Speech By

Joseph Kelly

MEMBER FOR GREENSLOPES

Record of Proceedings, 18 February 2016

MENTAL HEALTH BILL; MENTAL HEALTH (RECOVERY MODEL) BILL

Mr KELLY (Greenslopes—ALP) (3.45 pm): I rise to speak in support of the Mental Health Bill 2015. Madam Deputy Speaker Linard, I start by thanking you and the other committee members for the work done and the very many people who made submissions to the committee. The Mental Health Bill has many aspects to it, many of which create a great deal of division. There are many passionately held views about these things. These things are incredibly important because they go to interfering effectively or actually with people's liberties. While we heard from many passionate people on both sides of the argument, our job, I believe, as a committee is to stay focused on the evidence and to base the decisions that we make on the evidence.

The legislation is quite important. Care and support for people with a mental illness is extremely important and extremely challenging. We need to set a framework to not only support healthcare professionals who provide care but also, more importantly, allow people with a mental illness to control the management of their disease and to allow for self-directed healing and recovery. We also need to provide space for family and support people to be involved in that process.

The Palaszczuk government listens. We have taken the time to properly consult with stakeholders on this legislation. We also recognise that as a government we cannot nor should we attempt to provide the entire solution. I am extremely pleased that organisations in my electorate such as Grow and Stepping Stone Club House do great work and are very much focused on supporting people in their recovery journey through a process of self-determination and empowerment. By listening to the stakeholders we have significantly improved the legislation.

The key to this legislation, I believe, is the principle of least restriction. We want to help people who are mentally ill manage their situation in the least restrictive manner. Those of us who have worked in the field know that there are times when people lack the capacity to make sound decisions or to behave in a rational manner. Those times involve situations where people pose a risk to themselves and to other people and to the broader community. So there are times when we have to consider the use of physical and chemical restraints. These, in my opinion, should be used with great caution, they should be used as a last resort and they should be used in very controlled circumstances.

I want to pick up on a few things that the member for Mudgeeraba said. Our committee worked extremely effectively together. It was great to have both clinical and non-clinical people involved. We worked very constructively in a bipartisan manner to work through some very challenging and difficult issues. In relation to restraints and medications, if I understood correctly, there were concerns raised around red tape and making it more difficult to apply restraints.

I cast my mind back to the early period of my nursing training and to some of the work I did in aged-care facilities and mental health facilities where we did not necessarily have the restrictions around the use of restraints that are thankfully in place now. It was not uncommon to have patients with

challenging behaviours simply tied to a chair. While I really appreciate the very good intention of the member for Mudgeeraba and her passion for trying to make the clinical work of people at the coalface easier, I do think we have to be very, very careful when it comes to the use of restraints.

The bill includes provisions to regulate the use of physical restraint on patients in authorised mental health services. Authorised doctors or health practitioners in charge of a unit must authorise the use of physical restraint and only if it is necessary to protect the patient or others from physical harm, to provide treatment or care to the patient and to prevent the patient from causing serious damage to property or prevent a patient from leaving a service. The regulation of the use of physical restraint is very much in line with contemporary practices and it very much fits in with the notion of managing people in a less restrictive way. It enables the monitoring and management of these practices and provides for a safer environment for staff and patients.

I note the concerns raised about the use of chemical restraints. Again, I have lived through a period when reaching for chemical restraints was common and, as we now know, absolutely the wrong thing to do. We used to call it 'vitamin H'. We would find a patient whose behaviour was difficult and challenging and simply hold them down and inject them with Haloperidol until they stopped doing what they were doing. It did not matter whether that was in a mental health situation or in another clinical situation.

There has been great work done at the PA Hospital and in many other places, but particularly at the PA Hospital, looking at the issues related to what causes challenging behaviour. There has been great work done in relation to educating nursing staff and establishing policies and procedures so that we can separate out delirium from dementia. Quite simply, over many years we were reaching for chemical restraints when really we should have been adopting very different practices. I know delirium and dementia are not the subject here. But the purpose of this illustration is to show that, if we just simply allow carte blanche use of medications to restrain people and do not think of other options, it can have very serious consequences. We know that if somebody has a delirium there is very likely something physical causing that, like an infection. We know that if we deal with that we will quickly eradicate the challenging behaviours. In fact, these days in hospitals we tend to use one-on-one nursing supervision with patients with challenging behaviours rather than any form of physical or chemical restraints. They are the options of last resort.

We have developed processes, we have developed assessment tools and we have developed practice guidelines which lead us along a pathway to manage these patients well. I know that in this bill the approach being taken around restraint and medication very much fits in with that least restrictive way. I am pleased that under the bill the Chief Psychiatrist will be developing binding policies on these matters and, more importantly, reporting on compliance with these policies.

The issue of GPS tracking and forensic orders was also discussed extensively in the committee. GPS tracking, to my understanding, is not necessarily well supported by the evidence as an effective tool, but the submitters, by and large, acknowledged that it was an option and a common tool and something that there was a genuine desire from clinicians and the community to have access to. So they supported the limited use of GPS tracking under very strict circumstances.

The bill removes the ability of the Chief Psychiatrist to require a forensic patient to wear a GPS tracking device and instead limits that ability to the Mental Health Court and the Mental Health Review Tribunal, where the issues can be considered in a transparent manner. This goes to giving patients rights in these situations as well. The Mental Health Court and the Mental Health Review Tribunal will consider the risk management needs of the patient and consider and set out any other conditions required for the safety of the patient and to protect the community.

To further strengthen community protection, this bill enables the Mental Health Court to impose a non-revocation period of up to 10 years on a forensic order for the most serious violent offences such as murder, manslaughter, rape and grievous bodily harm. These offences are called 'prescribed offences' under the bill. This gives some assurance to victims of these unlawful acts that the patient will receive treatment and care for a known period. It will also enhance certainty in the broader community of these types of forensic orders.

I have touched a few times on patient rights. I think the bill goes a long way to improving patient rights. We must at times infringe on the liberty of people for their own safety and for community safety. The bill clarifies the circumstances in which a person may be taken to a public sector health service facility for emergency examination, treatment and care.

There would be very few people in this House who have not been approached by a family member or a friend of somebody with a mental illness who expresses deep frustration that they are unable to be as involved in the care and decision-making of an adult with mental health issues as they would like. The bill strengthens the requirement for doctors and health practitioners to consult with

families, carers and other support persons. For me personally that is very, very important. These provisions recognise that family members, carers and others who help support people with mental illness are critical in a recovery oriented approach to treatment.

Sadly, as we know, many people who suffer from mental illness have family situations that have broken down. So the bill strengthens the independence of the new statutory positions—the independent patient rights advisers—by requiring that those positions are to be employed outside of mental health services. Under the bill, consultation must occur unless the patient specifically requests that communication does not take place. This means that we must talk to family members unless the patient indicates otherwise.

The use of advance health directives has been common outside of mental health services for a very long period. We most commonly use them to guide end-of-life care as people lose capacity to make or communicate decisions. As we know, there are very many types of mental health illnesses. Some of them fluctuate and have periods where a person has full capacity and other periods where they are quite incapacitated. The bill strengthens the use of the advance health directives, which enable a person to consent to treatment in advance should the person lose capacity to consent.

Advance health directives must be used instead of placing people under involuntary treatment if the directive is adequate to meet the patient's healthcare needs. That gives us an option to not limit the liberty and decision-making of those people. However, we still retain that option, and if we take that option the bill requires authorised doctors to explain to a patient and document in the patient's records why an advance health directive was not followed. That provision was made as a direct result of consultation with stakeholders.

The Mental Health Court will also see improvements. Operational aspects of the Mental Health Court are improved under this bill. This includes enabling the court to hold a hearing with one assisting clinician where it is appropriate to do so. This is a much more efficient use of resources where a case is not contested. Operational aspects of the Mental Health Review Tribunal are also improved under this bill, and that is very welcome. This includes enabling the tribunal to refer questions of law to the Mental Health Court. The bill also explicitly enables information to be given or recorded electronically rather than in hard copy form. During the implementation of this legislation, opportunities to optimise the use of electronic information exchange and storage will be considered. Where this can be achieved, compliance costs, especially for clinicians in authorised mental health services, will be reduced.

Before I conclude, I want to talk about two other issues that were raised quite frequently with me both by people who live in my electorate and individuals and groups from right around the country. First, I want to talk about the use of ECT. There is a very significant group of people who believe we should not be using ECT in minors. I was certainly open minded enough to listen to their concerns and try to understand their concerns and the evidence. I have witnessed and assisted in ECT procedures many years ago—over 25 years ago. I have seen patients personally who are catatonic, unable to self-care, unable to get out of bed, receive two to three treatments of ECT and be discharged from hospital within days. That was 25 years ago. The procedure is nothing like it is portrayed in some popular movies.

I particularly queried this during the hearings and did further reading, and the evidence for the effectiveness for ECT is strong. The evidence for the safety of ECT is strong. The evidence for the use of ECT being effective and safe at all ages is also strong, but there is recognition that with minors we have to put further safeguards in place, and that has been done in this legislation. It was also pleasing to note that the use of ECT in minors is extremely rare. I would have to go back and check the transcript, but I think fewer than five cases over the last 12 months have even been considered by the mental health tribunal. Dr Stathis summarised it accurately when he said that, if we do not allow the use of ECT in minors, we are committing a form of age discrimination. If Panadol works in minors and it works in adults, we would not think of leaving a child in pain. We would give them the drug if it is safe to do so, and it is in this case. This procedure is safe.

Deep brain stimulation similarly creates a lot of discussion and division in the community. It has been used quite effectively for certain types of illnesses such as Parkinson's. There is some evidence, as I understand it, that it is effective in some forms of mental illness. However, the evidence at this stage is not strong. The bill is simply making provisions to allow the use for research purposes. Again, it has significant protections for patients.

The government's bill improves significantly on the previous private member's bill. Those improvements have come about largely due to the thorough consultation process with stakeholders. Almost 100 submissions were received on the consultation draft on the Mental Health Bill, and they all made very valuable contributions and certainly broadened my understanding of the issues in mental health. This feedback has helped to refine the bill and has made substantial improvements.

In conclusion, as indicated by the health minister in introducing the bill, there are important differences between this bill and the Mental Health (Recovery Model) Bill. However, the bills have many reform directions in common, and in the spirit of bipartisanship the opposition support for these reforms is welcome. I was pleased that we were able to work through some very difficult issues that were potentially very emotive in a very sound manner. I commend the Mental Health Bill 2015 to the House.