QUEENSLAND'S FEAR OF PEOPLE WITH MENTAL ILLNESS LIVING IN THE COMMUNITY - A BALANCING ACT?

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INTRODUCTION

Ten years ago, the rate of mental disorders in Queensland was found to be higher than any other Australian jurisdictions, and was 20% above the national average.[1] Since 1990, much has been learned about the presence of mental illness. Today, it is conservatively estimated that 20% of Australian adults will suffer from a mental illness at some point in their lives.[2] Suicide is increasing dramatically and accounts for more than a quarter of deaths among young Australians.[3] Despite the nation's overall decreasing mortality rate, more Australians are said to be dying from Alzheimer's.[4] As more Australians suffer from depression caused by the increase in pressures of everyday life, there has been a 30% surge in prescriptions of anti-depressant medications administered within the last decade, despite well recognised adverse effects.[5] At least 50,000

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1 See Queensland Mental Health Plan 1994, Mental Health Branch, Queensland Health, 12-13.

2 *National Survey on Mental Illness and Wellbeing: Profile of Adults, Australia*, (Australian Bureau of Statistics: Canberra, 1997), 5-6. For the purposes of the survey, prevalence of mental disorders relates to any occurrence of selected disorders during the 12 months survey period. The survey also found that prevalence of mental disorder generally decreased with age finding young adults aged 18-24 years had the highest prevalence of mental disorder (27%) declining to 6.1% of those aged 65 years and over. While men and women had similar overall prevalence rates, women were more likely to experience anxiety disorders (12% compared with 7.1%) and affective disorders (7.4% compared with 4.2%), whereas men were more than twice as likely as women to have substance use disorders (11% compared with 4.5%).

3 Report on Causes of Death (Australian Bureau of Statistics: Canberra, 1997), 5-8. In 1998, the standardised death rate was 14% above the 1989 figure. Suicide accounted for 2,683 deaths (16.7% of deaths in the 15-24 age group and 22.7% deaths in the 25-44 age group). Also see 'Suicide Rate on Increase', *Townsville Bulletin*, Jan 16, 1999,13.

4 C. Dore states that statistics released in *The Australian Institute of Health and Welfare report* show that deaths from Alzheimer's disease has increased by 20% each year since 1981. See 'Alzheimer's death rate grows 20pc a year: report', *The Australian*, 6 October 1994.

5 Department of Health and Family Services statistics are reported to have shown a rise in prescriptions for anti-depressants from 5.1 million in 1990 to 6.9 million in 1996. See D. Gray, 'More Seek Drugs to help beat the blues.' *The Sunday Age*, 16 November 1997, 6. Also, the Citizens Commission on Human Rights are reported to have had in 1994, over 90 documented cases of children between the ages of 4 and 18 who were taking Prozac committing violent or suicidal acts. The CCHR urged users of Prozac to report

children in Australia are reportedly using powerful psychiatric drugs for Attention Deficit Hyperactive Disorder (ADD).[6]

Psychiatric institutions are generally under-funded, overcrowded and under-staffed as hospitals in Australia struggle to cope with the ever increasing number of people with mental illnesses in need of care and treatment.[7] As hospital beds empty in the push for deinstitutionalisation, people lost to the system are found in nursing homes,[8] boarding houses, shelters, prisons[9] or on the streets.[10] In 1993, a national report on the Human Rights of People with Mental Illness (commonly known as the *Burdekin Report*), concluded that Australia had violated the fundamental rights of people affected by mental illness and that these people were among the most vulnerable and disadvantaged in the community.[11] The report ignited a national response on mental illness.

Reform has come in various forms including new mental health policies and plans (at both national and state levels), amendments to mental health legislation, and increased funding. In addition, awareness campaigns have been launched to remove the stigma associated with mental illness. However, while changing perceptions are occurring from the federal government through to individual members of the community, awareness has not filtered to all levels of society. As Webster pointed out, the real problem is about the way the professions view people with mental disorders including, medical staff, nurses, the education system, the Housing Department, and lawyers. The problem is also reflected in the way police and ambulance drivers respond to people with mental illness when they meet them on the street. In addition, the media is considered a part of the problem due to 'the way the newspapers respond in their articles'.[12]

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adverse effects in Australia since more than 28,600 adverse reaction reports had been allegedly provided to the US Food and Drug Administration (FDA) and the drug was linked to the death of 1700 people in just over 5 years. See letter by J. Eastgate CCHR International, *The Advertiser*, 15 June, 1994, 9.

6 It is reported that South Australian Democrats leader, Mike, Elliot, provided statistics of Australian children who are using drugs to treat ADD whilst calling for a parliamentary inquiry into the disease. See S. Stock and R. Lusetich, '50,000 children on psychiatric drugs', *The Australian* 24 March 2000, 3.

7 E. Hannan, 'Hospitals Ineffective in treating the Mentally Ill', *The Australian* 11 April 1991.

8 J. Kerin, 'Nursing Home Bashing Claims', *The Australian*, 14 March 2000, 4.

9 A. Lovell, N. Scheper-Hughs, 'Deinstitutionalisation and Psychiatric Expertise: Reflection of Dangerousness, Deviancy and Madness' (1986) 9 *International Journal of Law and Psychiatry* 361-381; F. Alder, 'Jails as a repository for former mental patients' (1987) *30 International journal of Ther & Comp Criminal* 225-236.

10 D. Mechanic and L. Aiken, 'Improving the care of patients with chronic mental illness' (1987) 317 *The New England Journal of Medicine* 1632.

11 Human Rights and Equal Opportunity Commission, *Report of the National Inquiry into the Human Rights of People with Mental Illness*, (AGPS: Canberra 1993), 908, 925.

12 Professor Ian Webster, the then president of the NSW Association for Mental Health in F. Hararl, 'Mean Streets of the Mentally Ill', *The Australian*, 26 October 1994, 20.

This article focuses on the Queensland experience by highlighting the enduring inconsistency that exists between civil libertarians with their contemporary notions of equity and human rights as they fight to improve the lives of people with mental illness within the community, and the general attitude of a community that is not fully prepared to accord such people their basic human rights because of their fear of violence from them. This article will briefly review the current National and State mental health policies in Australia that support the deinstitutionalisation of people from psychiatric hospitals. The discussion will then turn to the new Queensland *Mental Health Bill* 1999, but will be limited to proposed provisions relating to human rights. Finally, the article will review literature on violence and mental illness that further belies the reasonableness of the fear of Queenslanders of people with mental disorders.

Whilst acknowledging the lack of clear, uniform definition of the terms 'mental illness' and 'mental disorder' in the legal and medical lexicons, for the purposes of this article, the terms will be used interchangeably.[13]

THE PUSH FOR DEINSTITUTIONALISATION

Throughout the course of history, public perceptions of mental illness have undergone substantial change. In the Middle Ages, madness was viewed as a manifestation of possession by demonic spirits.[14] During the 19th century public perception was inclined to the view that people with mental illness could not be cured and as such required seclusion from mainstream community life through segregation into long term pastoral asylums. Asylums essentially assumed 'whole life care' for their residents and in time they quickly became overcrowded and under-funded institutions that developed into a custodial rather than therapeutic environment, resulting ultimately in neglect and abuse.[15]

In partial response to the growing notion that improved and more humane care could be provided for people with mental health problems outside of large institutions, Australia began its deinstitutionalisation process of psychiatric patients around the early 1970's.[16] By 1975, this perception was reflected in *the*

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13 See, L. Crowley-Smith, 'Intellectual Disability and Mental Illness' (1995) *3 Journal of Law and Medicine* 190-201; D. Sullivan, 'Commitment Laws' (paper presented at the 24th International Congress of the Academy of Law and Mental Health , Toronto Canada, June 1999).

14 Such perceptions existed during the Middle Ages when Christianity spread through Europe. This justified the punitive measures adopted to exorcise and persecute those who were labelled as witches because they displayed signs of mental disorders. The period of 'Enlightenment' saw a further change in perceptions as a 'medical model' favoured confinement of the poor, criminals and those with deranged minds. Salvation was expected from this exclusion and for those who excluded them. See M. Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, (London: Random House Inc., 1965), 7.

15 S. Garton, *Medicine and Madness: A Social History of Insanity in New South Wales, 1880-1940 Modern History Series 5*, (NSW University Press: Kensington, 1988); also *supra* n. 10 at 1634.

16 *Ibid.*

United Nations Declaration on the Rights of Disabled Persons Art. 9 of which stated that, 'No disabled person shall be subjected, as far as his or her residence is concerned, to differential treatment other than required by his or her condition or by the improvement which he or she may derive therefrom'.17

Although never clearly defined, and thus a subsequent source of considerable debate concerning its enforceability,[18] a 'right to health' also began to emerge in numerous international agreements. For instance, the *Universal Declaration of Human Rights* (UDHR) recognises that everyone has the right to a standard of living adequate for health and well-being, including medical care.[19] Article 12(1) of *the International Covenant on Economic Social and Cultural Rights* (ICESCR) provides State Parties are to 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'[20] However, perhaps the most widely used modern definition of health, which explicitly includes the mental as well as the physical dimensions of well-being, is found in the preamble to the *Constitution of the World Health Organisation* (WHO) which states, 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. That document further expanded the scope of health thus: 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being'.[21]

More specific declarations and conventions have also been adopted at the international and regional levels which frequently include the right to health care.[22] Amongst these is the United Nations *Principles for the Care and Protection of People with Mental Illness* that specifically recognise the rights of people with mental illness.[23]

Current public perception is that people with a mental illness are 'better off' living and being treated in the community. This change in perception is partly due to a series of hospital scandals in the form of malpractice suits that captured media attention and reinforced the idea that large institutions were harmful.[24]

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17 U.N.G.A. Res. 3447(XXX) of 9 Dec 1975.

18 See for instance, J. Mann, L. Gostin, S. Gruskin, T. Brennan, Z. Lazzarini and H. Fineberg, 'Health and Human Rights' (1994) 1 *Health and Human Rights* 7; S. Bell, 'Rationing the Right to Health (1998) 6(1) *Journal of Law and Medicine* 83; I. Freckelton and B. Loff, 'Health Law and Human Rights' in D. Kinley (ed) *Human Rights in Australian Law* (Sydney: the Federation Press, 1998), 290.

19 U.N.G.A. Res. 217A(III) of 10 Dec 1948 Article 25(1).

20 U.N.G.A. Res. 2200A (XXI) of 16 Dec 1966.

21 World Health Organisation, Constitution, in Basic Documents, 36th ed. (Geneva, 1986).

22 See for example, art. 24(1) of the *Convention on the Rights to the Child* U.N.G.A. Res 44/25 of 20 Nov 1989, Art 5(e)(iv) of the *Convention on the Elimination of All Forms of Racial Discrimination* U.N.G.A. Res 2106 (XX) of 21 Dec 1965 and art 11(1)(f) and 12 of the *Convention on the Elimination of All Forms of Discrimination Against Women* U.N.G.A. Res 34/180 of 18 Dec 1979.

23 U.N.G.A. Res 46/119 (1991).

24 J. Zadolinnyj and K. Zadolinnyj, 'Deinstitutionalisation of Mental Health Services' (1991) *Australian Journal of Mental Health Nursing* 1 at 5.

The public outcry generated by reports of neglect and mistreatment of patients led to inquiries and the closure of numerous psychiatric institutions. One such closure that attracted much publicity, was the closure of Ward 10B at the Townsville General Hospital following the discovery of negligent, unsafe, unethical and unlawful treatment of patients.[25] In Ward 10B, the preferred method of treatment involved treatment by 'therapeutic community' related principles based on 'resocialisation of the patient'. All psychiatric staff, patients and their relatives were involved in compulsory daily group and ward meetings that determined all aspects of each patient's treatment including the dose, type and change to medication regimes, and whether or not a person should be placed in seclusion or given potentially lethal doses of medication.

The Commission identified 65 patients who died in circumstances which justified close investigation and in the case of 7 patients, charges of criminal negligence were considered. The treatment administered in Ward 10B was not used in other hospitals and was never peer reviewed or substantiated by critical analysis or assessment.

Australia has embraced the United Nations *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* which were adopted by the United Nations General Assembly in 1991.[26] These Principles stipulate that every person with a mental illness has the same basic rights as every other person,[27] including the right to the best possible health care,[28] to protection from exploitation, abuse and degrading treatment,[29] the right to live and work, as far as possible in the community,[30] and to be recognised as a person before the law.[31]

The closing of hospitals and discharging of patients to 'community care', also provided economic relief from an increasing financial burden experienced by a health system unable to maintain large psychiatric institutions.[32] An intention to focus on the promotion of mental health and improvement of the quality of life for people with a mental illness, through community housing and improved mental health services, is a crucial thread that has strongly sounded in federal and state mental health policies and programs since the National Mental Health Policy was formulated. The importance of community living was further reflected in legislation, such as the *Disability Services Acts*, at both the state and federal level. For instance, the Queensland legislation states that people with disabilities

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25 *Commission of Inquiry into the Care and Treatment of Patients in the Psychiatric Unit of Townsville General Hospital*, Royal Commissioner Carter QC, 1991 Vol 1 at v- viii.

26 See the *National Mental Health Policy* and the *National Mental Health Plan* (Canberra Govt Printer, 1991).

27 *Supra* n.23. Principle 1.5.

28 *Ibid.* Principle 1.1.

29 *Ibid.* Principle 1.3.

30 *Ibid.* Principle 3.

31 *Ibid.* Principle 13.

32 Zadolinnyj, *supra* n. 24 at 9.

have the right to 'services that support their attaining a reasonable quality of life in a way that supports their family unit and their full participation in society...'[33]

While not disputing that the closure of overcrowded and under funded psychiatric institutions is obviously a good thing for a range of ideological and practical reasons, the effectiveness of the deinstitutionalisation process, particularly for people with severe or chronic mental illness, is not without criticism.[34] Some observers note that there is a problem with gaining agreement on a definition of subjective life quality or well-being, and then of establishing appropriate measures to determine the effectiveness of deinstitutionalisation.[35] Carney also warns that state governments risk breaches of fundamental human rights, civil citizenship or medico legal precepts if adequate debate on the likely outcomes of reform initiatives does not take place prior to their implementation, or if there is a lack of conclusive evidence that substantiates their benefit in terms of such outcomes as improved quality of life or a healthy environment for people with mental illness.[36] The release of the *Burdekin Report* in 1993, reminded us that the availability of appropriate community based accommodation coupled with necessary mental health care services is inextricably linked to the potential improvement of quality of life or well-being of a person with mental illness.[37] Apart from numerous adverse findings, the report presented general recommendations to address the various inadequacies relating to community housing for people with a disability.[38]

Despite the growing body of international covenants providing for the protection of human rights, their enforcement is uncertain. The language most used in the formulation of human rights covenants and documents is that 'state parties' undertake to respect a certain right or enforce adequate repressive mechanisms, rather than an individual's possession of a specific right.[39] As such, some

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33 *Disability Services Act* 1992 (Qld), s 9(2)(c).

34 J. Morrissey and H. Goldman, 'Cycles of Reform in the Care of the Chronically Mentally Ill' (1984) 35(8) *Hospital and Community Psychiatry* 785; J. Fitzgerald, *Include Me In - Disability, Rights and the Law in Queensland* (Queensland : Queensland Advocacy Incorporated, 1994), 172; S. Zifcak, 'The United Nations Principles for the Protection of People with Mental Illness: Applications and Limitations' (1996) 3 *Psychiatry, Psychology and Law* 1.

35 R. Cummins, 'On Being Returned to the Community: Imposed Ideology versus Quality of Life', (1993) 2 *Australian Disability Review* 64. See also, M. Cleary, P. Woolford and T. Meehan, 'Boarding house life for people with mental illness: An exploratory study' (1998) 7 *Australian and New Zealand Journal of Mental Health Nursing* 163.

36 T. Carney, 'New Configurations of Justice and Services for the Vulnerable: Panacea or Panegyric?' (paper presented at the 24th Congress of the Academy of Law and Mental Health, Toronto Canada, June 1999).

37 The shortage, or in many cases, the total absence of appropriate accommodation coupled with a lack of adequate services was found by many to be 'the single biggest obstacle to mentally ill people's treatment and quality of life'. See *Burdekin Report* at 337, 338.

38 See *Burdekin Report* at 916-921.

39 See for example, Simsek v Macphee (1982) 148 CLR 636, Dietrick v The Queen (1992) 177 CLR 292, Coe v Commonwealth (1993) 118 ALR 193. Also, J. Delbrueck, 'International Protection of Human Rights and State Sovereignty' (1982) 57 *Indiana Law*

observers suggest that before an international human right can be used either to directly afford protection to individuals or as a means of enforcing a civil remedy, the relevant state would have to implement a process to protect human rights, namely by formulating appropriate legislation that recognises those rights,[40] which in turn will then depend on a duly administered machinery, namely the courts of law, for their enforcement.[41] However, with regards to rights that exist in respect of health, Freckelton and Loff point out that although such rights have been narrowly articulated by Australian jurisprudence, the enactment of guidelines and object clauses within legislation that binds those who supply health care services provides patients with a means of asserting their rights to treatment that accord with the underlying principles of international human rights instruments.[42]

Criticism in the *Burdekin Report* was further aimed at legislation in several Australian jurisdictions that failed to adequately ensure that the rights and freedoms of people with mental illness were protected.[43] In Queensland, the *Mental Health Bill* 1999, addresses principles of treatment and care (drafted in human rights language) to which psychiatric patients are entitled, once the Bill is enacted.

QUEENSLAND'S MENTAL HEALTH BILL 1999

The Queensland Mental Health Bill proposes that government health departments will have the responsibility of providing involuntary assessment, treatment and care, and protection of people with mental illness while at the same time safeguarding their rights.[44] The powers and functions under the proposed Act are to be performed in the least restrictive way, 'to protect the person's health and safety or to protect others', and that any effect on the person's liberty and rights must be 'the minimum necessary in the circumstances'.[45] The draft Bill contains perhaps the most extensive principles aimed at the protection of rights and freedoms of people with mental illness in Australia. Examples of principles that are to apply to the administration of the proposed Act in relation to people with mental illness, include:[46]

- 'the right of all people to the same basic human rights must be recognised and taken into account', including a 'right to respect for his

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Journal 567 at 574.

40 D. Kinley, *supra* n. 18 at 20.

41 *Id.* 573.

42 See for instance, *Health Services Act* 1991 (Qld) s. 3.18(2)(a); *Disability Services Act* 1992 (Qld); *Medicare Agreements Act* 1992 (Cth); *Health Rights Commission Act* 1991 (Qld) s. 37ff; *Health Act* 1958 (Vic) s. 119 cited in Freckelton and B. Loff, *supra* n. 18 at 290.

43 *Burdekin Report,* Chapter 30.

44 Consultation Draft, *Mental Health Bill* (Qld) 1999 s. 4 (hereafter referred to as MHB).

45 *Id.* s. 9.

46 *Id.* s. 8.

or her human worth and dignity as an individual';

- 'a person's age-related, gender-related, religious, cultural, language, communication and other special needs';
- 'the importance of a person's continued participation in community life' and the need to maintain 'existing supportive relationships' in the community in which the person lives;
- 'treatment provided under this Act must be administered to a person with a mental illness only if it is appropriate to promote and maintain the person's mental health and wellbeing'.

In addition, a person with mental illness is, to the greatest extent practicable:

- 'to be encouraged to take part in making decisions affecting the person's life, especially decisions about treatment' and 'the person's views and the effect on his or her family or carers are to be taken into account';
- 'to be provided with necessary support and information to enable the person to exercise rights under this Act';
- to have his or her 'cultural and linguistic environment and set of values (including religious beliefs) maintained';
- 'to be helped to achieve maximum physical, social, psychological and emotional potential, quality of life and self-reliance'.[47]

The draft Bill would appear to address most of the suggested legislative changes put forward in Chapter 30 of the *Burdekin Report*. For instance, as it currently stands, the Bill clearly sets out the principles on which it is based and emphasises the principle of 'the least restrictive form of appropriate care and treatment';[48] a clear and consistent definition of mental illness is provided;[49] there is provision for treatment in the community;[50] administration of ECT or psychosurgery is subject to stringent and clearly specified requirements for consent of the patient, where possible, and independent specialist approval;[51] the position of involuntary patients regarding consent to psychiatric treatment is clearly set out;[52] and the criteria and procedures for involuntary admission are clearly specified including detention in emergencies.[53]

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47 *Ibid.*

48 *Burdekin Report* at 896.

49 *Ibid.* MHB, *supra* n. 42 s. 11(4) specifically states that a decision that a person has mental illness must be in accordance with internationally accepted medical standards, that is, Principle 4.1 of the United Nations *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.*

50 *Burdekin Report* at 900.

51 *Ibid.* MHB, *supra* n. 44 ss. 128-130.

52 *Burdekin Report* at 900. See MHB, *Id.* ss. 123-127.

53 *Id.* at 898. See MHB, *Id.* Part 3.

Should the draft Bill gain legislative force, it will create an avenue for potential legal challenge to decisions relating to involuntary assessment, admission, care and treatment of people with mental illness where their enunciated rights have been breached. For instance, if as a result of financial constraints, the provision of treatment has not been fashioned so as to promote or maintain the person's mental health and wellbeing, there may be resort to litigation. Where a person's special needs have not been acknowledged in the provision of care or treatment, this may afford a means of redress where none had previously existed.[54] The Bill has been introduced for debate and will hopefully be passed by midyear 2000.

MENTAL ILLNESS AND VIOLENCE

Approximately one in five Australians are said to experience mental illness at some point in their lives,[55] yet as a whole, very little is known about mental illness as compared to other widespread and prevalent illnesses. This may be due to the diversity in the manifestations of mental disorders, the difficulty in determining the nature, extent or severity of a person's mental illness, or because it is not contagious. Lack of knowledge is also perhaps the greatest impediment to meaningful treatment. There are those who are of the opinion that mental illness is treatable,[56] but treatment usually involves some form of chemotherapy intended to sedate and achieve management rather than to provide any real or recognised curative effect.

Thus, public perceptions about mental illness are slow to change. Deinstituionalisation and the relocation of people with mental illness into community-based accommodation offers the latest pattern of mental health care and service delivery, bearing in mind that it is not a new phenomenon. For many, mental illness is associated with discrimination, fear, lack of control, violence, abuse and above all, resounding silence. The stigma and discrimination associated with mental illness no doubt accounts for a substantial proportion of the silence on the part of people with mental illness - many would be deterred from seeking assistance or admitting to family and friends that they may be experiencing symptoms associated with mental disorder.

The media has played a significant role in generating, or at least perpetuating, public fear through its misrepresentation of people with mental disorders. For instance, one United States study, following an analysis of drama programs (including soap operas, plays and films) on television over a 12 month period, found that:

- 73% of people shown with a mental illness were depicted as violent and

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54 For a similar discussion of mental health legislation in other jurisdictions see Freckelton and Loff, *supra* n. 18 at 285-289.

55 Australian Bureau of Statistics, *supra* n. 2.

56 SANE Australia (1999). Factsheet No 6, 'About mental illness' in K. Healey (Ed.), *Issues in Society: Mental Illness,* Vol. 102 Spinney Press, 10.

- 23% were depicted as homicidal maniacs.
- 90% of television and print news media stories on people with mental illness, similarly depicted those people as violent and usually homicidal.[57]

In Australia, the infamous Port Arthur Massacre, provides and example of the power of the media to mould public perceptions. The multiple murders committed by Martin Bryant at the historic site, Tasmania's premier tourist attraction on 28 April 1996, remains firmly etched in the public's imagination. It would have been difficult for anyone reviewing the newspapers of that and subsequent days not to conclude that Martin Bryant had a mental illness - headlines ranged from 'Face of a Killer - 'He would go from a 25 year old to a 12 year old kid who was a delinquent just like that'' to 'Violent loner spooked locals'. [58] The stories made constant references to Bryant's state of mind - 'he was a Jekyll-and-Hyde character'; 'his family informed police he was a schizophrenic',[59] he was '10 cents short of a dollar',[60] and his actions were described as 'evil' by one of the FBI's leading forensic psychiatrist.[61] Bryant was later convicted of 35 murders and numerous other charges, and sentenced to imprisonment for the term of his natural life.[62]

A further example of the media's influence on public perception of mental illness recently occurred in Townsville. By way of background, five years after the Ward 10B scandal, the Townsville General Hospital psychiatric unit gained national and global notoriety as it was selected to participate in a World Health Organisation project. The unit was chosen to contribute to the world psychiatric arena for several reasons. For instance, it was one of the few university cities capable of conducting studies on the effects of climate and humidity on mental disorders; the hospital's back pain centre was the only public psychiatric facility in Australia with a chiropractor and acupuncturist as well as traditional medical practitioners, and it had a teleconferencing service.[63] A new Townsville Hospital and psychiatric unit are now being constructed adjacent to the James Cook University campus and is scheduled to open in the year 2001. It is the proposed establishment of a new mental health ward (which will include both an unsecured and a high security unit) that recently led to public discussion via a local radio talk-back show. The discussion further exposed public fear associated with mental illness.

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57 See G. Gerber, L. Gross, M. Moragan and N. Signoielli, 'Health and Medicine on Television' (1981) 305(15) *New England Journal of Medicine* 902; also Healey, *Id.* at 12.

58 *The Australian* 30 April 1996, 1.

59 *Id.* 6.

60 *Id.* 1.

61 *Id.* 6.

62 'Bryant says he no longer needs lawyer's services', *The Townsville Bulletin* 30 November 1996, 9.

63 M. Hore, 'Psych ward honoured by health organisation', *The Townsville Bulletin* 13 April 1996.

It was suggested by the radio commentator that residents living in suburbs adjoining the new hospital site, particularly the more affluent suburbs, were at risk should the new mental health ward be built at the proposed site. Such fears, (although understandable in light of the portrayal of people with mental illness in the press and on television) are unjustifiable, wrong and destructive.

Through its portrayal of people with severe or chronic mental disorders as overwhelmingly violent, dangerous, and unpredictable,[64] the popular media ignites powerful conscious and unconscious fears that translate into negative societal views of such people. There is a perceived need to increase the distance between 'us' and 'them'. Contemporary literature and empirical findings support the suggestion that people with severe mental illness are viewed negatively by the public.[65] A major source of discrimination has also been found to exist within the mental health system itself, among the professionals with whom people with mental disorders deal with daily.[66] These include mental health care professionals, ambulance drivers, and police.

Over the past decade, there has been a spate of fatal police shootings of people who had a history of mental illness.[67] The response tactics of police in some Australian jurisdictions, highlighted the inadequacy of police training and

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64 S. Rovner, 'Mental Illness on TV', *The Washington Post* July 6, 1993; H. Steadman, J Cocozza, 'Selective reporting and misconceptions of the criminally insane' (1978) 41 *Public Opinion Q.* 523-533.

65 MC. Angermeyer, H. Matschinger, 'Social distance towards the mentally ill: Results of representative surveys in the Federal Republic of Germany' (1997) 27 *Psychological Medicine* 131-141; I. Brockington, P. Hall, J. Levings et. al., 'The community's tolerance of the mentally ill' (1993) 163 *British Journal of Psychiatry* 93-99; J. Greenley, 'Social factors, mental illness, and psychiatric care: Recent advances from a sociological perspective' (1984) 35 *Hospital and Community Psychiatry* 813-820; P. Hamre, A. Dahl, U Malt, 'Public attitudes to the quality of psychiatric treatment, psychiatric patients, and prevalence of mental disorders' (1994) 4 *Norwegian Journal of Psychiatry* 275-281; J. Nonahan, 'Mental disorder and violent behavior: Perceptions and evidence' (1992) 47 *American Psychologist* 511-521; G. Wolff, S. Pathare, T. Craig et. al., 'Community attitudes to mental illness' (1996) 168 *British Journal of Psychiatry* 183-190.

66 See the reference to a study by the National Community Advisory Group on Mental Health in F. Harari, 'Mean Streets of the Mentally Ill', *The Australian* 26 October 1994, 19. Also D. Penn and J. Martin, 'The Stigma of Severe Mental Illness: Some Potential Solutions for a Recalcitrant Problem' (Fall 1998) 69(3) *Psychiatric Quarterly* 236.

67 For instance, five people with mental disorders were shot to death by police in 1994. In one case, a 41 year old woman was shot and killed on a bench outside of the institution where she had been receiving treatment for her mental illness. See J. Sexton, 'Psychiatrist accuses police of shifting blame for shootings', *The Australian* 29 September 1994, J. Sexton and S. Henry, 'Family to sue police over fatal shooting', *The Australian* 28 September 1994, 8. In 1997, much publicity was attracted when New South Wales police shot and killed a man with a mental illness after a 30 minute stand-off at the shoreline of Bondi Beach in Sydney. The two police officers involved in the killing were later suspected of being under the influence of cocaine or alcohol at the time of the shooting. See J. Este, 'Levi's killer peddled cocaine', *The Australian* 29 October 1999, 10; J. Este, 'I shared coke with Levi shooting officer: Witness', *The Australian* 4 November, 1999, 9; J. Este, 'Levi case puts Bondi police culture under microscope', *The Australian* 17 November 1999.

education when dealing with people with psychological disorders. The then human rights commissioner, Brian Burdekin, further blamed the under-funding of community support networks and the lack of appropriate mental health experts to deal with situations involving people with mental disorders.[68]

Most of the media's portrayal of people with mental illness is grossly inaccurate and has important implications for public and social policy.[69] In addition, it affects the legal, clinical, ethical and social responses to violence perpetrated by people with mental disorders.[70] Research indicates that people receiving treatment for a mental illness are no more violent or dangerous than the general population.[71] People with an illness, such as schizophrenia for example, are two thousand times more likely to hurt or kill themselves than seriously harm or kill another person.[72] One study, over a 30 year period, found that despite what the popular press would have us believe, there is no suggestion that the rate of crime among schizophrenics is rising faster than in the rest of the population or that changes to community care are putting us more at risk.[73] That an association between mental illness and violence exists is accepted,[74] but the exact association remains undefined.[75]

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68 Sexton, *Id.* 8.

69 One such implication is public assumptions that those responsible for massacres must have a mental disorder. A NSW Bureau of Crime Statistics study of 1393 homicide offenders is reported to have shown that only 16% were known to have some kind of mental disorder at the time of or prior to the offence. See S. Chapman, 'Massacres have one thing in common: It's the guns, stupid!' *The Australian* 22 April 1999, 13; see also, S. Wesseley, 'The epidemiology of crime, violence and schizophrenia', (1997) 170 *British Journal of Psychiatry* 8.

70 J. Webb-Pullman, 'Violence, Dangerousness and Mental Illness' (Dec 1994) *Law Institute Journal* 1166.

71 The AMA federal vice president Sandra Hacker said that the most violent crimes were perpetrated by people who were not mentally ill and if the suggestion by the Victorian Police Chief Commissioner, Mr Comrie to ban the mentally ill from owning guns is taken to its logical conclusion then all males aged 18-30 should be banned from owning guns because most crimes involving firearms were committed by young men. B. Haslem, 'Mentally ill gun ban wins backing', *The Australian* October 6, 1999, 9.

72 The lifetime risk of someone with an illness, such as schizophrenia, seriously harming or killing another person is estimated at .005%, while the risk of that person killing themselves is nearly 10%. See Healey, *supra* n. 54 at 12.

73 Wesseley, *supra* n. 69 at 11.

74 J. Monahan, 'Mental Disorder and Violence: Another Look' in S. Hodgins (ed) *Mental Disorder and Crime* (Newbury Park (CA): Sage Publications, 1993), 287-302; E. F .Torrey, 'Violent Behaviour by Individuals with Serious Mental Illness' (1994) 45 *Hospital and Community Psychiatry* 653-62; N. Nedopil, 'Violence of Psychotic Patients: How Much Responsibility Can be Attributed?' (1997) 20(2) *International Journal of Law and Psychiatry* 243-247; M. Eronen, M. Angermeyer and B. Schulze, 'The Psychiatric Epidemiology of Violent Behaviour' (1998) 33 *Social Psychiatry Psychiatric Epidemiology* S 13-S 23.

75 J. Arbolida-Florez, 'Mental Illness and Violence: An Epidemiological Appraisal of the Evidence' (Dec 1998) 43 *Canadian Journal of Psychiatry* 989.

Despite numerous studies on the relationship between mental illness and violence offering diverse perspectives, key methodological barriers in such research are said to preclude the establishment of a causal link between mental illness and violence.[76] General or premature statements of causality carry potentially devastating effects for people with a mental illness. The increase of stigma that mar the individuality and dignity of these people, and the stress that is associated with such imputation, threatens re-integration into the community and increases the likelihood of future relapse.[77]

CONCLUSION

Although the pendulum has swung away from the 19th century views of confinement towards more humanitarian notions of social reintegration and community based services and facilities to better perform the functions of large institutions, public fear remains perhaps the greatest impediment to community acceptance and recognition of people with mental disorders and of their equal rights as citizens. This is reflected in the three essential themes that run throughout this article.

Today, the general public perception is that community care is preferable to institutional care on the premise that individuals have a right to be treated in the least restrictive environment available.[78] Australia's support for increased recognition of human rights is reflected in its state and federal mental health policies and in its willingness to subscribe to the various international instruments and agreements that recognise and protect the rights of people with mental illness. However to date, successful legal actions based on breaches of a right to health have been limited due to a lack of legislative recognition of such rights in Australia.

The proposed Queensland *Mental Health Act* demonstrates a further drift by current governments towards greater commitment to the needs of people with mental illness. There are legitimate concerns in society to balance the need for intervention and the civil liberties of people with mental illness, and the need to protect the community. The unpredictable and diverse nature of mental illness, which can significantly fluctuate in intensity and duration and which often results in functional disabilities, coupled with the lack of knowledge about mental illness as a whole, makes it unique. It is the only non-communicable illness that permits compulsory detention for the purposes of the treatment of the patient under the mental health legislation.

Although still presently in the form of a Bill, the new legislation promises extensive principles aimed at the protection of rights and freedoms of people with mental illness. By adopting a human rights framework that considers issues of gender, social and cultural developments as well as circumstances of

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[76] J. Arbolida-Florez, H. Holley and A. Crisanti, 'Understanding causal paths between mental illness and violence' (1998) 33 *Social Psychiatry Psychiatric Epidemiology* S38-S46.

[77] *Id.* at S 39; also Penn and Martin, *supra* n. 66 at 236.

[78] Bachrach (1978) cited in Zadolinnyj, *supra* n. 24 at p 4.

vulnerability, the proposed legislation will build bridges towards successful litigation based on breaches of human rights. In addition, the legislation will address much of the criticism of existing legislation raised by the *Burdekin Report*.

If the process of deinstitutionalisation and community based living and care and treatment of people with mental illness is to be successful, lingering public fear and negative perceptions of these people must be addressed. One suggestion to increase community awareness is through education campaigns. Much has been achieved, and there has been great advancement in public perceptions of, for instance, AIDS and HIV illnesses as a result of vigorous media campaigns which has lifted much of the stigma and discrimination associated with those illnesses. The same could be achieved with mental illness.

The government may also alleviate public fears by establishing adequate safeguards in the form of community mental health support services appropriate to cater for the special needs of people with mental illness particularly those people with severe or chronic disorders and those with comorbidity. In addition, there must be sufficient and adequate affordable short and long term accommodation available with easy access to mental health services to ensure people with mental disorders do not end up in nursing homes, shelters or homeless. Clearly there is also enormous potential for the role of community input from those who are affected by the deinstitutionalisation process in relation to the management of people with mental illness. For example, as one author suggests, the perceptions of living conditions in community based residences by the residents of these facilities[79] or by the family members or friends that help to care for such people, has been a frequent omission in previous research.

However, before any significant advancement in the quality of life for people with mental illness can be achieved through the relocation of such people into the community, the general public, at all levels, must endeavour to overcome conscious and subconscious fears associated with this specific group of people.

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[79] Cleary, Woolford and Meehan, *supra* n. 35 at 163.