Speech By

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MEMBER FOR NUDGEE

Record of Proceedings, 18 February 2016

MENTAL HEALTH BILL; MENTAL HEALTH (RECOVERY MODEL) BILL

Ms LINARD (Nudgee—ALP) (3.09 pm): I rise to speak in support of the Mental Health Bill 2015, which will repeal and replace the Mental Health Act 2000. The current Mental Health Act was developed after a detailed review to replace a 1974 act. The current act substantially modernised Queensland's mental health legislation and incorporated international principles to reflect the rights of people with a mental illness. Now, 16 years later, once again it is time to ensure that this vital legislation keeps pace with developments in patient rights and clinical practice. I say 'vital', because an overarching purpose of the current act and the bills before the House is to provide a regulatory framework for the management of people who are so unwell that they do not have the capacity to make decisions about their own treatment and care.

In cases where a person does not have the capacity to make decisions about their treatment and care, the bill provides a lawful authority to treat a person with a mental illness. The vulnerable nature of the people to whom this legislation will apply and the gravity of the powers and orders that it contains was certainly not lost on me—and, indeed, I think it is fair to say on any of my fellow committee members—as we conducted our inquiry into the bill. The committee was charged with looking at the Mental Health (Recovery Model) Bill, a private member's bill, and the government's Mental Health Bill and chose to do so concurrently. The genesis of both bills stems from a Department of Health review of the Mental Health Act, which commenced in 2013. The private member's bill, introduced by the member for Caloundra in May 2015, is similar to a bill that was introduced in 2014 by the former government, which lapsed upon the dissolution of the House. In 2015, the Department of Health undertook significant further consultation and review of the bill. This further consultation and review resulted in the introduction of the Mental Health Bill, which provides significant additional safeguards that were absent from the 2014 bill.

In his explanatory speech on the Mental Health Bill, my colleague the Minister for Health and member for Woodridge commended the former health minister for commencing the review into the Mental Health Act and noted that, although there are important differences between the 2014 bill and the government bill, the bills have in common many reform directions. The committee undertook its consideration of the bills in a similarly bipartisan manner. Although the committee could not reach an agreement on whether either of the bills should be passed, the committee supported the common purposes of the bills and was able to reach informed agreement on and include commentary around the majority of the provisions in the bills.

Although there are many reform directions in common between these bills, there are also important differences. It is these important differences, most notably the additional measures and safeguards contained in the government's bill, that led my colleagues—the member for Greenslopes, the member for Thuringowa—and I to support the passage of the government's bill. Such differences include a principle of recognising and taking into account a person's hearing, visual or speech impairment; allowing the Chief Psychiatrist to regulate the safe use of medication used to treat mental

illness; and making it an offence to administer medication to a patient unless it is clinically necessary. The government's bill makes a number of related provisions of which there are no comparable provisions in the private member's bill. The government's bill defines physical restraint and specifies the circumstances in which it may be used, making it an offence to use physical restraint on a patient other than under the legislation. There are no comparable provisions in the private member's bill.

With regard to electronic tracking devices, the government's bill removes the ability of the Chief Psychiatrist to require a forensic patient to wear a GPS tracking device. This authority is limited to the Mental Health Court and the Mental Health Review Tribunal where the issues could be considered in a transparent way. The government's bill also allows the court to impose a non-revocation order of up to 10 years on forensic orders for particular serious offences, providing certainty to victims, compared to seven years under the private member's bill.

The government's bill improves operational aspects of the Mental Health Court, including enabling the court to hold a hearing with one assistant clinician where it is appropriate to do so. The bill also improves operational aspects of the Mental Health Review Tribunal to enable the tribunal to refer questions of law to the Mental Health Court. The private member's bill does not contain reforms to operational aspects of the Mental Health Court and the Mental Health Review Tribunal.

But most importantly for me, the government's bill further strengthens patients' rights. The bill strengthens the independence of patient rights advisers by requiring them to be employed outside of authorised mental health services. The bill also expands the functions of these advisers, including requiring them to work cooperatively with community visitors under the Public Guardian Act.

The bill takes a significant step forward in facilitating and promoting the use of advance health directives, which give patients an opportunity to have greater control over their future healthcare needs. As someone who has seen an advance health directive in practice in the treatment of a member of my own family, I know the importance of such documents in empowering and providing a sense of control to those who otherwise may feel completely bereft of it owing to physical or mental incapacitation.

The mental health bills before the House are large and complex. I will limit my specific comments to a number of key aspects of the bills, the first of which is treatment authorities. The bills regulate providing treatment and care to people without their consent. Under the current act, once a person has been assessed, involuntary treatment can be provided to the person if an authorised doctor assessing the person with a mental illness is satisfied that the treatment criteria apply to the person. Under the bills, a treatment authority would replace involuntary treatment orders. Both bills provide for the making of treatment authorities for persons who have a mental illness if the treatment criteria apply to that person and there is no less restrictive way for the person to receive treatment and care. The name change reflects a shift in focus to make the use of involuntary treatment an option of last resort where there is a less restrictive way of treating the person. Both bills place a greater emphasis on a less restrictive way as a means of reducing the adverse effects on the rights and liberties of the person.

Unlike the current act, the bills require that a patient on a treatment authority must be treated in the community unless it is not possible to meet the patient's treatment and care needs in this way. That change is described as supporting a recovery orientation for patients with a mental illness. The government's bill provides additional safeguards in regard to the use and adherence to advance health directives. The committee noted the views of the Queensland Mental Health Commission that least restrictive practices form an essential foundation to a recovery oriented approach to mental health service delivery and have been accepted internationally and nationally as best practice.

During the inquiry, the committee received significant evidence on regulated treatments. Some of this evidence was emotive and at times contradictory. Regulated treatments include electroconvulsive therapy and non-ablative neurosurgical procedures, such as deep brain stimulation. The bills provide that regulated treatments can be performed on both adults and minors with a mental illness in certain circumstances. The efficacy and safety of electroconvulsive therapy—or ECT—was a particular contention during the committee's deliberations, with stakeholders expressing strong views both for and against. The committee heard testimony from treating specialists within the Department of Health, the Royal Australian and New Zealand College of Psychiatrists and the Australian Medical Association of Queensland about the efficacy of ECT. Both the department and the royal college of psychiatrists referred to the treatment as being effective for mental illnesses such as clinical depression, mania and psychosis and for particular groups of patients, including those whose illnesses do not respond to medication. Similarly, the AMAQ stated that the evidence of the efficacy of ECT on adults is pretty robust.

The committee considered stakeholder concerns in relation to ECT within the context of the regulatory framework outlined in the bills to determine whether it was satisfied that sufficient safeguards are in place. The bills required the informed consent of the person or the approval of the tribunal before

a regulated treatment such as ECT can be performed. Before a person can give informed consent, the treating doctor must explain a number of things, including the purpose, method, likely duration and expected benefit of the treatment; the risks and side effects of the treatment; alternative treatments; and the consequences of not receiving treatment. The committee considered that this framework provides adequate safeguards for patients who may receive and benefit from ECT.

Stakeholders have particularly strong views on whether regulated treatments such as ECT should be available to minors. The bills recognise the importance of providing appropriate treatment for younger people with a mental illnesses by including a specific principle for minors, which requires persons acting under the bills to recognise and promote a minor's best interests. This includes receiving treatment and care separately from adults if practicable and having their specific needs, wellbeing and safety recognised and protected.

The committee diligently considered whether these safeguards are sufficient in regard to minors. Broadly speaking, ECT may only be performed on a minor if the tribunal has provided approval. The tribunal must consider the views of the minor's parents and the views, wishes and preferences of the minor when deciding whether to grant the approval and may only give approval if, among other things, there is evidence that supports the effectiveness of the therapy on minors. The bills also require the tribunal to appoint a lawyer to represent a minor at all hearings at no cost to the minor and to ensure that where a proceeding relates to a minor the membership of the tribunal includes at least one psychiatrist with expertise in either child or child and adolescent psychiatry.

The treatment of minors with regulated treatments such as ECT weighed heavily on me as a parent and as a legislator. Advice provided by treating specialists that ECT is rarely performed on minors, that ECT in children and/or adolescents is permitted with safeguards in every state and territory in Australia, that the safeguards in these bills rank amongst the most comprehensive in Australia and that to deny someone access to an effective treatment such as ECT solely on the basis of their age is discriminatory and a breach of their human rights ultimately led me to put aside my emotive response in favour of expert testimony.

I would like to turn now to patient rights under the government bill. In regard to patient rights the current act provides that health practitioners and a legal or other adviser may visit an involuntary patient at any reasonable time. The bills extend that right by providing patients of an approved mental health service with the right to receive visits at any reasonable time from their nominated support person, family, carers and other support persons, a health practitioner and/or other legal adviser. The bills provide that an authorised mental health service and authorised persons involved in a patient's treatment have particular responsibilities with regard to communicating with patients, their nominated support persons, family, carers and other support persons. These are important legislative amendments that will better respect and protect the rights of patients. The government bill also provides greater detail about when the obligation to communicate with a patient's family member, carer or support person does not apply. The committee supports the expanded provisions in the government bill.

In closing I would like to thank my fellow committee members for their diligent approach to considering the bills and the often confronting and emotive evidence presented to the committee during its inquiry. I would like to thank those who made written submissions on these significant bills. I would like to also thank officials from the Department of Health who briefed the committee and assisted us to work through the often complex detail contained therein. I would also like to thank the witnesses who provided evidence at the public hearings and the committee secretariat. Finally I would like to thank the minister for accepting many of the recommendations of the committee in good faith. I commend the Mental Health Bill 2015 to the House.