in Cairns. These are people who have suffered mental illness, who have been hospitalised on one or more occasions and who attend a day centre in Cairns where they can support each other and where they can be led in activities that will assist them in growing in confidence and developing skills to manage more independently in the community. Their message to me was that they need expanded facilities, and I am pleased to support them in examining the present level of their facilities and how we may find a way to increase the level of support and to improve the facilities.

They were saying that they are certainly prepared to do the work themselves where they can but that some support from the system is needed. They made the point very clearly that they have illnesses that cannot be cured. Their illnesses are such that it is likely that most of them will from time to time experience an exacerbation of their symptomatology, whether of anxiety, depression or cognitive confusional states. Their point was well made that, if they are provided with the support at the beginning of these exacerbations of their illness, then they may well be able to manage better by staying in the community rather than requiring hospitalisation.

Not only has the community been calling out, particularly over this past decade, for changes in the way mental health services are delivered, particularly for those with serious levels of illness, but so also—less publicly—have been the police and the Ambulance Service. I am pleased to say that there are provisions within the Bill that will really reflect the sensible areas wherein there needs to be cooperation between the Police Service and the Ambulance Service and those who provide the treatment services for the mentally ill.

I note, too, today that there is a large number of speakers on this Bill. That in itself is recognition of the timeliness and importance of the Mental Health Bill in electorates right across this fair State of Queensland. This is not a topic, I dare say, on which honourable members would have felt competent or even interested to speak some 10 or 20 years ago.

I would particularly like to give recognition to the important and very sensible elements of the Bill that attend to involuntary assessment and treatment. Of course, there need to be principles around this. The policy positions in the Bill achieve a balance between the need to protect the community and the need to protect the rights of people with a mental illness who are treated involuntarily. These are complex and difficult issues on which there is a divergence of views, but the Bill balances the conflicting views while maintaining consistency with the policy objectives, which are to provide a more effective and accountable system for the involuntary treatment of people with a mental illness. No longer will people be simply found to be unable to be responsible for themselves and disappear into some hospital where there is no further communication. We hope that the system will now not only be more effective but also of account not just to the patient but to their family, the community and professional bodies.

Additionally, the new system is focused on the determination of the mental state and the treatment and care of an offender in such a way that it is open and accountable. The Bill facilitates the early involuntary assessment and treatment of people who represent a risk to themselves or other members of the community. This is a major shift in attitude. Rather than minimising—denying—the extent of symptomatology of serious mental illness, that assessment can occur earlier than before. However, there are many protections and additions to the way involuntary assessment will be carried out.

The Mental Health Bill will make it easier for members of the community to assist the person to gain access to services to be involuntarily assessed for treatment. The current Mental Health Act sets up barriers to people gaining access to early involuntary assessment and treatment by allowing only certain people to make a request for an assessment of the person to be made. The Bill does not limit the type of person who can make the request for assessment. This means that any member of the community—a family member, teacher, friend, counsellor or health professional—can make the request if they have reason to believe that the person has a mental illness of a type or to the extent that

warrants involuntary assessment. This really is a sensible provision, because it is more likely that a teacher, a colleague at work, a family member at home or a close friend will be the one to note the changes in the person and be the first to be alerted to the fact that there might be serious mental problems that require some assessment. In times past, unfortunately, such people have been powerless or have been ignored by the system.

There are safeguards to make sure that involuntary assessment and treatment are appropriate. Before making a request for involuntary assessment, the community member must have seen the person within the last three days so that the information is accurate and timely. Also, before the person can be detained involuntarily for assessment, a recommendation for assessment must be made by an authorised mental health professional, such as a doctor or other authorised mental health practitioner. They must then be satisfied that the person meets strict criteria. This is a significant change in recognising that persons other than medical practitioners may be suitably qualified to make this judgment. Also included are strict penalties against a person making a request for assessment based on information that the person knew to be untrue, out of some anger or mischief. The Bill makes it easier to prosecute offenders under this provision. Therefore, it will not be possible in any practicable way for somebody to suggest involuntary assessment of another person without there being substantive information on which that involuntary assessment can be made.

The legislation also provides for involuntary treatment in the community. This, too, is very important. In relation to those whose illness becomes so severe that they are a risk to themselves or the community, it has been normal procedure to have those people admitted to hospital where they can be kept, albeit against their will, while they are treated and until they are again in control and it is safe for themselves and the community.

Time expired.
