Speech By

Hon. Cameron Dick

MEMBER FOR WOODRIDGE

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MENTAL HEALTH BILL; MENTAL HEALTH (RECOVERY MODEL) BILL

Hon. CR DICK (Woodridge—ALP) (Minister for Health and Minister for Ambulance Services) (5.38 pm), in reply: There has been so much confected outrage by the LNP this afternoon that we are all on the verge of hypoglycaemia. There has been so much confected outrage about so many things. I thought that I might put some facts into the debate. I thought that I might conclude by talking about the LNP's legacy when it comes to mental health. I can assure you, Madam Deputy Speaker, it is nothing that the members opposite will be crying about by the end of this debate.

What did the Report on Government Services tell us this year? The report was released by the Productivity Commission, not the Labor Party, not the gutless, weak, dishonest Labor Party that the member for Caloundra stooped to saying. Here we were having quite a sensible debate this afternoon and the member for Caloundra could not restrain himself. Notwithstanding the very thoughtful contributions by a range of members—

Opposition members interjected.

Mr DICK: Let them catcall. Let them cry out. The bravest person in this debate was the member for Mirani, who spoke about his own lived experience with mental illness. We need more people in our community talking about their experience and sharing their experience. It is difficult for people with mental illness on many occasions to talk about their experience, to talk about their sons speaking to them on the telephone and changing the direction of their life. So the debate was sullied by the closing comments of the member for Caloundra when we had a very thoughtful and considered debate. I can tell the House one person in the Australian Labor Party who is not gutless, and that is the member for Mirani. He never has been. He has been a man of conviction. He has always stood up for what he believes in, and it is a pity that there are not more members in this chamber like that.

What is the history of the LNP's contribution? We had the confected outrage from the member for Nanango bravely defending her leader, Lawrence Springborg. On 2 February, the Productivity Commission released the Report on Government Services. That report showed that under Lawrence Springborg as health minister Queensland's spending on mental health fell to the lowest amount in Australia on a per capita basis. In 2013-14, when Lawrence Springborg was the minister for health, Queensland also had the lowest number of full-time-equivalent staff employed in a specialist mental health service per 100,000 population.

But this was not the first time that Lawrence Springborg had cut mental health. If we go back to the previous year, the Report on Government Services released in 2015 showed that expenditure on mental health services fell by $45.4 million in 2012-13 in Lawrence Springborg's first full year as health minister. In nominal terms, the cut by Lawrence Springborg was the single largest cut to mental health expenditure ever recorded by any state or territory government. It was also the first time that Queensland has ever recorded a reduction in expenditure on mental health services in both nominal and inflation adjusted terms.

No-one in the Australian Labor Party in this government will be lectured to by the Liberal National Party about expenditure and support for mental illness. I am glad the members opposite sit in silence. What a legacy that was left by the member for Caloundra, as a member of that cabinet; by the member for Callide, as a member of that cabinet; and by the other former cabinet members here today. That is their legacy when it comes to mental health.

I can also report to the House that we have increased funding for those Queenslanders living in distress because of the drought. We heard a lot of discussion by members opposite about the support we need to provide for Queenslanders living in the west but not one acknowledgement of the investment this government has made: $2.9 million allocated to the tackling adversity in regional drought and disaster communities program and $600,000 to community based projects—so $3.5 million in one commitment that I made in November last year on top of $1.5 million that we announced in the budget. I am happy to have a bipartisan debate on mental illness and mental health, but it is appropriate that credit be given to certain initiatives.

I also want to go to this point that there is no difference between the bills, that the bills are substantially the same except for a couple of tweaks. Again, I set that out in detail in my second reading speech, but of course facts never get in the way of the LNP when it comes to substantive matters of policy. The provisions in the government's bill will, for the first time, enable the use of physical restraint to be managed and modified—not in the private member's bill. The government's Mental Health Bill 2015 includes provisions to ensure the appropriate use of medications such as sedation on patients in authorised mental health services—not in the private member's bill. The Mental Health Bill 2015 enables a person to appoint in advance up to two nominated support persons who may receive information about the person and support the person if they become an involuntary patient—not in the private member's bill.

The government's bill also expressly states that the bill does not limit how information may be disclosed under the Hospital and Health Boards Act to family and support persons—that is, clause 286 of the government bill. Under that act, personal information can be disclosed to a person with sufficient interest in the patient or for the patient's treatment and care—not in the private member's bill. The Mental Health Bill strengthens the independence of independent patient rights advisers by requiring them to be employed outside of mental health services—not in the private member's bill. So this bill is a significant and substantial improvement on the bill that was prepared by those members opposite. It is worthy and deserving of support by members of the parliament.

There were a number of issues raised during the debate including discussion about electroconvulsive therapy and how it can be treated under the bill. In the debate there was discussion around clinical advice that ECT is an effective treatment for severe psychiatric disorders such as clinical depression, mania and psychosis, and is occasionally used to treat other neuropsychiatric conditions. It is specifically regulated under the bill. The parliamentary committee gave particular attention to the use of ECT in minors and supported the safeguards. I recall the comments by the member for Greenslopes on that particular issue and the deep way that members of the committee engaged in that issue when it was before the committee for consideration.

The opposition has proposed an amendment to the bill to enable the Chief Psychiatrist to impose a condition that a forensic patient wear a GPS tracking device—a significant difference. In the explanatory notes for the amendment, the key reason given is that 'the process of obtaining a court order in emergent circumstances might be onerous and cause lengthy delays for the treatment of an individual'. That is simply not the case. Where the Mental Health Court decides to impose such a condition, it would be done at the time of the hearing that makes the forensic order for the person—so there would be no delays. The Mental Health Review Tribunal may decide to impose such a condition as part of a regular review of a forensic order. Again, there would be no delays. The Chief Psychiatrist could apply to the tribunal to have a forensic order amended to add a condition that a forensic patient wear a GPS tracking device. If this was needed quickly, the tribunal could hear the matter in a matter of days. The patient would continue to be treated during this time.

As I indicated in my second reading speech, stakeholders consulted on the bill do not support the approach in the opposition's bill. It is not supported by the AMAQ and it is not supported by the Royal Australian and New Zealand College of Psychiatrists. It is important that these matters be considered in a transparent and accountable way—before the Mental Health Court or the Mental Health Review Tribunal.

The reforms in the bill in relation to magistrates' powers will greatly improve the rights of persons before the courts. Again, as I indicated in my second reading speech, I wish to acknowledge the strong, consistent and persistent advocacy of Mr John Avery and Mrs Collein Avery, who, over many years, have presented the case for reforms to the justice system as it affects persons who are not fit for trial whether they have a mental illness or intellectual disability. Frankly, notwithstanding all of the debate in

this chamber, it is people like the Averys and their family and their journey through the justice system that we should be reflecting on—the people with a lived experience of mental illness and the people with a lived experience of an intellectual disability.

The member for Mudgeeraba raised some serious concerns about the Robina Hospital. I will refer those matters to the hospital and health service for consideration. They are not relevant in a direct sense to the legislation, but I will refer them to the HHS for consideration. The member for Mudgeeraba also raised concerns about the need to use GPS tracking devices due to the proximity of the Robina school to the Gold Coast Hospital. I must say, with respect, this is an unnecessary and alarmist statement by the member for Mudgeeraba. GPS devices have only ever been used twice in the entire state and they have never been used in the Gold Coast area. There are extensive safeguards in the bill in the way the Mental Health Court, Mental Health Review Tribunal and Chief Psychiatrist regulate community treatment for forensic patients.

The other point is that there is a further, additional safeguard that could be invoked in extraordinary circumstances. In the event that the Chief Psychiatrist considers that there is a serious risk to the life, health or safety of a person or to public safety in relation to a forensic patient, the Chief Psychiatrist has the power to suspend leave provisions for a forensic patient or convert a patient on a community order to an inpatient order. This would have the effect of immediately recalling that patient to secure inpatient treatment.

This provision exists in the government bill at clause 311, and a similar provision already exists in the private member's bill at clause 302. Frankly, if there were genuine urgent concerns for the safety of the community, I would much rather that the forensic patient be returned for secure treatment and assessment at an inpatient facility rather than having a GPS attached which, as we know, may not prevent any incident from occurring.

The member for Mudgeeraba expressed concern that the requirement for the Chief Psychiatrist to approve the use of mechanical restraint will jeopardise staff safety. That is not correct. This only applies to mechanical restraints which are almost exclusively in use in the high-security unit at the park. The Chief Psychiatrist will ensure that restraints are only used when necessary. Physical restraint can be used in urgent circumstances without any approvals under the act. The vast majority of times that restrictive practices are used in emergency departments have nothing to do with mental health law. That is why I announced today a legislative review of restrictive and safety practices in emergency departments.

The bill recognises the important role that rural and remote mental health services play in the state. Under the current act, restrictions are placed on the use of audiovisual technology in making recommendations for assessment and involuntary treatment orders. That is being removed. We need to embrace telehealth across our health system. In designated rural and remote areas, authorised doctors may make a recommendation for assessment and perform assessments if the authorised doctor is the only authorised doctor reasonably available.

The member for Mudgeeraba made a statement she was concerned seclusion is frowned upon. I am not sure whether she saw that as a good thing, but she is correct. Since 2005, every Australian state and territory has been committed to the reduction and, where possible, the elimination of seclusion. The original agreement included the then federal Liberal National government, but I also know that it was an objective subscribed to by the Newman government, in which the member for Mudgeeraba served as a minister. I understand that notable reductions in seclusion were achieved under the Newman government over the period 2012 to 2015 while the Leader of the Opposition was the health minister, and I think that was an important development.

It is clear from the debate that the Mental Health Bill is a far superior bill, in my respectful submission to the parliament, than the opposition's Mental Health (Recovery Model) Bill. It provides greater protections to patients in many areas including the regulation of physical restraint and the appropriate use of medication. I look forward to the support of members for this important piece of legislation.

In conclusion, I briefly acknowledge those staff members from the Department of Health who have worked very long and hard over a number of years to bring this bill to the parliament. I acknowledge Mr Paul Sheehy, the director of the Mental Health Act review, and his staff Fleur Ward, Phil Hall, Will Alker, Bobbie Clugston, Nada Wiley and Leanne Hartley. I also acknowledge two executives in the Department of Health, Dr Bill Kingswell, the Executive Director of the Mental Health Alcohol and Other Drugs Branch, and Associate Professor John Allan, who currently occupies the statutory role of Director of Mental Health—soon to be renamed the Chief Psychiatrist as this bill passes through the parliament. I thank them for their executive leadership of this project. I commend the bill to the parliament.