PARLIAMENT OF WESTERN AUSTRALIA

INAUGURAL SPEECH

Dr Carmen Lawrence, MLA

(Member for Subiaco)

Address-in-Reply Debate

Legislative Assembly, Tuesday, 10 June 1986

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ADDRESS-IN-REPLY: FIRST DAY

Motion

DR LAWRENCE (**Subiaco**) [4.30 p.m.]: I move —

> That the following Address-in-Reply to His Excellency's Speech be agreed to —
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> May it please Your Excellency: We, the Legislative Assembly of the Parliament of the State of Western Australia in Parliament assembled, beg to express loyalty to our Most Gracious Sovereign, and to thank Your Excellency for the Speech you have been pleased to address to Parliament.

I am deeply honoured to have been asked to move this motion in reply to His Excellency's Speech. I am also pleased to be one of the first in this Chamber to have the opportunity, Mr Speaker, to congratulate you on your appointment to that position. It also gives me pleasure to formally congratulate the Government on its re-election for a further term and to thank the electors of this State for their support and acknowledgment of the substantial achievements of the Burke Labor Government.

As the new member for Subiaco, a seat which has not been held by the Labor Party for 30 years, I am conscious of my obligation to represent all the electors in my district to the full extent of my energy and ability. My thanks go to all those who supported me and worked so diligently to ensure my election and the re-election of the Government of which I am proud to be a member.

As a member of Parliament I am particularly sensible of my obligation to give voice to and further the aspirations of all citizens, regardless of their status, wealth, sex, race, creed or disability. Today, I wish to draw members' attention to the plight of a group in our community which is frequently without an effective voice, whose members are unseen, unwanted and ignored: I refer to those people who suffer from mental illness.

Too often, debates within our community are restricted to a few glorious issues which become sacred emblems for one or other of the articulate pressure groups attempting to influence policy and public opinion. Despite the fact that mental disorder is one of the nation's most serious medical and social problems, it attracts little media attention and rarely provokes sustained analysis of the strategies which might improve the position of the mentally ill and alleviate the severe pressure placed on them and their families.

Mental disorders in Western Australia account for more hospital in-patient bed-days than any other major category of illness. In 1984–85, the hospital admission rate for mental illness was more than 130 per 10 000 adults. It has been estimated that up to 10 per cent of the population will, during their lifetime, spend time in a psychiatric unit or hospital. A significant proportion

of those people will be involuntarily detained; that is, committed or certified, and it is about these people that I wish to address my remarks.

In discussions of the treatment of mental illness, it is likely to be asserted that services to the mentally ill have been improved dramatically during this century. Examination of the history of mental illness reveals a variety of exotic, bizarre and fantastic views about the causes of mental illness and a catalogue of correspondingly inhumane and brutal methods to manage those afflicted. While there have been significant changes in our attitudes, there are some disturbingly-constant features of our thinking about and behaviour towards the mentally ill which make any simple theory of enlightened progress suspect.

I would not deny that there are obvious differences between the ancient practice of expelling mad men and women from the community like lepers and the relatively recent policy of committing them to mental hospitals. However, this should not blind us to the similarity of the ultimate goals of both these practices: To cast the mad out of the community and separate them from family and society. We are still made uneasy by odd behaviour and thinking, frightened by the—unlikely—possibility of dangerous and unprovoked assault, and suspicious, one might even say superstitious, that close association with those with mental illness will result in moral contagion.

There are those who would assure us that the coercive incarceration and enforced treatment of those with mental disorders has declined markedly and that mental hospitals are no longer the punitive dumping grounds they once were. Nonetheless, there are still numerous patients forcibly detained in our State psychiatric hospitals. Of the nearly 2 000 patients admitted to approved hospitals under the Mental Health Act during 1984–85, 60 per cent were admitted as involuntary patients.

We need to re-examine the usual assumption that involuntary detention is an inevitable component of any mental health service. Committal to mental hospitals is a civil and not a criminal procedure. Directed towards persons suffering from illness, rather than those charged with a crime, its purpose is alleged to be therapy, not punishment; but when mental hospitalisation continues in large measure as a coercive process, we must ask: What professed social needs and aims will justify this involuntary detention? Does the practice of involuntary hospitalisation and treatment actually protect society or the individual in the way intended?

I believe that in this area we should always invoke the principle of “the least restrictive alternative”. This phrase, common to legal debate, is based on the moral premise that when the State has a legitimate communal interest to serve by regulating human conduct, it should use methods that curtail individual freedom to no greater extent than is essential for securing that interest. To put it colloquially, “One should not use a cricket bat to swat a mosquito”.

This principle places an obligation on the State and its agencies to explore alternatives to compulsory in-patient care. It also requires that they clearly articulate the interests the State seeks to serve through the relevant law or regulation. Commitment should be assessed in terms of whether it provides the needed protection or rehabilitation, not in terms of simply screening from sight those who make others in society feel uncomfortable.

With respect to the question of liberty and civil rights, it is instructive to contrast the position of law-abiding mentally-ill patients with murderers. The latter will almost certainly have access to legal assistance. If they dispute the allegations of law breaking, their guilt will have to be proved beyond reasonable doubt and if convicted they may again have legal help to mount a series of appeals. By contrast, there is no provision in the current Mental Health Act for any type of independent inquiry during the committal process. It seems to be assumed that the State, through the agency of its medical practitioners, will always act in the patient’s best

interests and that the benefits of enforced hospitalisation and treatment invariably outweigh the costs, even if this is not always appreciated by those affected.

Apart from their loss of liberty, involuntarily-committed patients also lose other rights. For example, they may not enter into binding contracts or vote and, if they are migrants, they may be deported if hospitalised in a mental institution within five years of entering the country. Clearly, the consequences of committal are serious. It is expected that many of these impediments to patients' rights will be removed in an Act to be introduced some time during this Parliament.

Two major questions inevitably arise when one considers the issue of involuntary detention: First, what is the rationale for such treatment, and secondly, are provisions for such hospitalisation and treatment justified?

Without going into the details of the rationale and justification, I think at this stage it would be fair to say that very few of us can actually assess the extent to which people are likely to engage in behaviour which is injurious to themselves or to others, and that professionals in the field would be the first to agree that it is almost impossible to make such an assessment. However, we are prepared in our Statute to detain people against their will on the basis of an assumption about what might occur.

The decision to commit someone may be something of a lottery. There are considerable differences among psychiatrists in both the frequency with which they commit patients and the grounds on which they make such decisions. Recent research has shown that doctors rarely agree about the criteria which should be used in making the decision to admit patients. Even when there is agreement about the desirability of admitting certain types of patients, for example, the potentially dangerous, psychiatrists vary considerably in their definitions and tolerance of these behaviours.

Despite these shortcomings in the accuracy of predictions about who will engage in behaviour harmful to self and others, some still argue that it is better to err by wrongly detaining some who are unlikely to engage in such behaviour in order to prevent those who might. However, where involuntary hospitalisation is abandoned in favour of comprehensive community-based services, there have been no obvious changes in community levels of assaultive and suicidal behaviour. In Italy, where since 1981 it has been extremely difficult to compulsorily hospitalise people who are mentally ill, there has been no increase in either suicides or assaults by such people. Similarly, in New South Wales a recent trial found no difference in the frequency of assaultive or self-destructive behaviours between those hospitalised in the usual manner and those offered genuine community treatment.

It is likely that many patients would choose voluntary status if the options were routinely explained to them. There is little evidence that treatment is likely to be more successful if the patient is coerced rather than cooperative. In some cases, the lack of an efficient and readily available community service may lead to delays in seeking help which result in exacerbation of the symptoms to the point where the family or immediate community is unable to tolerate the disordered behaviour and requests committal as a last resort. In many cases, they may not be fully aware of the consequences of committal or of other options which may be available. Given a choice, families and patients both prefer voluntary, community treatment, especially if backup support and counselling is provided.

It is also likely that many patients and their families delay in seeking help because of the stigma associated with psychiatric hospitalisation. Paradoxically, this may result in the outcome they most feared, under circumstances which make it unlikely that the patient will cooperate in voluntary treatment. There is substantial literature which shows clearly that, apart from the indignity and sense of stigma suffered by the patient, the effects of being

hospitalised are often prejudicial to later adjustment. Staff often reward dependent, help-seeking behaviour rather than independent moves toward readjustment. Procedures adopted in the hospital, which may be necessary for the security of those who have committed offences, may be damaging to other detained patients. They often have little control over the daily routine of their lives and are deprived of many rights, either by law, or because they are not informed about the rights they do have. Treatment in a large institution may also lead to benign neglect, particularly when services are low status and poorly funded compared with other hospitals, as they frequently are.

There is considerable evidence that mentally-ill persons need far less protection than is commonly believed and that protective segregation may undermine a person's ability to look after himself or herself in the future.

While it may be anticipated that the provisions of the new Mental Health Act planned by this Government will result in fewer people being involuntarily detained, there is no reason to suppose that the proportion will decline dramatically unless alternatives to hospitalisation are offered. In South Australia, whose 1977 Mental Health Act has been suggested as a model for WA, the number of patients detained increased by almost 40 per cent from the last full year of operation of the old Act to the first full year of operation of the new Act.

A large proportion, over 80 per cent of the psychiatric services budget is spent on in-patient care in the approved hospitals. As long as such a high proportion of expenditure is on institutional care, there is little possibility of developing the community-based alternatives needed to support a policy of reduced compulsory hospital treatment.

Conversely, the continued availability of compulsory detention as an easy treatment option may thwart attempts to develop services which emphasise early intervention, emergency care and community-based out-patient treatment. The medical fraternity and law enforcement agencies are likely to find it more comfortable to stick with their established habits and dispose of difficult cases into the State asylums. Even a deliberate policy of deinstitutionalisation is unlikely to be successful unless community facilities are substantially upgraded. In the United States the move toward community treatment has not been an unqualified success, mainly because inadequate resources were diverted into providing high quality alternatives to hospital care.

My own view is that it is desirable to make it exceedingly difficult to involuntarily detain those suffering from mental illness except in cases where the person has actually committed or is charged with an offence under the Criminal Code. This legislative change would need to be accompanied by radical reallocation of resources and money away from hospital treatment and in favour of regional services which include 24-hour emergency psychiatric teams; small, short-stay residential facilities for patients during the acute phase of any illness; home-like residential units for the chronically disabled; and comprehensive after-care in which the emphasis is on rehabilitation.

I believe such changes are consistent with the principles of a democratic society such as ours which values individual and civil liberties and which abhors the unnecessary use of authoritarian, State-sanctioned power. Severely limiting coercive detention of the mentally ill and providing suitable alternatives would almost certainly result in substantial benefits to the whole community. It is a clear case where, as der Rohe puts it, "less is more".

I support the motion.

[Applause.]
