## MENTAL HEALTH BILL 2013
## MENTAL HEALTH LEGISLATION AMENDMENT BILL 2013

*Cognate Debate — Motion*

On motion by **Hon Helen Morton (Minister for Mental Health)**, resolved —

> That leave be granted for the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013 to be dealt with cognately.

*Second Reading — Cognate Debate*

Resumed from 7 May.

**HON STEPHEN DAWSON (Mining and Pastoral)** [2.28 pm]: I say from the outset that I welcome the cognate debate today on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. I also want to say from the outset that the opposition congratulates the government particularly on the Mental Health Bill. It was a long time coming and it is very welcome. I am pleased the debate is commencing today.

The Mental Health Bill 2013 is a bill for an act to provide for the treatment, care, support and protection of people who have a mental illness; and to provide for the protection of the rights of people who have a mental illness; and to provide for the recognition of the role of carers and families in providing care and support to people who have a mental illness, and for related purposes. It is an incredibly long bill and it is quite complex, and there has been much consultation on the bill. Although there has been some criticism of elements of the bill, there is consensus in the sector: it wants the bill passed without delay. There are a number of concerns and I will highlight many of those concerns. However, it is an important bill and it is supported in the community. It is long overdue, but it is just one piece of the mental health jigsaw.

Anyone who reads the newspaper, watches the news or is in touch with the community will know that Western Australia's health system is in a bad way. In 2012 Professor Bryant Stokes delivered a report to the Western Australian government into the admission, transfer and discharge practices of public mental health services within the state, and that report was given to the government in July 2012. The report was ordered in late 2011, after three mental health patients tragically took their lives after being discharged from Fremantle's Alma Street Centre. The report highlighted a range of inadequacies in the Western Australian mental health system and it made recommendations in a variety of areas, including governance; carers and families; beds and clinical services; the Office of the Chief Psychiatrist; acute issues and suicide prevention; and the criminal justice system and the judiciary. From memory, there were about 117 recommendations in the report. It is fair to say that they recommended wholesale changes to the mental health system in this state. The report identified the need for an increase in the number of adolescent beds to take into account the increasing population of young people seeking assistance; it highlighted the urgent need for more beds to be provided for child forensic and eating disorder patients; it particularly highlighted the need for child, adolescent and youth beds being needed as a priority in regional Western Australia; and it called for those initiatives to be implemented as a priority. It is almost two years to the day since the report was presented to the government, and it pains me to say that we are still waiting for the Barnett government to implement all those recommendations. It is disappointing that, although immediate action on the recommendations was promised, we are still waiting for a number of the recommendations to be delivered.

We know that people are falling through the cracks in the mental health system. A couple of months ago a brave mother gave evidence to the Legislative Council's Standing Committee on Environment and Public Affairs' inquiry into a petition for more mental health beds at the new Perth Children's Hospital. Christine Brown spoke about her daughter's struggle with mental health issues. It is fair to say that it was a shock to this mother three years ago when her daughter said that she was having suicidal thoughts, and when she sought assistance from our mental health services, she struggled to get it. Even when her daughter was assessed as needing acute inpatient care, there were no beds available. In her evidence before the committee on that day, she spoke of how they spent 48 hours in the emergency ward at Armadale hospital because there were no mental health beds available. Anyone who has ever been in an emergency department will know that it is not an appropriate place to help people recover from a mental illness. Christine contacted me again this week to say that her daughter was again assessed as needing acute inpatient care but she was struggling to access a bed.

I make these points this afternoon because I said that this is a jigsaw. I am comparing the mental health system to a jigsaw, and the bill that we are discussing this afternoon is one piece of that jigsaw; it is one piece of the puzzle that needs to be addressed so that we can have confidence in our mental health system. Christine contacted me again this week to say that her daughter had spent time in an emergency room waiting because there were no beds available. Since our committee hearing a few weeks ago, Christine had taken out private health insurance because she had been told by another mother with a child who had mental health issues, was suicidal and needed

care immediately that she should take out private health insurance, and so she did. Unfortunately, when Christine struggled to get access to an acute inpatient care bed for her daughter this week, she was told by some of these private institutions that, because her daughter was at risk and in high need of care, they could not take her.

**Hon Helen Morton**: That is also because of age.

**Hon STEPHEN DAWSON**: I was just about to say that it was also because of her age. She was told by another institution that although it takes 16-year-old children, because she did not have an eating disorder, she could not be admitted to the hospital. Christine contacted me again and I raised the issue with the minister's office. I am pleased to say that, whether it was because of this or it just happened as a matter of coincidence, Christine's daughter finally got a bed last night and she is being given the care that is needed. I make the point that Christine's case is not an isolated one.

Again, at a public hearing a month or six weeks ago, experts from the Royal Australian and New Zealand College of Psychiatrists gave evidence about the need for more acute inpatient beds for young people. Dr Aaron Groves from the Royal Australian and New Zealand College of Psychiatrists told the committee that the state was short about 70 beds for young people between the ages of 16 and 24 years. In evidence before the committee, we also heard that we have only about 50 per cent of the child psychiatrists needed in this state. Although the bill before us deals with issues relating to psychiatrists, it will not help us attain the number of psychiatrists we need.

Another piece of the puzzle relates to suicide. I need to point out this afternoon that again it pains me to say that we have no suicide prevention strategy in this state at present. The last suicide prevention strategy, from 2009 to 2013, expired last year and we are still waiting on the government to release a strategy for the next four years. The recent Auditor General's report into the suicide prevention strategy pointed to the increase in suicides in this state. In that report, it was revealed that this state's suicide rate is higher than the national rate and is climbing, while the national rate is going down. The WA rate is about 14.8 per 100 000 people, and the rate in the Kimberley is almost three times this rate; in fact, I think the Auditor General also pointed out that the rate in some Kimberley communities is almost 20 times higher. We know from that report that suicide is the leading cause of death in this state for both men and women aged between 15 and 44 years. We also know that more people die from suicide than from skin cancer or road trauma. We know that the economic cost to Western Australia of suicide and attempted suicide could be more than $1.8 billion a year. As I have said, this issue of suicide needs to be addressed and more work needs to be done in this area, and the report confirms this. The report also confirms that we have a tragic suicide rate in this state. It is a vexing issue for me, but I have to ask: why is the suicide rate in this state increasing while the national average is going down?

As I have said, our suicide crisis cannot be allowed to continue; it is time for urgent action. Despite the Auditor General's report, the state is yet to commit further funding for the program that was designed to address this issue. The Barnett government must include ongoing funding for the suicide prevention strategy for another four years, and I appeal to the minister to ensure that the report and the review of the last suicide prevention strategy is released without delay so that we know what will happen for the next four years.

As a regional member of Parliament—I see a number of regional MPs in the chamber this afternoon—I see and hear about the increase in suicide numbers and the increase in attempted suicides firsthand throughout my electorate. Whether it is Carnarvon, Fitzroy Crossing, Broome, Derby, Kalgoorlie or indeed amongst fly in, fly out workers, it just seems to me that I am hearing more and more about this tragic issue. In making a contribution to this bill this afternoon, I want to place on the record my support for the Legislative Assembly's decision this week to have a parliamentary inquiry into suicides of FIFO workers in Western Australia. I understand the Education and Health Standing Committee will look at some of the systemic issues surrounding the deaths of FIFO workers, and I congratulate members for their bipartisan support of the motion passed in the Assembly last night. The minister made a comment earlier today, and I think it was probably before the session started, so perhaps it was behind the Chair, but she did point out that the debate on the bill in the other place had a level of bipartisanship and support, and I expect that same level of bipartisan support in the debate before us in this place.

Although I have said we have many concerns about elements of the bill, we do support it. At this moment I will also pay tribute and thank the minister's advisers, from the Chief Psychiatrist down to Kristen, in the minister's office, as well as the many Mental Health Commission staff who briefed members in this place over the past weeks, months and, in fact, probably over the past year—it seems that long. They have all been, as has the minister, very courteous in briefing us as often as we needed. We have had briefings again this week about the amendments that the minister was moving to the bill. We have also had briefings about electroconvulsive therapy and psychosurgery, and I believe that it was well worth the time the minister allowed us to have with those briefings. When members on this side make a contribution to this bill, I know those briefings will have made a difference and hopefully it will allow for a smoother passage. As I have said, we have had the

Stokes review, but we are waiting for the recommendations to be fully implemented, and we have the suicide prevention strategy 2009–2013. Yet as I said, we are still waiting on the review of the strategy before a new strategy is released. Given the recent deaths by suicide of FIFO workers, I hope that the minister hurries up with this review.

However, I believe it is important to place on the record giving the government credit for the number of things it has undertaken in the mental health space. The government created the state's first dedicated mental health minister, it established the Mental Health Commission, it appointed a Mental Health Commissioner, and of course it has introduced the bill we have before us. The Mental Health Bill will replace the Mental Health Act 1996. I have said in this place previously that I believe it was a failure of the former Labor government not to modernise the Mental Health Act 1996. Although the then Attorney General appointed Professor D'Arcy Holman to undertake a review of the 1996 act to make recommendations and alterations in the then legislation, the review did not result in the bill we have before us today. I pay tribute to those people concerned because when I was talking to some psychiatrists recently, they pointed out that under the Attorney General at the time, namely, Hon Jim McGinty, a number of positive changes were made in the system, but we obviously did not go as far as introducing a new bill, and again, I give credit to this minister for taking the initiative.

From the minister's lengthy second reading speech of the bill, we know that the act needs to be brought up to date to ensure that current best practice in mental health is in place by reflecting principles of recovery for those living with mental illness. We know that this act focuses primarily on the processes, safeguards and protections around involuntary treatment and detention. We know, as I mentioned briefly earlier, that the bill significantly reforms the judicial processes surrounding involuntary detention. I will quickly touch on some of the rights for patients established under the bill. Under the bill, there is the right to an independent further opinion about treatment, which can be requested by the patient or a support person; there is the right to the freedom of communication; there is the right to access a patient's medical records; and there is the right to have their wishes considered by their psychiatrist. Involuntary patients and mentally impaired patients have the right to a treatment, support and discharge plan and they have the right to an authorised visit or to be contacted by an advocate from the new Mental Health Advocacy Service within seven days or 24 hours if the service is required by a child. In mentioning all these rights that are in the bill, I am not at this stage saying that we agree with all of those rights or agree with them to the extent that they are expressed in the bill. In fact, in some of those cases, we may well seek to move amendments because we believe that what is included in this bill perhaps does not go far enough or in some cases may go too far.

Also, in this bill we know that doctors and authorised mental health practitioners can only refer a person for an examination by a psychiatrist when they reasonably suspect that the person is in need of an involuntary treatment order. The other thing I wanted to point out was the fact that referrals can now be done via audiovisual means by those in rural areas. Again, as a regional-based MP, I know that many people in the regions struggle to access a range of services provided by the government. We do not always get the same quality of education; we do not always get access to the same quality health care that the city does or indeed the same breadth of services that the city does. But one area of services I believe really lags behind relates to mental health and access to mental health services. The fact that referrals can now be done via audiovisual means is an initiative and inclusion I fully support.

I need to also place on the record or acknowledge the contribution made by a number of non-government organisations or agencies over the past few months. As I touched on earlier, the bill initially was introduced to Parliament late last year and since that time, particularly Sandy Boulter and the Mental Health Law Centre, but also Martin Whitely, the senior advocate at the Health Consumers' Council of Western Australia, have been very active in ensuring that MPs, on both sides, were aware of what they saw as perhaps failures of the bill. But they, too, were also gracious in acknowledging that the minister deserves some congratulations with the many improvements contained in the Mental Health Bill.

I also acknowledge the very lengthy and in-depth debate on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013 in the Legislative Assembly. Members will recall that these bills were debated in the Assembly for weeks. I congratulate the member for Armadale, Dr Tony Buti, who led the debate on behalf of the opposition, on his very worthy contribution. I believe his fine contribution ensured that these bills include a few more elements that I think people on the outside would thank him for. The other person who contributed, of course, was the Parliamentary Secretary to the Minister for Mental Health, the member for Kingsley.

Over the past few months, thanks to the Legislative Assembly, a number of amendments have been made to the Mental Health Bill 2013 that related to the criteria for an involuntary treatment order, which included reference to the unreasonable refusal of treatment in clause 25. Based on feedback from a range of stakeholders, the bill was amended to remove that reference. Concerns had been raised about what constitutes unreasonable refusal

and who should decide what is unreasonable. Amendments relating to decision-making capacity and informed consent were also made.

One of the issues I will briefly touch on this afternoon is that of electroconvulsive therapy, about which there was debate in the other place. Over the past few months there has been debate in the community on this issue. I place on the record that I recognise the level of concern that exists in the community, particularly around the age limits attached to ECT and the psychosurgery provisions in the Mental Health Bill 2013. This bill will introduce age limits on the use of ECT and psychosurgery, which many would see as an improvement on the 1996 act. Members would know that the current act does not contain the same safeguards as in this bill. I ask the minister, when she responds to the second reading contributions that will be made over the next few weeks, to outline the reasons the government decided on the age limits it did. Most of the representation I have had from agencies or individuals outside this place has been related to the age limit being too low, although there is no age limit in the current act. A number of psychiatrists have also made representation in the past couple of weeks, suggesting that an age limit should not be specified in the Mental Health Bill. They have said it could be managed with the right parameters and oversight, and that we should not seek to limit the profession or future technology. I believe that debate has been lost, and that the psychiatrists sought to enter the debate too late; however, I ask the minister to let us know why government landed on the age limit it did.

The other issue I will touch on relates to the future of the Council of Official Visitors. We know that after royal assent is given to these bills, the Council of Official Visitors will be no more; it will be replaced by the Mental Health Advocacy Service. I place on the record my belief and view that the Council of Official Visitors has played a very valuable role over the past few years; it has shone a spotlight on and been able to bring to the fore a number of concerning actions or situations in the mental health system. The government has said that the role it currently has will be expanded with the creation of the Mental Health Advocacy Service; however, I fear that some of the independence the council had will be lost in this new entity. I am also concerned because it is still unclear to me whether the Mental Health Advocacy Service will get the extra funding required for it to carry out its increased workload. I look forward to the minister's assurances, when she replies to this debate, that the Mental Health Advocacy Service will receive the extra level of funding required to carry out its expanded role. I would also like an assurance from the minister that the Mental Health Advocacy Service will not become a toothless tiger as a result of the Mental Health Bill. I know it will be busier as a result of the bill, but I am just not sure whether the level of independence the Council of Official Visitors currently has will be diluted by the bill.

I turn to the submission made by the Mental Health Law Centre and Martin Whitely's organisation, the Health Consumers' Council of WA. Members will be aware that a number of organisations made a joint submission to members of the Legislative Council over the past few months on the Mental Health Bill. Although the submission was prepared by the Health Consumers' Council of Western Australia, it was endorsed by the Consumers of Mental Health WA, the Mental Health Law Centre WA and Mental Health Matters 2; it also had in-principle support from Arafmi, Carers WA, the Mental Illness Fellowship and the Richmond Fellowship Western Australia. I will quote from the document because, as I said, I believe the issues raised deserve to be on the public record and considered by this place. Some of the issues raised by these groups will of course be taken up during Committee of the Whole. Page 2 of the document reads —

> Despite these improvements over the current legislation there are problems with the Mental Health Bill 2013 (the Bill), and in one important area the bill represents a significant backwards step from the Mental Health Act 1996 (the Current Act). In particular the criteria for making patients involuntary have been broadened heightening the risk of unwarranted detention and involuntary treatment.
>
> It must be remembered people who are believed to be mentally unwell and in need of urgent 'involuntary detention and treatment' have not committed a crime and that on many occasions throughout history the power to detain and treat those deemed to be 'mentally ill' has been abused in the guise of therapy or protecting the public. Although the majority of mental health practitioners are competent and responsible there are too many historical examples of mental health practitioners precipitating considerable harm, including avoidable deaths. And regrettably there is an unhappy local, national and international history of self-regulatory failure by some in the mental health professions.
>
> Despite the improvements in the Bill it is interesting to note that the penalty for ill treatment or wilful neglect of a patient is a maximum penalty of $15,000 and/or 2 years imprisonment.

Because of amendments that will be before us in this place, those provisions will be changed and that penalty will be increased to a figure of approximately $24 000, if I am correct. That is a recognition of the concern raised by these groups, and hopefully that amendment has been made. The document makes the point that $15 000 is a small amount for a penalty in this area, when under the Animal Welfare Act 2002 the maximum penalty for causing unnecessary harm to an animal is $50 000 and/or five years' imprisonment. I do not seek to make any

further comment on that point, but I acknowledge that the penalty will increase as a result of amendments before the house. The document continues —

> We therefore encourage Legislative Council Members to consider the following suggested amendments which are proposed having regard to Professor Stokes July 2012 Report and our coal face experiences in working with the current Act.

The major issues that have been raised relate to clause 25, which contains the voluntary detention criteria. In the existing act, the Mental Health Act 1996, section 26 states, in part —

> **26. Persons who should be involuntary patients**
>
> (1) A person should be an involuntary patient only if —
>
> …
>
> (i) to protect the health or safety of that person or any other person; or
>
> (ii) to protect the person from self-inflicted harm of a kind described in subsection (2); or
>
> (iii) to prevent the person doing serious damage to any property;

Section 26(2) states —

> (2) The kinds of self-inflicted harm from which a person may be protected by making the person an involuntary patient are —
>
> (a) serious financial harm; and
>
> (b) lasting or irreparable harm to any important personal relationship resulting from damage to the reputation of the person among those with whom the person has such relationships; and
>
> (c) serious damage to the reputation of the person.

Clause 25 of the Mental Health Bill 2013 states, in part —

> **25. Criteria for involuntary treatment order**
>
> (1) A person is in need of an inpatient treatment order only if all of these criteria are satisfied —
>
> …
>
> (b) that, because of the mental illness, there is —
>
> (i) a significant risk to the health or safety of the person or to the safety of another person; or
>
> (ii) a significant risk of serious harm to the person or to another person;

In this advice to members of the Legislative Council, the signatories to the document state —

> the Bill expands the criteria for detaining and/or treating patients without consent by substituting *'significant risk of serious harm'* for the narrower criteria in the Current Act. Specifically the Current Act limits 'risk' criteria by which a person can be made an involuntary patient to five risks (health and safety of self or others, property or financial, relationships and reputation). Although the Bill limits the number to two (health safety of self and others and unspecified serious harm), the term *'serious harm'* is so broad that the net effect is to make it likely that many more people will be involuntarily detained and treated. Furthermore clause 25(1)(b)(ii) of the Bill expands the criteria by applying it to unspecified harm to *'another person'*, not just 'self-inflicted' harm to the patient.

I believe the minister was on the record previously as having commented about this issue on the radio. I seek some particular comment on why the changes proposed in clause 25 have been made. Why is there a broadening of the powers, if the minister agrees that that has happened?

Some of the other issues raised in this document relate to oversight of powers of medical practitioners and authorised mental health practitioners by the Chief Psychiatrist. The document states —

> The Bill gives Medical Practitioners (who are not psychiatrists), 'Authorised Mental Health Practitioners', and Police very significant powers to detain, restrain, seclude and search people they suspect of having a mental illness. The Chief Psychiatrist can designate social workers, occupational therapists, registered nurses, midwives and psychologists as '*Authorised Mental Health Practitioners*' …

> A Medical Practitioner or an Authorised Mental Health Practitioner have the power to restrain (clause 230) and seclude patients (clause 214). In addition they may detain a person for up to 144 hours initially … When extended transportation orders … and delays for examination … are taken into account, an individual could potentially be detained for up to seven days in the metro area and thirteen days outside the metro area … before being assessed by a psychiatrist.
>
> Those suspected of having a mental illness should be given at least some of the same protections as those suspected of committing a crime. When the powers of detention or transportation are exercised by those who have limited mental health expertise, for example General Practitioners or Authorised Mental Health Practitioners, there needs to be an automatic process of timely independent review. This will at least ensure there is accountability after the event for the use of these extra-ordinary powers.
>
> Recommended Action — Amend the bill to establish a requirement that any detention or transportation instigated by a Medical Practitioner or Authorised Mental Health Practitioner is reported to both the Chief Psychiatrist and the Chief Mental Health Advocate who may choose to initiate a visit to the detained person without being requested.

At this point I might say that a number of the amendments that the opposition will seek to move in this debate relate to the inclusion of Chief Mental Health Advocate. As I said, it is a good initiative to create this position, but we believe that, where possible, a requirement should be included to report to the Chief Mental Health Advocate. In many places in the bill—I will not go into them now; I will point them out during the committee stage—there is a requirement to report to the Chief Psychiatrist alone. We believe that, in a number of the areas we will point out later, at the same time as letting the Chief Psychiatrist know, we should also be letting the Chief Mental Health Advocate know, who then can choose to initiate a visit to that detained person.

A number of other concerns in this document from these organisations relate to the use of seclusion and bodily and chemical restraint. Essentially, these groups are asking members of this place to amend clauses 226 to 240 and 224(2) to expand the requirements to apply to chemical restraints in addition to bodily restraints, and to include the requirement that the information provided to the Chief Psychiatrist about each incident of restraint and seclusion also be provided to the Chief Mental Health Advocate. The bill should also state that use of all forms of restraint are measures of absolute last resort. That essentially says that if we are going to use extreme measures, we should have extreme oversight. If we are going to use extreme measures, we should be sure the Chief Mental Health Advocate is aware of the measures being used, is aware of the situations and circumstances in which they are used, and is able to initiate a visit to ensure that everything is in order.

Another concern I flag, which we will seek to move amendments on, relates to advance healthcare planning. We believe that the bill is not quite as strong in this area as it should be or perhaps it is too strong in one area in that advance health directives can be overruled by psychiatrists, and we have a concern in relation to that point. People make decisions in relation to advance health directives when they are well, and when they are well, I think it is fair to say that people with a mental health condition have an intimate knowledge of their treatment—what works, what does not work, and the drugs they have taken before and their side effects or likely side effects. Our amendments will relate to that point. This is an extreme case, but we know that some of the drugs prescribed can kill people, so I believe that when a healthcare directive has been made, those decisions should not just be regarded by psychiatrists, but should be the treatment. If something is ruled out in those directives, it should be ruled out by the psychiatrist and if that is overruled, there has to be some sort of mechanism for review, perhaps via the State Administrative Tribunal or some other body. I just flag that we will raise that again.

I will not go to the rest of this document, but I flag that we will again raise a number of issues that have been raised in this document. As I have previously noted in my contribution this afternoon, I believe that there is general support for this legislation in the sector and in the community. There are still a number of concerns held in the sector and, as I said, the opposition will raise those concerns when we go into the committee stage. I also make the point that we will not seek to spend more time on this bill than is necessary, but we believe it is important to place a number of things on the record. With those comments, I complete my remarks today and I look forward to the committee stage of this bill.

**HON LJILJANNA RAVLICH (North Metropolitan)** [3.13 pm]: I, too, rise to support the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. In doing so, I would also like to put some comments on the record about this very, very important area, and in particular, about the history of this legislation coming to this place and some of the matters proposed within it.

First of all, I want to go back to 1 September 2008 when the current minister, then in opposition, produced a policy document on mental health in which she made a number of commitments. Basically, in that policy

document she made a number of comments that Labor had done nothing to stem the high rate of suicide, that it had failed to deliver on WA's suicide prevention strategy, that patients will find it harder to secure timely inpatient treatment and beds, and, of course, that mental health patients were often discharged from treatment before they were ready to go. She also said that she would, within that term of government, deliver a mental health bill, and of course, here we are six years later and finally we see this bill in this place. This bill has been a long time coming. Although the bill has finally arrived, I think the minister has really dragged her feet in bringing it to Parliament. We rightly expected to see it in the first term of this government. We did not see it. We waited for nearly four years and it did not happen, and now, nearly two years into this term it is finally here. That is very disappointing; however, having said that, at least it is here, so that is something to be pleased about. I understand that the bill, given that it has taken so long to get here, has had extensive consultation in relation to what it contains. That, in part, might explain why it has taken that long. As I understand it, there has been ongoing consultation as this issue has been of major interest to the stakeholders; everybody wants to get this right. The problem in trying to get this bill right is that people in the sector—the professionals, families and all the stakeholders—at the end of the day have differing views about how to actually achieve the best outcomes and what should be legislated for to ensure that those outcomes are achieved. It is no simple thing to try to get unanimity in terms of how this bill should look and how it will best serve the end users—that is, people with mental ill health who are at the high end, if you like—and how they can get the best possible treatment available.

I want to make some comments about the second reading speech to the Mental Health Bill 2013, which, naturally, defines the policy of this bill. The first page of the speech states —

> Subsidiary legislation will follow, together with a clinicians' guide, guidelines developed by the Chief Psychiatrist, and other resources. All these materials will provide a legal framework for the implementation and enforcement of the legislation. Legislation does not, and should not, compel best practice …

I want to put on the public record that I do not find that good enough. I think it should compel best practice and I want the minister, when she gives her response to the second reading debate, to explain to this house why this legislation does not and should not compel that best practice. I would have thought it normal to aspire to that, at the very least, accepting that sometimes it may be difficult to achieve. There should at least be the aspiration that some of the most vulnerable people in our community have a right to expect best practice. The speech states —

> Legislation does not, and should not, compel best practice, but these other materials will provide flexibility and promote continuous improvement.

I would like the minister to provide a response about why that is the case.

Hon Stephen Dawson spoke about the fact that this bill will enshrine a whole lot of rights for people with mental ill health and one of those is that patients will have the right to access medical records in addition to their provisions under freedom of information legislation; however, access to particular information contained in the patient's record may be refused for confidentiality reasons or where access would pose a risk to the patient or another person. The patient is able to nominate a lawyer who will have unfettered access. The decision to deny access will be reviewed by the tribunal. I am wondering why these conditions have been put in. On the one hand, the second reading speech refers to improving access. But it is clear from the second reading speech that limitations will be placed upon that access. I wonder whether the minister could provide the house with an explanation of what things on a person's medical records would not be able to be accessed by the person, and whether that includes things such as the name of the treating psychiatrist. It would help the house when we get to the committee stage if we could find out what information contained in a person's medical record may be refused access for confidentiality reasons.

I will not go through all the rights, because they are clearly listed in the bill. But the second reading speech goes on to state that involuntary patients and mentally impaired accused persons in authorised hospitals will have the right to a treatment, support and discharge plan, which is to be developed in collaboration with the patient and their support persons. I would have thought that the right to access treatment would be a fundamental right for people with mental ill health. I say that because the minister would be aware of the work that I did with a number of families in relation to the suicides involving patients who had attempted to get treatment at Fremantle Hospital's Alma Street clinic and who were refused any treatment—in fact, they were just refused admission. Consequently, many of those people took their own lives. That work led to the Stokes report. I would have thought that it would be a fundamental right for a person who was severely mentally ill to present to a hospital and be at least admitted for assessment prior to being given the treatment that they need. I wonder whether the minister can explain to me why that right is not contained in the bill—or whether it is contained in the bill but I have overlooked it.

I want to go back to the suicide-related deaths at Alma Street. The minister may remember the case of Ruby Nicholls-Diver—whose family is still waiting for a coroner to investigate her death—who died on 2 March 2011. She was 18 years of age, and she was discharged, despite trying to take her life the day before while she was an inpatient at Alma Street. She had in fact told the staff that there was no-one at home, because her father was not in the state at the time, and she begged for them not to discharge her. But the hospital went ahead and discharged her, because there was so much pressure on the beds at that hospital, and she took her life in a park, just hours after having been discharged to an empty house. I would have thought that there would be some right for a patient to stay within the confines and care of a secure environment—that being a hospital—under a certain set of circumstances, rather than be pushed out the door.

We also have the case of a young unnamed male who committed suicide on 20 March 2012. He had sent his mother a text message before stepping off a high-rise building in Fremantle—the Johnson Court flats, which are notorious for people committing suicide by jumping off. The minister might remember the case of another unnamed male who on 28 March 2112 stood in front of a truck on Hampton Road in Fremantle after having been let out of Fremantle Hospital for a smoke. The minister might also remember the case of Carly Elliott, who died on 31 March 2011. She was taken by police and ambulance officers to Alma Street, and she shot through and was never followed up by the hospital. She also never had a full psychiatric examination. The CERT team visited her at her Beaconsfield house and spent less than 15 minutes with her, and that was passed off as a full psychiatric examination. I would have thought that a patient would have the right to a full and proper comprehensive psychiatric examination, and that that examination might take longer than 15 minutes. She suicided at home.

We also had the suicide of an unnamed male, 27 years old, who was turned away from Alma Street clinic and was found hanging from a tree at Fremantle Primary School. The minister might remember the case of Michael Thomas, a husband and father, who took his life 24 hours after having been discharged from Fremantle Hospital. He was sent home in borrowed jeans and slippers, and with a travel card. I would have thought that a person who was so sick and had suffered a traumatic experience would have had the right to be sent home in a more dignified way. I would have thought that the hospital would have contacted his loved ones and ensured that they picked him up and brought clothing to him so that he would not have had to leave the hospital in borrowed jeans and slippers. He was found on 2 September 2011, date of death uncertain. There was also the case of Neil Marcial, a father of four, 34 years old, who on 2 November 2011 had hanged himself at home after being told that he would have to wait for six weeks before he could be assessed. Mr Marcial was referred to the hospital's Alma Street clinic by his general practitioner on 3 November but was told that the earliest he could be seen was 13 December, and he committed suicide.

I bring that to the attention of the house, because none of that is satisfactory as far as I am concerned. I would like this bill to provide some certainty about the rights that will be enshrined in this legislation. This was a very sad chapter in our history. But I am not sure that things have improved all that much.

The second reading speech states also that the bill makes it an offence to ill-treat or wilfully neglect a patient. I would have thought that for people with mental ill health who are seriously ill to be told by a hospital to go away is about as neglectful as it can be. I would be interested to know how "neglect" is defined in this bill and whether turning a person away from a hospital will be deemed to be neglect under the provisions of this Menta Health Bill, or whether a patient will need to be admitted to hospital before the definition of "neglect" is applied. The second reading speech goes on to state that the maximum penalty for this offence is two years' imprisonment, which has been doubled from the current legislation. The bill also places a duty on staff to report unlawful sexual contact or unreasonable use of force by staff to the Chief Psychiatrist, and noncompliance will attract a maximum fine of $6 000. I found it very interesting that this provision is in the second reading speech, as I know from work I have done on the requirement by practitioners to report deaths and serious incidents, as outlined on the website of the Chief Psychiatrist, that there is already a mandated reporting requirement. The fact is that nobody does it. The Minister for Mental Health needs to ask herself why nobody does it. The minister might explain to the house why nobody does it and why she has not had any success in making sure that it does in fact occur. We already know that if there is a death or a serious incident such as unlawful sexual contact, it needs to be reported to the Chief Psychiatrist. However, when we have a look at the statistics to see how often these events are reported to the Chief Psychiatrist, we find that it is in fact hardly ever. That particular policy and operation as it currently stands, therefore, simply does not work.

I understand that one of the big problems between Health and Mental Health is that there is a total disconnect. This is what Bryant Stokes found in his 2012 report "Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia". One of the problems, of course, is that the Mental Health Commission is a purchaser of services. That is what it is and that is what it does. It is not a commission established under statute; it is like an extension of the Department of Health.

It purchases services from the health department; it really does not have jurisdiction over the Department of Health.

I will be interested to know about this new provision in the bill, referred to in the second reading speech as the duty of staff to report unlawful sexual contact or unreasonable use of force by staff to the Chief Psychiatrist. That provision carries with it a maximum fine of $6 000 for noncompliance. I will be interested to know how that provision will be put into operation to ensure that it is not yet again a provision that exists but nobody actually does anything about it; in other words, it looks good in legislation but basically makes no difference and provides no protection for those people to whom a serious incident occurs, or in the event of a death it provides no record to the family members of the person concerned. There are therefore a number of concerns about this bill before us.

I want to quickly touch on the issue of police transport. I have spoken in this house on a number of occasions about police transport for people with mental ill health. Under the bill before us, referral orders will be valid for 72 hours. The second reading speech states —

> However, in regional and remote areas where transportation to an authorised hospital may take longer, the order can be extended by a maximum of an additional 72 hours.

I suppose that sounds reasonable. It continues —

> Transportation to the place of examination should be done in the least restrictive way. This may involve police or transport officers if there is no other safe means of transportation.

There are a lot of questions surrounding the qualifications and training of transport officers such as: What powers will transport officers have? Will there be any standards associated with the roles that they perform? Will they be under the authority of the police department, or will they be people seconded from the public and then trained to a certain standard in order to perform that function? I have no idea. Certainly some information in relation to this whole area would be very helpful, because this is an area of great concern to people with mental ill health. It is an area of great concern particularly to families who have family members with mental ill health. I am sure that they will be very interested in the minister's answers to some of those questions.

Mental health is not an easy sector. I must give the minister credit, as she has at least finally after six years brought a bill into this place, and I know that the sector is pleased about that. However, it is a big job for anyone, and for anyone who thinks that things are going well out there, it is simply not the case. There is enormous pressure on resources—human and non-human resources. As commonwealth funding becomes harder to get and as state funding has more pressure on it, it is harder and harder to maintain the resources to deal with the increasing growth in demand in this area.

Not long ago, on Thursday, 14 August 2014, we had the new mental health chief, Tim Marney, before a committee of the Parliament. As the head of WA's Mental Health Commission, he said that he does not know how anyone manages to navigate their way around WA's mental health system to find the help that they need, particularly if they are unwell. Mr Marney went on to say —

> "I don't know how anyone finds their way through the system to be honest, particularly if someone's unwell," Mr Marney said.
>
> "It's hard enough when you're actually thinking clearly."
>
> Mr Marney said mental health services in WA relied far too heavily on acute services, with people often getting "very, very unwell" before they entered the system.
>
> "Because we don't have enough of those early intervention services, the acute system is overwhelmed," Mr Marney said.
>
> "The acute setting is really what we want to keep people away from.

I think that that is about right. However, unfortunately, it is hard without early intervention; it just means that people get to that acute position much quicker than they otherwise would.

I want to go back to the second reading speech in which the minister, on the role of the bill, states —

> This bill brings vital change, but it is not the role of this bill to increase the number of psychiatrists, create more beds or increase community-based services; that is not the role of the Mental Health Act in Western Australia, or in other Australian jurisdictions. A bill such as this has a specific role, focused primarily on the processes, safeguards and protections around involuntary treatment and detention.

I have to say to the minister that any user of the mental health services in this state would recognise that this is a cop-out. Although it may not be possible or may even be impractical for the minister to legislate numbers and so on, the fact is that this bill should go hand in hand with additional resources to ensure that there are more

psychiatrists, that there are adequate beds and that there are adequate community-based services for those people who use the mental health services across the state. There is an acute shortage of psychiatrists, there is enormous pressure on beds and there certainly are not enough community-based services. Although these bills are a good start, there needs to be adequate resourcing in those areas. Unfortunately, I do not think there is a plan to ensure that that will happen.

Along the lines of the comments that I have been making, I want to put on the public record some of the concerns expressed by Professor Bryant Stokes about inadequate facilities and specialist skills, including psychiatry skills, to assist people with mental ill health. Pressures on resources means that people simply are not getting the help that they need. We can have the best mental health bill around, but if it is not backed up by adequate resourcing, it simply will not make much difference. A person who is very mentally ill needs a bed and medical attention, certainly at the acute end. No bill will provide that, particularly this bill.

I refer to page 1 of the Stokes report where he states —

> In the context of limited resources, the mental health system is under considerable stress, particularly in relation to staff already stretched, endeavouring to adhere to formal policies, procedures, legislative requirements and their own professional expectations and the expectations of patients …

I know that Professor Paul Skerritt has been a critic of the new Mental Health Bill, saying that it will lead to more formal policies and more administrative requirements of psychiatrists and other medical practitioners, who will be so flooded with paperwork that they will not be able to get on with the task of administering good psychiatry.

Professor Stokes' review went on to state —

> This Review notes that within the hospital and clinic situations there appears to be an absence of a single point of authority with a described responsibility for accountability for patient care and for consistency of process and practices.

I am not sure whether these bills will address that. That seemed to be a very big criticism, as the Minister for Mental Health would be aware, from the Stokes review. The review goes on to state —

> Best practice demands clinical and corporate governance remain separate entities, while a single point of authority must ensure linkages across a mental health system to deliver patient-focused care.

Professor Stokes also went on to state that there is a requirement to improve management information across the whole mental health area. I have not seen any reference to management information systems in the bills, but I could be wrong. What is before us is only one part of the equation. I worry that without adequate resourcing, the bills will not be as effective as they could be.

For members who take a key interest in this area, on page 22 of the November 2013 edition of *Medicus* there is a very interesting overview by Professor Paul Skerritt about what is referred to as "The Mess of Mental Illness". There are a number of headings including "Inadequate frontline community services". He is critical of the government for a lack of front-line community services. He is also critical of the lack of beds, which is the point that I am making. Professor Skerritt's other headings to the cover story are "Where are the beds?", "What about our children?" and "Bureaucracy & Red Tape". The article commences —

> Under-resourced and inefficiently managed, Mental Health Care in WA is our great shame—and the just-released Mental Health Act won't improve things, says Professor Paul Skerritt
>
> We all know that health is expensive and that hospital beds are the most expensive part. We also know that being in hospital is not very good for your health anyway.
>
> Mental illnesses are chronic and the more severe ones often need lifetime specialist professional care. Patients also need support and accommodation in the community. Emergencies are common and need an appropriate timely response.
>
> All of the above are done badly in Western Australia. Not only are the services inadequate but the funds that we accept are scarce and moreover, wasted by inefficient and excessive bureaucracy. Morale is at an all-time low leading to an exodus of locally-trained psychiatrists from the public system. Section 457 visas—reviled in the mining industry—are common and we could not manage without our overseas-trained colleagues.

I must admit there have been a number of cover stories in *Medicus* in recent times. The cover story "Mental Trap" appeared in the March 2013 edition of *Medicus*. It commenced —

> With professional treatment pathways sacrificed in favour of amateur systems, are we headed towards an era of anti-psychiatry …

That has been a criticism of the way in which the Minister for Mental Health has handled the mental health portfolio. According to some health professionals, there has been too much of a focus on community treatment and not enough on recognising the importance of psychiatry and the skills of psychiatry to deal with mental ill health. There are divergent views on how best to deal with patients with mental ill health, whether through psychiatric intervention or community intervention, but certainly there are differing views about what is best for mental health patients.

Having said all of that, this is a very challenging area. Over the last few years some things I have heard and seen have been scary. I am passionate about the role of government, and the role that government can play in making things better. The minister has good intent in trying to do that, albeit it has taken some time. I do not think it is a case of "either/or" in terms of community treatment versus medical intervention. It can become a very dangerous game if that becomes the debate. I will be satisfied if I get the answers to the questions that I have asked. I support the Mental Health Bill 2013 and I will be very interested to participate further in the committee stage of the bill.

**HON SALLY TALBOT (South West)** [3.49 pm]: Finally, we get to the Mental Health Bill 2013. It has been a while wending its way through the other place. Before that, of course, it spent a couple of years in some sort of consultation stage after the government released a draft bill. I think it is a much better bill for having been through those stages of extensive consultation, and it is also a better bill, although it pains me slightly to say so, for having been through the other place. To echo the remarks of Hon Stephen Dawson, the shadow minister, I pay tribute to the work done in that place by the member for Armadale, who has given us a much more straightforward task in this place because of the many, many hours that he put in to make some very substantial improvements to the bill and also to air some of the issues around some of the more controversial points. I think the member for Armadale did a very fine job and should be commended for that.

I want to make some more acknowledgements, but before I do that I will make some comments about the bill itself. I note that a couple of my colleagues have said that we support the bill because we believe that it is a very significant improvement over the existing legislation, which dates back to 1996, which, for the provision of services and resources for people with mental illness, is rather like the Dark Ages. It is a better piece of legislation than the one we have to rely on now. I note that some of my colleagues have said that we will not hold up the bill in this place. Of course, members on this side of the chamber never hold up bills; we always subject bills to the scrutiny that they need. There are a number of bills that we support on which we nevertheless spend quite some considerable time in this place trying to improve. However, we also must remember that, in a house of review, part of our job is to make sure that we get on record clarifications and statements that courts may well depend on in the decades to come, so we have a very important job to do.

We have a very challenging task ahead of us with this bill. This bill is nearly 400 pages long and has nearly 600 clauses and a couple of schedules. That compares with the existing act, which is lightweight in comparison. Again, one would have to say that that reflects the significant advances that have been made in our understanding of mental illness in the past 20 years or so. The current act is only 100 pages long and has only 200 clauses, so we are dealing with a very substantial piece of legislation. It is indeed an important step forward. It will improve significantly the current legislative framework that operates around the provision of services and resources for people with mental illness. However, of course—I sometimes hesitate before I say what once, in my more naive youth, might have seemed a self-evident truth, and perhaps even the minister will agree with me—there are a number of things that the bill in itself will not do. The minister has acknowledged on many occasions—I know that she is appreciated in the sector for her frankness about the fact that mental health is a very complex area of service provision for government—that the brutal reality is that there is no magic bullet to improving the life of people, many of whom find life completely intolerable. This bill is part of that, but there are a number of things that the bill will not do. I am sure that the minister will understand the point I am making when I go through some of those things. I am guarding against the assumption that, with this very substantial piece of legislation, we will fix the problems and they will all go away. Expectations are running very high in the community, but of course there are still a number of very significant challenges.

The first point I want to take up was alluded to by the previous speaker, Hon Ljiljanna Ravlich, who, like me, has the experience of being a previous shadow Minister for Mental Health and so has some considerable understanding of the inside workings of this portfolio—that is, the issue of resourcing. The Stokes report was a shocking document; I think we all concede that. One of the things that shocked me most was that on page 2 it refers to the history of these kinds of reports and it goes back almost 100 years to a royal commission that was held in Western Australia into the provision of mental health services. That is breathtaking in terms of pointing us to the challenge in front of us. Of course, it would be ridiculous to say that nothing has changed in 100 years. Nevertheless, the sorts of situations which I am sure we are all constantly referenced to in this debate, regularly

hear about in this place and regularly read about in the newspapers, and which certainly mental health stakeholders constantly bring to our attention, are pretty shocking. We might think we were living in Dickensian London after hearing about some of the poor resources described in some of these case studies. The whole issue of resourcing underpinned the Stokes report. Professor Stokes had quite a narrow term of reference; it was about the discharge of mental health patients and improvements that needed to be made urgently to that system. Some of those changes have been made; some of them of course have not, and I will come to that a little later.

Of course, Professor Stokes could not not talk about the issue of resourcing. One of the fundamental points he made is the point that has been taken up by people such as Debora Colvin, the head of the Council of Official Visitors; that is, many of our resources are in the wrong places. What Professor Stokes says specifically is that the number of acute care beds is probably about right, but the problem is that there are not enough resources to help people before they get to the acute stage. One of the best descriptions of that situation that I read recently was provided by Debora Colvin in her comment piece in *The West Australian* of 28 April this year following the report of the State Coroner's findings into the deaths of the 10 people who had died recently at Graylands Hospital. In this article, Debora Colvin states —

> The constant bed shortages exacerbate the problem. People are more unwell by the time they get to hospital and take longer to get better, which uses up more hospital bed days. Alternatively they are discharged too quickly so need readmission.

I know that the minister knows that this is a problem, and we have thrashed this out in a number of different forums, including estimates. I know that the minister would like to get to a stage at which the provision of subacute care or step-up, step-down facilities is much more widely available than it is at the moment. I make the point that this bill in and of itself is not going to meet those expectations in communities such as Bunbury, where the government made a specific promise prior to the 2013 state election that we would have a step-up, step-down facility. It is now 2014 and we do not have one and it is not in the budget. As I say, expectations are running very high, but what we need to see alongside this bill is a substantial reorientation of government funding into the provision of subacute care. It is not until we get to that stage that we can see whether the provisions in a new piece of legislation, which are much more comprehensible than the provisions we have now, will be able to make some of those cultural changes that we so desperately need to make the lives of people with mental illness a little more tolerable.

Just while I have the Debora Colvin article in front of me, she has another way of expressing it, too, which I think is quite evocative. She states towards the end of the article —

> As a result we find ourselves in this very strange place of people banging at the door to get into mental health services with people at the other end banging to get out … but with nowhere to go.

That is a very difficult problem for governments to start to rectify. I know that the minister has made a start in trying to rectify this, but I do seriously wonder when I look at the amount of money that is being spent on things such as sports stadiums and quayside developments in the centre of Perth whether a stronger voice around the cabinet table might have just got an extra few million dollars to put into these absolutely vital services.

We have had a lot of other problems surfacing in the last few years, some of which are almost unspeakable in terms of the horror that has been inflicted on people. I know that is strong language, but when I told the house and we discussed the story of Tristan Dimer, that was absolutely shocking. He was a very troubled young man who was administered an extremely powerful drug as a result of a case of mistaken identity in a prime A-class provider of mental health care in Western Australia. I think there is very little doubt that as a result of that mistreatment at the hands of those health professionals at Graylands, he has suffered a lot more than he should have done. It was indeed a relief to see from the coroner's report into the 10 deaths at Graylands, which I will speak about in a little more detail later, that of those 10 deaths, only one was attributed to a failure of care. Therefore, we can take some comfort from the fact that the quality of care provided to the other nine people met some kind of basic standard of the sort of care we would expect to be provided to people in extremely difficult circumstances. But the sad thing is that the quality of life of those other nine people, many of whom committed suicide, was simply appalling. I think Graylands has some 170 beds. The latest figures I have been able to find are about a year old, but a year ago, 37 patients in Graylands had been there for more than two years; 21 patients have been there for more than five years, and one patient has been there for over 20 years.

That might not sound like very high figures, but the coroner's reports on the 10 deaths and the quality of life those people had—I do not know how many honourable members have actually read through those reports—are chilling reading. They are extremely distressing. They are not stories about troubled people living a life with support in the best way that we can imagine they could have been supported; so there is still a lot of work ahead of us.

The final point I would mention here is that there are several references throughout the 400 pages of this bill to addressing the problems associated with the stigma of mental illness. Obviously, stigma is not addressed by a piece of legislation and the stigma of mental illness is as rife in our society today as it has ever been, frankly. I would like to think that was not the case. However, having had direct experience of the mental health system some years ago, both as a patient and as somebody caring for people with a mental illness, when I hear stories today about people who choose to disclose in their workplace that they are suffering from mental illness, they show an enormous amount of courage. Recently, I heard a couple of stories about people who I think showed an enormous amount of courage by disclosing that, yet when I hear the comments that are made back to those people, I can tell members that for every supportive comment there is an unsupportive comment, and that is very distressing. It should not be that way.

I know one of the things the minister was able to achieve with the trial—I think it is fair to call the suicide prevention strategy a trial—was to provide education in workplaces to help the workplace cohort understand what it is like to work with somebody suffering from a mental illness. I think we have made a small start; we have taken the first steps, but there is still a terribly long way to go. When I hear stories about the sorts of comments that are picked up in the workplace after somebody has self-disclosed, I wonder what it must be like to be a young person in a workplace. I think that if a young person came to me and asked my advice about self-disclosure of a mental illness, I would think very hard before I told him or her to take the courageous step of being frank with their employer and fellow employees. So we have got a very long way to go with all those very troubling aspects of caring for people with a mental illness.

Part of what I am saying is that we cannot rely on a piece of legislation to fix all those problems. It is one important cornerstone in changing the culture and in addressing issues to do with resourcing, but it provides a framework. We have to check, and this is why I suspect we will probably spend a considerable amount of time at the committee stage of the bill, whether the framework that was provided by the legislation is sufficiently robust. On my reading of the legislation, despite the lengthy consultation that has gone on and the lengthy debate in the other place, I suggest that a few places in the bill could be improved to make it more robust. I am not going to go through the bill clause by clause at this stage because, frankly, with a bill of nearly 600 clauses, some 45 minutes is simply not enough time to do so, and we will have the opportunity to do that at the committee stage of the bill. What I would normally do with a shorter bill would be to go through some of those questions and hope that the minister would address them in her reply to the second reading debate. I am departing from what I would normally consider to be a more productive process, but I think the minister would probably agree with me that it would be better to leave the detail to the committee stage. Therefore, I will just make a couple of observations about where those areas are that I think are a little troubling.

Before I do that, however, I want to make some acknowledgements because it is obvious that the arguments from the opposition side of the chamber and I dare say the government's drafting of this and the previous draft bills have been substantially helped by input from some of the stakeholders. My colleague Hon Stephen Dawson has already mentioned Sandy Boulter from the Mental Health Law Centre, who has followed the development of this bill in forensic detail since its inception. I think that Sandy is a magnificent advocate for people with mental illness in general, but most particularly for that small cohort of people who find themselves in very serious difficulties coping with the legislation and coping with the structures that they are confronted with when they are made involuntary patients. I take my hat off to Sandra Boulter; I thank her for her help and hope she considers that we have done justice to the points she has made. I also want to single out by name three other stakeholders whom I met with when I was shadow minister. I met just about every stakeholder in the state as well as a couple of national stakeholders, but there are three amongst a raft of extremely impressive people—I hope nobody will be offended by being omitted from this list—who deserve special mention.

The Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013 are better because of the work of Arafmi, as, indeed, are, I think, the lives of carers, who are often forgotten when we come to think about the damage and trauma mental illness inflicts on our community and the trauma that families have to live with. Arafmi, right from its inception a couple of decades ago, has done a fantastic job of making the people caring for the sufferers of mental illness feel that there is still a place for them in the life of somebody who might not quite be in the position to acknowledge that because of their illness. Arafmi does a fantastic job, and I know it did an enormous amount of work around the Stokes report, because of course it advocates for the families and relatives of people with mental illness. I think the minister would not dissent from my expression of thanks to it for that work.

I also want to mention the Richmond Fellowship WA. Over the past few months, as we have listened to the minister talk about the difficulty of providing suicide prevention services, it occurred to me that one of the most uplifting, heartwarming stories I heard while I was the shadow minister was from the Richmond Fellowship. It talked about the peer support it provides with its hearing voices group. It told me that since it had started the support group, not one single client of the Richmond Fellowship who is a hearer of voices—that encompasses

a whole range of other symptoms associated with schizophrenia—has committed suicide since they joined that support group. I say to the minister that it is worth going to the trouble of looking at what services are actually working. We are never going to be able to bottle and sell it on a shelf, but sometimes people jag either a structure or a process, or maybe there is a special person with a special capacity for delivering the service. But if we can get a better idea of what is actually working, I think we will have a better chance of preventing more suicides than we do at the moment. The Richmond Fellowship does a fantastic job, and I know it is a major service provider for the government. It also, I think, has shaped the path of the whole debate about the provision of mental health services in this state over the past decade or so.

**Hon Helen Morton**: I just add that they have been significantly influential in the whole process of a recovery-focused approach to mental health in this state.

**Hon SALLY TALBOT**: Yes, indeed, minister; I agree with the minister there. I think that whole change of philosophy that mental illness is something from which people can get better is very, very important. That, of course, is something that the minister will be grappling with at the moment in relation to the National Disability Insurance Scheme, in that it is not specifically tooled-up to deal with people who are going to get better. I think that is another important part; I thank the minister for reminding me of that.

The final group I want to mention is the Western Australian Network of Alcohol and other Drug Agencies. WANADA has a particular beef with the government at the moment about the change of name—the dropping of the reference to drug and alcohol from the government provisions. It makes a very good case there, and I think I have heard Hon Stephen Dawson, shadow minister, support its case. I want to pay tribute in a wider sense. Talking to the people at WANADA, I realised that there is actually a very, very mature, sophisticated debate going on out there in our community about how we could actually change things not in 20 years' time, when many of the people who need help right here and now are out of the system—hopefully because they have recovered, but sadly that will often not be the case—but right here and now in terms of concrete, practical service provision to people suffering from a whole lot of comorbidities—that awful term is used by the stakeholders. So what do we look at when we are looking at mental illness? I have talked about this on many occasions. I know that the minister understands what I am saying, but I am not sure that everybody else sitting around the cabinet table gets it. We cannot talk about mental illness without talking about addiction, homelessness, the challenges of living in regional and remote areas and poverty. A whole lot of things have to happen to be able to deliver a decent range of services to the people who so acutely need them. If the minister has not done it recently, she should go and spend an hour or two with WANADA; she will come out feeling that there is hope and light at the end of the tunnel, if only we could get our ducks lined up. I think WANADA does fantastic work.

**The ACTING PRESIDENT (Hon Liz Behjat)**: At that point I remind members that at the invitation of the President this afternoon we have Professor Matthew Flinders and students participating in the parliamentary studies unit being conducted at Murdoch University joining us in the members' lounge during the short adjournment. I am sure you will take that opportunity to impart to them your pearls of wisdom.

Debate interrupted, pursuant to standing orders.

[Continued on page 5723.]

*Sitting suspended from 4.15 to 4.30 pm*