

Ms Andrea Mitchell; Dr Tony Buti; Mr Roger Cook; Mr Dave Kelly; Ms Margaret Quirk; Mr Paul Papalia; Dr Graham Jacobs; Mr Chris Tallentire; Mr Peter Tinley; Mr David Templeman; Mr Peter Abetz; Mr Mick Murray; Mr Peter Watson; Mr John Quigley

MENTAL HEALTH BILL 2013
MENTAL HEALTH LEGISLATION AMENDMENT BILL 2013

Cognate Debate — Leave Sought

MS A.R. MITCHELL (Kingsley — Parliamentary Secretary) [3.13 pm]: I take this opportunity to advise the house that as Parliamentary Secretary to the Minister for Mental Health I am responsible for the carriage of the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. In accordance with standing order 169, I seek leave for the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013 to be considered cognately and for the Mental Health Bill 2013 to be the principal bill.

Leave granted.

Second Reading — Cognate Debate

Resumed from 23 October 2013.

DR A.D. BUTI (Armadale) [3.14 pm]: I rise to present the lead contribution for this side of the house on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013, which, as has been stated, will be debated cognately.

The ACTING SPEAKER (Ms J.M. Freeman): Are you the lead speaker?

Dr A.D. BUTI: I am the lead speaker, yes.

I say at the outset that the opposition will support both pieces of legislation but we will move a number of amendments that we believe are necessary to ensure the rights of the consumers—that is, people with mental illness or who have been diagnosed with mental illness—are fully protected and to improve the legislative framework of the mental health system. The first bill I mentioned, the Mental Health Bill 2013, is the more significant bill of the two and that is what I will be spending most of my time on in this contribution. I do not intend to spend much of my time on the second reading speech on the amendment bill, which we can deal with in consideration in detail, although this amendment bill seeks to be transitional legislation. It also seeks to make the 1996 Mental Health Act more workable. It also provides retrospective validation of a number of actions or purported actions by medical practitioners, who, at the time, may not have been authorised by legislation. Of course, any retrospective legislation that provides legal permission or validity that was not available at the time requires some consideration and, hopefully, we will deal with that in consideration in detail.

The stated aim of the Mental Health Bill 2013 is outlined at clause 10, which states in part —

- (a) to ensure people who have a mental illness are provided the best possible treatment and care —
 - (i) with the least possible restriction of their freedom; and
 - (ii) with the least possible interference with their rights; and
 - (iii) with respect for their dignity;

That is very laudable. The objects of the bill go on to provide for the recognition of the role that carers and families play in the treatment, care and support of people with mental illness and to facilitate the involvement of these people and, of course, to determine the best options and treatment for the person who has the mental illness. The objects of the bill state also that the bill seeks to minimise the effect of mental illness on family life and to ensure the protection of people with mental illness and the protection of the community.

Legislation in the area of mental health is very difficult. The enormity and complexity of the task should not be underplayed or understated. As noted by the Deputy Premier when introducing the bill into this house on 23 October 2013, mental health legislation involves a balancing act between the rights of the community, family members, carers and the patient. The bill before us is an improvement on the Mental Health Act 1996, particularly in respect to protection provided to mental illness patients. However, that is not a blanket support for the totality of this bill before us. We have a number of concerns, as I have already indicated, and as a result we will submit a number of amendments that we hope the government will give due consideration to. It is important to acknowledge and congratulate the Minister for Mental Health on this bill because in many respects, as I said, it is an improvement on the current legislation. It appears that the minister has listened to the various stakeholders in trying to provide this new mental health legislative framework, but, as I said, we have concerns. It would probably not be surprising that with a bill this complex, which contains 583 clauses, there will be areas on which we will disagree. I am sure even members on the government side may disagree with certain parts of the bill. The opposition certainly does not give blanket approval for every clause in the bill before us. We, as the opposition, come to this debate in good faith and acknowledge that it is an improvement on the current

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legislative framework for mental health in Western Australia, and Minister Morton's efforts in that respect are recognised and supported. But as was mentioned by the Deputy Premier when introducing this bill last year, there is always a fine balancing act when we seek to introduce mental health legislation. There is a balancing act between the rights of the community, the rights of families and carers, and, most importantly, the rights of the mentally ill. It is hard to ensure that such a balance is appropriately placed. We always argue that in the end the rights of people who are labelled "mentally ill" must take priority, unless, of course, major safety issues need to be considered.

This bill does not sit in a vacuum. No piece of legislation sits in a vacuum. Mental health legislation does not sit in a vacuum; rather, it sits within a mental health system. Although we congratulate the Minister for Mental Health for many aspects of the bill before us, we have many, many concerns about the operation of the mental health system in Western Australia. In fact, the mental health system of Western Australia is in crisis. I have received a number of telephone calls and had correspondence and conversations with mental health workers who have told me that the system in which they work is in crisis and that there is a chronic shortage of mental health experts. Moreover, their concern for young people with mental health illness, particularly adolescents, is alarming. For example, the Bentley Hospital adolescence mental health ward cannot cope with the demands placed on it. Many individuals of adolescent age require a bed at the ward, but are unable to obtain a placement, which puts them at great risk. One has only to travel on the Armadale line, for instance—of course, that is the train line with which I am most familiar—to know that our youth are in crisis. The number of makeshift monuments to those who have taken their own lives—generally youths and adolescents—between Maddington and Armadale stations is alarming. There is something chronically wrong in our society when individuals decide that it is all too much and take their lives. I challenge anyone to say that that is not the case. The evidence is in the makeshift monuments on the Armadale line, and I am sure that they can be seen on other railway lines. That crisis requires the government to not only introduce a legislative framework that improves the current system, but also marry that with increased funding and improved priorities in the mental health area.

I turn back to the bill before us. When one debates mental health legislation, I argue that it is an important responsibility for all members. I argue that debating mental health legislation is one of the most important responsibilities that members of this house will have during their parliamentary careers. When we deal with mental health, we deal with restrictions on the freedoms and rights that we hold so dear in our democratic society. As I mentioned previously, there are many stakeholders to consider—the families, the carers, the mental health professionals and the people with mental illness. When the Minister for Health introduced the Mental Health Bill into this house, he stated that there are occasions when, to protect people with mental illness and others, it is necessary to temporarily suspend the rights and personal freedoms of people with mental illness, but that in doing so, we must ensure that the restrictions on personal rights and freedoms are minimised as much as possible. That mirrors what is stated in the objectives of the bill in clause 10.

The need to get mental health legislation right cannot be underestimated. Unfortunately, while the majority of mental health practitioners are competent and responsible, that is not always the case. Many cases in Western Australia, Australia and internationally attest to mental health professionals abusing their power. They have an extraordinary power to involuntarily detain people and provide them with treatment to which they do not consent.

When one is talking about the values of the mental health system and the values of mental health professionals, one is often drawn to the name Dr Harry Bailey and the Chelmsford Private Hospital in Sydney. Between 1963 and 1973, Chelmsford Private Hospital in North West Sydney, led by Dr Harry Bailey, performed a type of psychiatric treatment called deep sleep therapy, in addition to electroconvulsive therapy, to treat a number of conditions, including schizophrenia, depression, anorexia, drug addiction and obesity. Deep sleep therapy was carried out by administering large doses of various medications, including tranquilisers and sedatives, thereby inducing patients into a state of unconsciousness that would be maintained for several weeks. The theory was that the treatment would rewire a patient's brain, thus curing them of their so-called "mental illness". Deep sleep therapy was often conducted in conjunction with ECT, and was often done without the permission of the patient or without appropriate muscle-relaxing medication. The consequences of the treatment were grave and alarming. As a result of deep sleep therapy, many patients left Chelmsford with other problems and long-term negative effects. A blog that relates to the Chelmsford hospital scandal reads —

Fatalities would also occur at a death average of about one or two a year with a total 27 individuals dying as a direct result of deep sleep therapy and 24 others committing suicide following the treatment or due to it.

For those who want to know more about this scandal, I highly recommend the book *Deep Sleep, Harry Bailey and the Scandal of Chelmsford*. The book deals with the scandal and the royal commission that was established

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to investigate it. It is worthwhile reading an excerpt from the introduction to the book, because it lays bare how much we must get things right in this area. We need a proper legislative framework to try to minimise the possibility of the abuse of the incredible power that mental health practitioners have over the vulnerable. The introduction reads —

It was, of course, impossible for us to ignore the constant accounts of human tragedy presented by the more than 100 former patients and their families who came forward to give evidence at the hearings. They recounted the horrors of hallucinations induced by the massive doses of the drugs they received at the hospital. We heard the soul-wrenching stories of guilt-ridden husbands, wives and parents who had taken their apparently mildly upset loved ones to the hospital on the recommendation of either Dr Harry R. Bailey or Dr John T. Herron, only to be later told that the patient had either died or been transferred, desperately ill, to Hornsby District Hospital.

We were daily presented with evidence which revealed an attitude to the practice of medicine by Drs Bailey and Herron, Dr Ian Gardiner and Dr John Gill, which would almost not have seemed out of place in a Gulag.

For one period of more than six weeks we listened to some 50 former nurses at Chelmsford, who, with some stark exceptions, showed an almost total ignorance of the dangers associated with the use of the Bailey version of Deep Sleep Therapy.

We heard Dr Herron describe his treatment for anorexia nervosa on a 13-year-old girl. She was nursed naked in a ward of similarly unclad adult males and females, and screamed in terror at being separated from her family (indeed her father was banned from visiting her), and at being placed in a darkened room. This young girl received 10 doses of electroconvulsive therapy (ECT) over a period of 14 days which Herron described as ‘perfectly appropriate’.

We heard how Dr Gill and Dr Gardiner, neither of whom appeared to have any real understanding of the dangers involved, administered Deep Sleep Therapy, with tragic results to some of their patients.

We heard the incredible story of Barry Hart’s attempts to pursue a damages claim against Dr Herron and the hospital, and his five-year campaign to persuade the healthcare authorities to institute disciplinary proceedings against the allegedly offending doctors. The remarkable irony is that his complaints about the failure of eye surgery, which were said to be indicative of his delusional state, subsequently resulted in a substantial out-of-court settlement by the surgeon’s insurers.

And so forth.

Of course, we in Western Australia have been fortunate that we have not experienced a scandal of that magnitude. However, a number of problems have been experienced in our mental health system in Western Australia. Not so long ago a petition was presented in the other place from concerned parents and friends about the shortage of beds for young people with a mental illness. Those members who were in this house in the last Parliament can cast their minds back to 24 May 2012, when the former member for Bassendean, Martin Whitely, brought before this house the case of Maryanne Connor, who had been made an involuntary patient at Fremantle Hospital on 23 March 2012. That case is quite germane to this bill, and in particular clause 25, which deals with the criteria to be utilised in allowing someone to be admitted as an involuntary patient. In presenting the case of Maryanne Connor, the then member for Bassendean, Martin Whitely, stated, as reported in *Hansard* —

It is really important to understand what the perceived threat here was to Maryanne and why she was taken into custody. She was taken into custody because the judgement was made that there was a potential for Maryanne to damage her reputation. In other words, perhaps if she was shouting in public, it might damage her reputation.

I understand that. For the benefit of new members who were not in this chamber at the time the former member for Bassendean presented this case, a person could be made an involuntary patient in a psychiatric ward—in this case it was Fremantle Hospital—because they may have shouted at someone, and that might damage their reputation. That is absolutely something that we should all be concerned about, and it has great relevance to this legislation, which I will refer to shortly. The former member for Bassendean went on to say that the Mental Health Act 1996 required, as a matter of urgency, a number of amendments. Members might recall that he took the matter into his own hands by introducing a private member’s bill on 20 June 2012—namely, the Mental Health Amendment Bill 2012. That bill did not pass this house. However, many of the issues that the former member for Bassendean raised in his second reading speech are pertinent and relevant to today and to the bill before the house that we are debating.

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Currently, Mr Whitely is a senior advocate of the Health Consumers' Council WA, and he has made a submission that I think may have arrived in our email boxes in question time. However, it has also been on the council's website, which I have been lucky enough to read in preparing my contribution today. I rely considerably on that submission, which I think is a very thoughtful, balanced and well-researched submission. I know that the Minister for Mental Health has that submission, and I hope that the member for Kingsley has it also.

I think it is important now to move on to the various clauses or various parts of the bill. Of course, we will deal with these in great detail in consideration in detail, but I think we need to lay out the framework of the bill before us and to also express the concerns that many members on this side of the house have with the current bill. However, as I stated, we support the bill. It is an improvement on the current act, but we have some concerns, which is not surprising with a bill that has 583 clauses.

I return to the involuntary patients section of the bill, which is clause 25. Under the current legislation, section 26 is the relevant one with regard to involuntary patients. To be made an involuntary patient under the Mental Health Act 1996, there are five criteria—that is, five criteria of a mental illness nature to be made an involuntary patient. The five criteria are safety, property, finances, relationships and reputation. The reputation criterion was the one utilised to have Maryanne Connor admitted as an involuntary patient. Under clause 25, we have a reduction in the number of criteria from five to two. Those two criteria are safety, which one would expect, and unspecified serious harm. *Prima facie*, obviously, it is good to have the number of criteria reduced from five to two, because, hopefully, that will reduce the number of people who incorrectly come under the involuntary patient powers of the act.

Clause 25(1)(b)(ii) states —

a significant risk of serious harm to the person or to another person;

That is rather broad. Page 14 of the explanatory memorandum to this bill states —

The concept of 'serious harm' is not detailed in the Act itself because it must be determined by a psychiatrist on a case by case basis, using the appropriate clinical tools. As examples, the harm may be to property, finances, reputation, or relationships.

Although, on the surface, the minister is to be applauded for reducing the five criteria to two criteria, that second criterion is really an all-encompassing criterion that, if anything, because it is not specified, broadens the criteria. The Mental Health Law Centre, in its submission to the minister, also expressed concerns about this and stated that, arguably, this broad criterion will result in more people coming under the jurisdiction and that it is not a clinical decision; it is more of a factual and social decision.

The 1996 act specifies what constitutes serious harm; the bill before us does not. As is stated in the explanatory memorandum, it is to be determined on a case-by-case basis by the psychiatrist. That, of course, is a major concern. What is serious harm? It seems to contradict an undertaking made by the Minister for Mental Health, Hon Helen Morton, in an interview with Paul Murray on radio 6PR on 25 May 2012. The minister stated —

The mental health bill that's now being drafted significantly changes the criteria by which people can be made involuntary and removes that area related to damage to reputation and there are other areas that have been removed as well.

It does not really, does it? Even though it does, on the surface, remove reputation as a criterion, this all-encompassing serious harm provision does include reputation, as stated in the explanatory memorandum. It will be interesting to hear the member for Kingsley's comments on that. The minister also talked about the issue that it removes other areas. It is unclear what she meant when she referred to those other areas. What was she referring to?

Although a minister should be applauded for reducing the five criteria down to two, the second criterion is so broad a criterion that it defeats the purpose the minister set out to achieve. I am sure that the minister was concerned about including all five criteria, particularly as the explanatory memorandum, which is a very important document for understanding the intention of the legislators, actually refers to reputation. It is very hard to justify reputation being included as a criterion for the jurisdiction of involuntary patients.

Another concern is clause 25, which deals with involuntary patients. Clause 25(2)(ii) deals with the issue of unreasonably refusing treatment. What is meant by that? The unreasonable refusal of treatment is very interesting. The Mental Health Law Centre deals with this issue and states on page 3 of its submission with regard to the Mental Health Act 1996 —

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Under the Act it can be seen section 26(1)(b)(c) provides a required criterion to make someone involuntary to be that, *the person has refused, or due to the nature of the mental illness, is unable to consent to the treatment.*

In recognition of the issues this raised and raised in submissions on the 2012 Bill, the Bill changes this refusal criterion for involuntary detention and treatment at cl. 25(1)(c)(ii) and for a community treatment order cl. 25(2)(c)(ii) to, *the person has unreasonably refused treatment.*

I further quote from the submission —

This change leaves the inherent and fundamental conflict in the Act and this clause that is so objectionable to many people subjected to the Act's provisions. That is, what is the objective test that separates a patient reasonably refusing treatment and the patient unreasonably refusing treatment? In the Bill, the person proposing the detention and treatment decides that opposition to their proposed course of action is also the person who decides the unreasonableness.

Do members understand the inherent conflict there? A mental health practitioner decides that a person should be treated. If that person refuses to be treated, then that mental health practitioner has the power to decide whether that is unreasonable. If a provision for the unreasonable refusal of treatment is to be included in the bill, surely it has to be determined by an independent body, not the same person who is making the original decision. As members know, in the judicial system, a judge at trial should not then sit on the appeal to their decision. In this bill, the appellant is the same decision-maker as the person who made the decision. I think that needs to be looked at.

Clause 28(1) is a very interesting provision. I quote —

A medical practitioner or authorised mental health practitioner may make an order authorising the person's detention for up to 24 hours from the time when the referral is made if satisfied that, because of the person's mental or physical condition, the person needs to be detained to enable the person to be taken to the authorised hospital or other place.

It is interesting that this clause refers to the person's mental or physical condition, because this amendment relates to the Mental Health Act. Why is the person's physical condition included in a clause that would allow someone to be detained? Maybe this is a mistake and it should be taken out, because it seems to contravene the long-held principle that mentally competent people are entitled to control their own lives and make decisions about their own treatment. At best, it is an oversight; at worst, it is deliberate and could have serious consequences. It also conflicts with clause 25(1), which states that to issue an involuntary treatment order or an inpatient treatment order, the practitioner must be satisfied that the patient is a mental health patient. The criterion is not that the patient has a physical condition but that they have a mental health condition. The inclusion of the word "physical" under clause 28(1) is superfluous at best and dangerous at worst. I really think that the government needs to reconsider whether the term "physical condition" should be included.

I will move on to the area of informed consent for treatment. We live in a system in which we wish to ensure as much as possible that people consent to treatment and that it is informed consent. Whether a person decides to give consent for treatment or to invest in an investment scheme, it is a good idea to know whether the person providing or suggesting the treatment or offering the investment scheme has a vested interest in the person's consent to the treatment or investment scheme. That might affect the way a person decides whether to give consent. The 2011 draft of this bill imposed very important disclosure requirements upon psychiatrists, including the requirement to disclose any financial advantages that could be gained by the medical practitioner or medical health services when admitting a patient or administering treatment. It also required the disclosure of any relevant relationship between the practitioner and the mental health service. There was an additional right for patients to be informed of their right to legal counsel. The 2011 draft of this bill—it has had a long gestation period—included important disclosures on financial advantage for the practitioner or the health service when admitting a patient or for any applicable treatment, and whether there was a financial relationship between the practitioner and the mental health service. I think they are incredibly important because of the longstanding legal principle regarding consent. Consent is not worth the paper that a consent form is written on if it does not involve informed consent. Informed consent involves full disclosure of the matters relevant to a person giving consent to something that has been offered or suggested to that person. I am interested to hear from the member for Kingsley why the 2011 draft bill had these important disclosure provisions that have been taken out of this bill. I would also like to know about informing patients of their right to legal counsel. Although this bill is, overall, an improvement on the 1996 act, the fact that these disclosure provisions have been taken out is rather disconcerting.

Again I will refer to Martin Whitely's submission, in which he states —

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The AMA recognises the need for full disclosure of potential conflicts of interest. They advise their members in a document titled *'Medical Practitioners' Relationship with Industry 2010 Revised 2012'* that doctors *'should inform patients when having an interest that could affect, or be perceived to affect, patient care. This includes referring patients to a medical or other health care service in which the doctor has a financial or other material interest as well as recommending a product in which the doctor has a financial or other financial interest (eg., a therapeutic device).'*

I am sure that the Minister for Planning understands from his former profession the issue of full disclosure. I know from my previous profession in the legal field that full disclosure was incredibly important. It is there to safeguard the practitioner and the professional as much as it is to safeguard the patient. In this regard, it is incredibly important that the patient understands that the practitioner is suggesting that they be treated with a certain type of treatment and that the practitioner does not have a financial interest in and will not receive a financial advantage from that treatment.

Mr J.H.D. Day: It was normally known as informed consent.

Dr A.D. BUTI: Yes, informed consent; that is right. The argument is that a person cannot be informed if all matters that would determine whether they consent have not been disclosed. It cannot be informed consent if it is consent under pressure. It was in the 2011 draft bill, parliamentary secretary. It seems absurd that it has not remained in the final bill.

I now want to turn to an area that is controversial. I am sure that many members on this side of the house will comment on the provisions that relate to psychosurgery and electroconvulsive therapy for children. Obviously, these are controversial medical procedures, whether they are performed on an adult or a child, but their use on children is particularly controversial. Interestingly, under the Mental Health Act 1996, there is no age restriction on psychosurgery, but it has not been performed on children in Western Australia since the 1970s because of its controversial nature. In an earlier draft of this bill, psychosurgery was to be allowed to be performed on children aged 14 and above. That was incredibly alarming to members on this side of the house, and I am sure members on the other side of the house also would have been alarmed by that provision. Under clause 207 of the bill before us, that age restriction has been increased to 16 years. The opposition still does not think that is appropriate. We believe that psychosurgery should not be conducted on any person under the age of 18. Some will argue that it may be necessary, but has the government provided the medical evidence to show that there is a significant benefit to be had from performing psychosurgery on children? There may be evidence, but that has not been presented to us. From our research, the literature on that issue is not conclusive. It is very problematic to allow psychosurgery to be performed on children, as its effects are irreversible; once it is done, it is done. If the practitioner gets it wrong, they get it wrong.

As we all know, surgery sometimes goes wrong; sometimes a person goes in for a knee replacement or a shoulder replacement and it does not work. My mother had a shoulder operation and it did not work. Now her shoulder does not allow her to raise her arm above 45 degrees. That is very bad; it is very uncomfortable. But imagine getting psychosurgery wrong. If the practitioner gets psychosurgery wrong, it is incredibly disastrous and catastrophic. I know from my time in the legal profession, and I am sure that people in this place who have been treated by doctors know, that some doctors are more eager than others for people to have surgery. Some doctors see surgery as the saviour for everything; others do not. If a person goes to a psychiatrist or another health professional who has more enthusiasm for surgery than another and something goes wrong, basically they have lost the lottery. It is a bit of a lottery. If we are going to allow psychosurgery to be performed on children, it will be a lottery, because they may not have needed it in the first place and it may go wrong. If that is the case, the rest of their life will be ruined. If we allow psychosurgery to be performed on children and it goes wrong, we can basically write off their life. We will also be inflicting incredible hardship on their families, not to mention the cost to taxpayers because these people will need support for the rest of their life. We do not agree that psychosurgery should be allowed to be performed on children. It should be allowed to be performed on adults but, of course, one would have to be very cautious even in that respect.

The procedure described in clause 205(b), which is the psychosurgery provision, equates to deep brain stimulation. Although its use has been approved in the United States for some non-psychiatric conditions, it has not been approved for psychiatric use. That is another alarm bell that the government needs to consider.

I move to electroconvulsive therapy in children. Although it is controversial, its effects are not of the same magnitude as those of psychosurgery, because, as I said, the effects of psychosurgery are irreversible. The effects of ECT are not necessarily permanent; however, it can still have some dire consequences. Clause 194 of the bill prohibits the use of ECT on a child under 14 years of age. We have concerns about that provision. Although we acknowledge that the magnitude of the risks or permanent side effects of ECT may not be the same as those from

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psychosurgery, we believe great caution needs to be shown with its use on children. That is why we believe that the age should be raised, and we will move an amendment to increase it to 16 years of age. We believe that psychosurgery should be performed only on adults and we believe that, although the jury is still out on the use of ECT in children, the lower age limit should be at least 16 years, not 14 years.

There is also an issue about parental veto. Should parents have the right to veto the use of ECT and, if this bill is passed in its current form, psychosurgery and, for that matter, even a number of psychiatric drugs on their children? We believe that parents have a major role to play and that they should have a right to veto certain treatment, but with a caveat, because sometimes parents do not act reasonably and may not have the capacity to make decisions. However, that should probably be determined by an independent body. We believe there should be a provision for parents to have the right to veto the use of psychosurgery, ECT and psychiatric drugs on their children, although, as I said, we do not believe that psychosurgery should be utilised in children—full stop.

I would like to move on to the issue of whether Western Australia should follow the US in the use of psychiatric medicine in its mental health system. Overall, we should be very careful of following the US in this area. The US is probably the most overprescribed, medicated society in the developed world, and nowhere more so than in the mental illness area. Clause 6(4) of the bill states —

A decision whether or not a person has a mental illness must be made in accordance with internationally accepted standards prescribed by the regulations for this subsection.

Page 5 of the explanatory memorandum states —

... internationally accepted standards ... will initially include the American Psychiatric Association's Diagnostic and Statistical Manual V —

Better known as DSM-5 —

and the World Health Organization's International Classification of Diseases 10.

The *Diagnostic and Statistical Manual of Mental Disorders* was published in May 2013 and is the fifth edition of the American Psychiatric Association's manual. In the US it is often referred to as the "Bible of Psychiatry" and it is also followed in other jurisdictions. It outlines the diagnostic criteria for more than 300 psychiatric disorders. If we look at the development of the various editions of the *Diagnostic and Statistical Manual*, we will see that it is like the *Yellow Pages*; it just keeps getting bigger and bigger. More and more mental disorders are being diagnosed. Allen Frances, the chair of the task force that put together DSM-IV, which is the edition that came prior to the edition cited in the explanatory memorandum, has written a book that criticises DSM-5. He has very valid and well-respected credentials and one should listen when he criticises a manual that he helped develop. This is quite an interesting book. He also wrote an article that appeared in the *New York Post* titled "We're all mad here", which is also very interesting. The first sentence reads —

Millions of people who went to sleep last night thinking they were normal woke up this morning with a new mental disorder.

...

DSM 5 has added many new mental disorders that include many symptoms and behaviors previously accepted as simply part of the human condition. The resulting overdiagnosis of mental disorder will have many harmful unintended consequences—the misuse of medication, unnecessary stigma, high costs, misallocated resources, narrowed expectations, a reduced sense of personal responsibility, and the misapprehension that we are all becoming sick individuals living in an increasingly sick society.

...

Consider these new additions to the DSM —

This is DSM-5, which is cited in the explanatory memorandum as something we should be following —

- Suppose the love of your life died suddenly just two short weeks ago and you are still feeling sad, have less interest in things, don't have much appetite or energy and can't sleep well. Yesterday this was consistent with perfectly normal grief. Today you fully qualify for the DSM 5 diagnosis of major depressive disorder.
- Suppose you are 70 years old and, like me, are having trouble recalling how the movie ended last night, or finding your car in the parking lot, or remembering the names or placing the faces of new acquaintances. Last night, we were just old geezers. Today, DSM 5 has graduated us up to mild neurocognitive disorder.

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- Suppose you have a cancer and worry that each headache may represent its having spread to your brain. Yesterday, this was completely understandable — today you have DSM 5 somatic symptom disorder.
- Temper tantrums used to be an annoying, but accepted and expected, part of childhood development. Now they have morphed into DSM 5 disruptive mood dysregulation disorder.
- All of us would like to be less distractible, to really focus our minds to get the job done. No worries. It is now extremely easy to qualify for DSM 5 attention deficit disorder and ask your doctor for a stimulant to help improve your cognitive performance.
- And DSM 5 has introduced the interesting concept that behaviors are just as addicting as substances. Gambling is the first DSM 5 behavioral addiction, but can the Internet, sex, shopping, jogging, golf, model railroading and (my personal favorite, sun worshipping) be far behind? Soon all the passionate interests in life will be relabeled as mental disorders.

...

DSM 5 should have held the line against the resulting diagnostic inflation. Instead, it has promoted reckless changes that will likely lead to hyperinflation with all its associated risks. The great tragedy in the United States is that we provide shamefully inadequate care for the really ill who need it, while falsely labeling as sick so many people who are basically normal and would do better on their own.

I ask the Parliamentary Secretary to the Minister for Mental Health, the member for Kingsley, to consider whether it is appropriate to follow DSM-5. We hope that the Minister for Mental Health, in the other house, Hon Helen Morton, will also acknowledge the controversy around DSM-5. What I read out is not from some quack or some pseudo-religious order but from Allen Frances, who was the chair of the DSM-IV task force. It would be hard to find anyone more qualified. I think those examples I read out are alarming and we should not go down that track.

As is clearly stated in the Mental Health Law Centre's submission, this bill dilutes the right to legal representation and advice. People should understand that legal representation and legal advice is not necessarily the same thing. The bill seems to dilute the right to legal representation and advice purely now to a permission to have legal representation. I quote the submission by the Mental Health Law Centre —

The Bill places considerably less emphasis on the desirability of legal advice and legal representation at Tribunal reviews, than at Board reviews under the current Act. Having regard to the Stokes Report and the finding in that report about the standards of care in authorised hospitals, patients must be entitled to real, effective, legal representation when their liberty has been withdrawn or they are at risk from the setting in which they have been placed without their consent.

Without a high levels of legal representation for the more vulnerable involuntary patients, then the welcome provisions of the Bill binding the Tribunal to the rules of natural justice will be hard to identify and follow, and incorporate into improving reviews of the status of involuntary patients.

...

Expert legal representation is the most likely route to satisfaction that the breach of a person's most basic human rights were, are and continue to be necessary. This is a legal, not a clinical, decision that requires expert advocacy by lawyers.

It is really quite concerning that the bill seems to dilute the right to legal representation. If people are assumed to have a mental illness, they may be admitted as an involuntary patient. Provisions in the bill refer to a restriction on communication to people needing legal representation because it might be harmful. How absurd! Their advice should be provided to the lawyer who seeks to represent an involuntary patient. Then it is up to that lawyer to use their legal judgement on what action they take and what advice they provide to the patient. It is not up to the medical professional to decide what should be legally told to a lawyer. Information needs to be communicated to the lawyer so that they can provide the appropriate advice.

Clause 347(j) of the bill basically deals with mental health advocates and the Council of Official Visitors. It has been relayed to us that under clause 347(j)—I stand to be corrected, member for Kingsley—the Council of Official Visitors has access only to involuntary patients, not voluntary patients. Members might say it is appropriate that it not have access to voluntary patients—they are voluntary so they probably have the capacity to look after themselves—but that is actually not the situation in real life. Not only is there a blurred line between involuntary and voluntary patients, but also sometimes they are in the same ward. If they are in the same ward, that ward is locked. Also, voluntary patients have to seek permission to leave the ward. Surely they deserve the

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right to a visit from the Council of Official Visitors or a mental health advocate. That is something that I hope the government will consider.

In regard to clause 353(2) of the bill, the chief executive officer of the relevant agency has the power to issue directions to the mental health advocate. That is absurd. The mental health advocate is there to advocate for the patient in respect to their treatment and custody, which is under the jurisdiction of the CEO. The CEO, who has jurisdiction over the treatment, custody or detention of the patient, can direct the mental health advocate about what they can and cannot do.

Unfortunately, time is going to beat me but I will have further time in consideration in detail to deal with a number of matters. In the last few minutes, I will talk about the proposed powers of mental health practitioners. It is interesting that the Chief Psychiatrist, under clauses 535 and 536, will be able to designate a number of professionals, including registered nurses, midwives, social workers and occupational therapists, as authorised mental health practitioners. Once they are classified as authorised mental health practitioners they can initially detain a person for up to 72 hours, but if a transfer order is in place, a person can be detained for as long as seven days in the metro area and 10 days in the country. An occupational therapist or social worker suddenly becomes an expert in mental health and has the power to initially detain someone for 72 hours, and up to 10 days in the country. That is something that should alarm us all. The first draft of the bill in 2011, which was released for public comment, stated in regard to police officers that reasonable steps should be taken to ensure that a medical practitioner or a medical health practitioner is present when apprehending people suspected of having a mental illness. That no longer exists in the bill before the house, which is quite disconcerting.

Clauses 156, 162 and 164 authorise police to apprehend individuals in certain circumstances and to enter premises, conduct body searches and seize articles from the individual. They are very powerful powers. They are needed in some cases—I am not suggesting that is not the case—but consideration has to be given to a provision, when those powers are used by police, that they should be reported to the Chief Mental Health Advocate. The Chief Mental Health Advocate represents the best interests of the patients. I note under clause 145 that psychiatrists making an involuntary treatment order have to inform the Chief Mental Health Advocate and the Mental Health Tribunal. This is a large and complex piece of legislation before us. We support many parts of it. We think it is an improvement, but as I have stated we propose to move a number of amendments which I have outlined in some detail in my contribution to the second reading debate. We come to this in good faith and hopefully the government will meet us in good faith and consider our proposed amendments.

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [4:14 pm]: I rise to make some comments on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. In doing so I am reminded of a very important political lesson: one should never follow the member for Armadale! He has been given a good hour to contribute to the debate. Members know that their contributions will always lack detail compared to what the member for Armadale is capable of doing. I commend the member for Armadale for his contribution to the debate today. It is always a pleasure to hear his very considered, well researched and particularly well-articulated points of view in this place. He points out some very important issues, not the least of which was towards the end of his speech concerning clause 347(j), which I think is a very important aspect. What we are always trying to do with legislation is to achieve what the member for Armadale described as the balance between care for vulnerable members of our community and their rights—most importantly, their rights as a person—and the rights of their family and carers, and their dignity. I note that the objects of the Mental Health Bill under clause 10(1) include —

- (a) to ensure people who have a mental illness are provided the best possible treatment and care —
 - (i) with the least possible restriction of their freedom; and
 - (ii) with the least possible interference with their rights; and
 - (iii) with respect for their dignity;

We are trying to strike that balance. There are people who need care for their sake; not only for their own protection but also for the protection of others. It is incumbent upon us as a community to craft laws that achieve that balance to make sure we provide the necessary care.

The Mental Health Bill has been many years in the making. The consultation process started under the previous government. We have had two Ministers for Mental Health under this government. It has come up with this behemoth of a bill. I think it is a monument to the length and breadth of the consultation that has gone into this bill, but not a particularly strong recommendation for the crafting of the legislation in itself. When we go about crafting and drafting these pieces of legislation, we have to strike a balance between wanting to be overly prescriptive and overly regulatory and trying to ring-fence every single activity that we might envisage under the

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legislation and, in doing so, prescribe the behaviour that we see underneath that. That is very evident. For whoever wishes to look at the Health Act 1911, it is a great piece of legislation. It sets out how many goats a person is allowed to keep in their cellar. It sets out how often a person should clean out their dry closet—that is, toilet—and what should be done when stepping onto a bus. By the way, first of all a person who has a cold should inform the conductor that he has a cold so that the conductor can place him in the appropriate place in the bus! It goes about all those things that we now look at and say would never happen because we have regulations or guidelines based upon years of practice and principle to regulate these activities.

These mental health bills have been a very long time coming. The government has been in place for five years. I think the Minister for Health said that public health legislation would be introduced in 2011. He then said it would be introduced at the beginning of 2012; then it was the end of 2012. We are yet to see the new health bill. The minister said that when it is introduced it will move on from that style of over-prescription or that complete set of activities that was envisaged under the act. In doing so, it would set a modern regulatory framework for governing activities under the Health Act. We would expect to see a modern bill; a bill that sets out a framework of regulation rather than trying to nominate the activity and in doing so ring-fence it or corral it.

For that reason this piece of legislation is very long, complex and cumbersome, and does not do credit to a modern regulatory framework. I am surprised, for example, that it goes into such detail on issues of psychosurgery or electroconvulsive therapy whereas, as the member for Armadale has pointed out, the time for the application of those particular disciplines for adolescents has long passed. From that point of view, we would expect the draft of this legislation to take a more modern regulatory approach. It strikes me that a lot of the drafting of this legislation is based on some sort of *One Flew Over the Cuckoo's Nest* horror depiction of mental health services and, from that point of view, seems to be out of step with modern mental health practices.

I should also acknowledge that I have a bit of a conflict of interest in relation to this. My father was a child psychiatrist, having practised in the public sector for many years, and he headed up child psychiatric services in Western Australia, so I have had a rich diet of anecdotal or descriptive discussions around how we see mental health services going in the future. I might add that it was a good background to have when I was, for a short time, the shadow Minister for Mental Health, and it was a period of some reward.

Dr G.G. Jacobs interjected.

Mr R.H. COOK: It was rewarding as much as for the time I spent opposite the member for Eyre when he was acting in that capacity.

I have some appreciation for what we are trying to achieve here. We are trying to achieve the most sincere demonstration of a civilised society—that is, how we as a society go about treating those who are most vulnerable. Mental illness, and people with mental illness, must be the manifestation of some of the greatest vulnerability in society; therefore, it is incredibly important that the community responds to mental illness in a robust fashion that does not stigmatise the disease or disorder and that we have a very compassionate, well-resourced, robust and whole-of-government system to wrap around those necessary services. There are a range of mental illnesses, from those suffered by the subacute patients who need support in the workplace or home or in dealing with family relationships, which therefore manifests itself as a form of mild anxiety or depression—they too need assistance—right up to those who experience very acute or chronic psychoses and need protecting as involuntary patients in our system.

I give credit to the government in establishing, when it came to power in 2008, the Minister for Mental Health and the Mental Health Commission, because, if nothing else, it ignited a public debate around these issues and enabled a bright light to be shone into the area of mental health. I will discuss in further detail what I believe are some of the issues associated with the grand experiment of the Mental Health Commission and look forward to developing that issue further.

I am also very aware of what is becoming an increasingly fashionable concept in mental health—that is, the issue of support for subacute mental illness or disorders. Indeed, when I first became the shadow Minister for Health and mental health it was made very clear to me by my predecessor, the former member for Fremantle, that he believed that how we create capacity in the mental health system is to strongly build subacute services and, predominantly, supported community accommodation to make sure that we are driving and building capacity in our system around subacute services to ensure that we, therefore, have the capacity of acute level of care. That was reflected in the Stokes report, when Professor Stokes made the observation that we had enough mental health beds in the system. He went on to say that we should not pull back the number of acute mental health beds, because we still have a chronic shortage of subacute mental health services, but he did make the observation that we have a high level of acute beds in our system; indeed, that by and large has been the focus of a lot of the debate in this place and the media.

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One thing that concerns me as a result of that is the move away from a focus on acute mental health services, because we are looking at what has predominantly taken over the public debate—that is, mild mental illnesses such as depression and anxiety and the more subacute mental illnesses—and because of that we are taking our eye off the ball somewhat in acute services. We all know both anecdotally and statistically that there is going to be an increasing demand for mental health services into the future. We know from what we see in emergency departments that there is a growing demand for mental health services and we know from the public debate that there is a great deal of anxiety in our community about how to resource those.

Dr Richard Choong, the President of the Australian Medical Association (WA), stated as recently as this month in *Medicus*, the association's magazine —

Mental Health is an area of particular concern especially as the State Government is yet to implement the recommendations of the Stokes Review. While I have been briefed about some aspects of the Mental Health Plan and remain encouraged by its scope and detail, I am quite alarmed by the potential cost of creating and funding a sustainable mental health system, one that will meet the needs of Western Australians.

Perhaps my cynicism grows each year but I have a niggling feeling that in the current economic climate, mental health will once again not receive the funding it so desperately needs. The current system is underfunded but will the enormous injection of funds required ever eventuate?

We have fantastic doctors, nurses and mental health workers in our system, yet the exponential growth in demand for mental health services is overwhelming them. There is no doubt in my mind when I say that mental health is our Achilles' heel.

The comments of Dr Richard Choong are reflected in the anecdotal evidence that I see and hear daily in our health system. For instance, when I spoke to the staff and the chief executive officer of the Joondalup Health Campus and asked what was the biggest issue they were confronting, the CEO did not say that it was the volume of emergency department presentations or the high level of elective surgery they have to get through but the patients who present to the emergency department with a mental health issue and the fact that, as he laments, there is no capacity to place those patients once they present to ED. There is no capacity to accommodate those patients, which is the reason that we on this side of the chamber went to the election saying that we would immediately create an extra 28 mental health beds, particularly for young people, at that hospital by utilising the extra capacity that they have at that institution to immediately bring those beds into play. I note that if imitation is the sincerest form of flattery, the Minister for Health has moved in that direction to create extra beds at Joondalup hospital to meet that demand in the system. Just yesterday, I was touring Royal Perth Hospital with the Leader of the Opposition. When we do these tours, we are constantly pulled aside by staff at or visitors to the hospital who want to have a word in our shell-like about some issues of concern. One of their staff pulled me aside and told me to go to the ED where there were about seven patients with mental health conditions who had been sitting there for four or five days and were medically restrained because they simply did not have a place to go, and that when they do have a place to go, the hospital struggles to get the police resources to move them to the appropriate place. There is a huge demand.

Mr C.J. Barnett: Often staff requirements are greater. There's stress too.

Mr R.H. COOK: Yes, indeed. As the Premier pointed out, it is stressful for the staff and it sucks up staff resources. They have to medically restrain the patient and I can imagine that after four or five days that will take its toll on the patient and on the staff who have to supervise the patient. It is a huge gap in our system. I know these are not subacute mental health patients and they are not the sexy part of the debate, but they are a crucial part of the debate because how we treat them is what determines whether we are a civilised society.

[Member's time extended.]

Mr R.H. COOK: I draw the attention of the house to comments made by Hon Dr Graham Jacobs, the former Minister for Mental Health, when, in November 2008, he commented on the report of the Council of Official Visitors. He said —

The report has highlighted a significant shortfall in the standard of living conditions in a number of facilities, which include the Bentley adolescent unit and the Murchison ward at Graylands Hospital.

I might add that the Bentley adolescent clinic has since received some upgrades, but not so the Murchison ward at Graylands. I asked him in the May 2009 estimates hearing about the Graylands Hospital and the money that was in the budget at the time to create an extra 50 mental health beds at Osborne Park Hospital and therefore to create the capacity to do things at Graylands Hospital. At that stage funding was in the budget for planning for

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the upgrades to Graylands Hospital. In response, Dr A.L. Hodge, a representative on behalf of the minister, said the following —

The configuration of Graylands Hospital is still being determined and planning is going forward to look at what the needs for Graylands campus will be over the next few years.

That was in 2009. To continue —

Osborne Park does not currently have a 50-bed unit. The proposed 50-bed unit for adults will be on a greenfield site, so that number of beds will be made available at that site and there will be a reconfiguration of Graylands to accommodate those 50 adult beds being sited more appropriately at Osborne Park.

He said further on —

The 50 beds at Osborne Park are a direct transfer of 50 adult beds from Graylands; therefore, the system currently has those 50 beds, and we will continue to have those until the Osborne Park unit is opened.

I asked —

Does the redevelopment at Graylands Hospital include a redevelopment or refurbishment of the Smith and Murchison wards?

The minister said —

The whole issue of the redevelopment of Graylands Hospital has yet to be decided on. There are concerns for me and the government in that whole development and how to do it better for Western Australia.

That was in May 2009. For the benefit of members present, since then, that funding has been removed from the Osborne Park Hospital development and those mental health beds will no longer be there. That means that we are not in a position to look at the upgrade of those Graylands Hospital wards. In 2009 the Minister for Mental Health was correct when he said that we needed to do something about the Murchison ward. I do not know whether members have been to the Murchison or Smith wards at Graylands Hospital; it is a deeply distressing experience. There are some very disturbed patients being housed in substandard conditions and the staff work in what I regard as some of the most trying circumstances in our public sector. If we do nothing else, we must upgrade those wards. I know these acute beds are not the fashionable aspect of mental health at the moment but I believe sincerely that that is where we must be doing some work to make sure that those poor souls in those wards receive what the objectives of this bill refer to as “respect to their dignity”. I fear that until we undertake those upgrades, we will not have fulfilled that particular requirement of respecting their dignity.

As I said, this government has had a great opportunity with the establishment of the Mental Health Commission to bring policy focus to this area. I think some aspects of the Mental Health Commission have been very important, as has the appointment of a mental health minister. I am sure, at least in the greater interest of the public debate and the higher expectation by the community that governments perform in this area, that we needed a mental health minister at any rate. I have said before that my concern about the Mental Health Commissioner and the Minister for Mental Health is that we risk ghetto-ising a particular policy area. I hear a lot of discussion inside the Department of Health about the treatment of the Mental Health Commission and to some degree the disrespect with which the large Department of Health—the single biggest contractor to the Mental Health Commission—shows to its key contractor on those mental health services. I have always had a concern about the tail wagging the dog in relation to some of those things. In particular, the Department of Health still is a great driving force for the development of the capital component of mental health services and a lot of those types of issues. Greater emphasis needs to be put on continuing to strengthen the Mental Health Commission so that it can be the dog that wags the tail.

Mr C.J. Barnett: You talk about fashion, and I guess community living is desirable. Do you still consider it needs to be an institution, for want of a better word, in the more acute cases?

Mr R.H. COOK: Absolutely.

Mr C.J. Barnett: So do I.

Mr R.H. COOK: Indeed, towards the end of my time as the shadow Minister for Mental Health I received representations from families with long-term patients in Graylands. They were talked into having their family members transferred into supported community accommodation units. One of the problems with that, particularly for long-term patients, is that it takes them from a very secure environment and puts them into what they regard as a highly insecure environment, and that causes a great deal of stress. Also, at the time, issues were

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put to me about the fact that a lot of those supported community accommodation modules are run by non-government organisations. People had concerns about the standard of the delivery of those services. I am not in a position to comment on that but it was a concern of theirs. Their main concern was that once their family members had come out of the Graylands facility, they could not then get them back in because, after three months, their file at Graylands had been closed. Despite the anxiety of their family members wanting to get the person back into the secure environment at Graylands, they had trouble getting them back there. I understand there is an imperative to get people out of those acute facilities into the supported accommodation facilities.

Mr C.J. Barnett: I have been to a community facility that I thought was excellent and people were happy there. I think we are probably agreeing that some people, unfortunately, cannot survive in a community facility.

Mr R.H. COOK: That is right. Even though it is fashionable to talk about subacute beds, let us not forget that we have a very big obligation to continue to work in that area. I am hopeful that Mr Marney, in bringing the gravitas of his reputation to the position of Mental Health Commissioner, will assert the authority of the Mental Health Commission and continue to increase its status and, therefore, its influence.

I seek from the parliamentary secretary clarification of the number of acute, non-acute and other lower order or lower acuity beds that Bryant Stokes presented in his report, which was in 2011 or 2012. I ask that she update the house in her second reading response as to where we are relative to that particular table. I am interested to see what the growth has been in the number of subacute beds, particularly relative to acute beds. It is particularly important that we continue to put resources in this area. We must do it not so much out of choice, but as a result of the increased numbers of children who will present to the tertiary children's hospital with mental health conditions. Indeed, as we heard during debate about the new children's hospital, statistics suggest a 20 per cent increase from 2008 in the number of children presenting with mental health conditions. There is no choice in the amount of resources that have to go into this area, because we will continue to see a growth in mental health illness and in the demand for mental health services across the board. Bryant Stokes observed that mental illness represents the fourth highest burden of disease in our society after cancer, cardiovascular disease and neurological disorders. He also observed that it will become the third highest burden of disease in our society by 2016, which is a warning to this and future governments that they cannot clip the bill on mental health. We will continue to need resources in this area. I understand the fashion of subacute services, but we must continue to keep our foot on the pedal in acute services to ensure not only that there are acute beds, but also that those that exist meet our expectations as a civilised society so that we continue to sit within the objectives of this legislation, which is respect for patients' rights and dignity. Bryant Stokes further observed in his report that the treatment of mental health illness between 2006 and 2012 increased by 23.7 per cent. We have no choice about whether we increase funding for mental health services. We have no choice about whether we increase the number of acute and subacute beds. This will be a driver going forward in all health services. We need to increase our capacity to respond to the epidemic of mental health illness that will continue to inflict our society. As I said, I have some conflict of interest, because I do not believe that the overly burdensome, regulatory and prescriptive nature of the bill is required, but I acknowledge the bill has been anticipated for a number of years and that it is largely welcome by stakeholders because they want a modern act in place. I look forward to presentations from other members and, in particular, to the consideration in detail stage so that we can cross-examine the parliamentary secretary about individual aspects of the legislation.

MR D.J. KELLY (Bassendean) [4.44 pm]: I start my contribution on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013 by acknowledging what many members have said; namely, that dealing with mental illness is one of the greatest challenges we face in our community. Enormous stigma continues to be attached to the issue of mental illness. That stigma prevents people from talking about it and seeking assistance, and that often makes the mental illness with which people are dealing much worse. We need to do everything we can to ensure that we have an environment in which people can speak openly about their mental illness and seek treatment when they need it.

My first contact with mental illness in any significant way was when I worked for Carmen Lawrence in her electorate office for a period after she was first elected to state Parliament. Dr Lawrence had a particular interest in mental health, so many people would go to her electorate office seeking assistance. I was a fairly young chap with not much experience in that area. I was struck by the distraught nature of many of those who came to her electorate office seeking help. They did not talk to me about their actual mental illness; rather, they talked about how they found the system. Overwhelmingly they said that they felt helpless within the system and believed that things were being done to them rather than them being in a system in which they had rights and could exercise choice. They did not feel as though the system was there to work for them; indeed, the people who went to see Dr Lawrence overwhelmingly felt that the system was working against them. They had no control over it and did not understand it. They did not understand their medication or what they should do if their medication was not

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right for them. They went to her office with a range of issues that we would want people to feel comfortable with, but they did not. We on this side of the house applaud the bill to the extent that it tries to tackle improving the rights of patients in the system. That is one of the great challenges. The medical system can be intimidating even for those with a physical ailment. If a person is grappling with a mental illness at the same time, one can imagine how the difficulties are compounded.

It is often said that resources are not the be-all and end-all to solve a problem, which I accept. But it is very important to have resources in this area. There must be sufficient resources in the system, firstly, to make sure that there is a certain standard of care. In a state such as Western Australia, we need to provide a first-class standard of care. Secondly, we need to ensure that there is access to that care. There is no point in having high-quality care if not everyone in Western Australia can access it. Thirdly, within that care there has to be a strong system of patient advocacy. Unless all three of those components are in place, we are not doing, as we should be, the best by those with a mental illness. The government can introduce the best of bills, but unless it provides the resources, the system will fail to provide quality care, access to that care and patient advocacy.

I am concerned that the current appetite within the state government for cutting budgets will jeopardise the resources that are needed if the mental health system is to work. Cuts are going on left, right and centre across the public sector, and those in the mental health area with whom I have spoken have said that such cuts are inhibiting their ability to provide quality care. They are being asked to do more with less. In this particular field, it just simply cannot be the case; it is not possible.

I will raise a couple of particular points about resourcing, funding and money—that is, where it is going. We have seen publicised in the last week or so the salary of the new Mental Health Commissioner. Former Under Treasurer Tim Marney was on a salary of over \$400 000 a year. He has taken that salary over to the new position of Mental Health Commissioner, a position his predecessor did on a salary of \$265 000 a year. There is an enormous disparity between the current salary for that position and the salary of Mr Marney's predecessor. That sort of issue fuels the view of many people in the public sector and in the community generally that there is one set of rules for people who are at the top of the employment chain, and another for the people who are at the other end—or the front line of delivering services in the public sector.

Government members might say, "Well, the former Under Treasurer had a contract with a salary attached to it; he is entitled to get the benefits of that contract." I do not have a problem with his contract. However, the government has made a decision. It wanted a new Mental Health Commissioner. It asked Tim Marney to come over and take that new role and he has taken the salary. If he did not want to take a salary cut, he could have continued to work in his existing position. There was no compulsion for him to take his new role. He was not being made redundant in his old position; it was simply his desire and the government's desire for him to change roles. Therefore, instead of taking up a salary similar to that of his predecessor, Tim Marney is on a salary of \$150 000 more. Comparing that to someone who works at Graylands Hospital in mental health in the public sector, we see that if that person at Graylands, whether he or she be a patient-care assistant, a nurse or a cleaner, is made redundant in the system and redeployed, under this government's legislation they can be redeployed to a position with a salary of 20 per cent less than the one they are currently in. They are doing their job. However, the government makes a decision telling a nurse that his or her position is redundant at Graylands Hospital, Osborne Park Hospital or somewhere else and that he or she will be redeployed into another position in the public sector. Under the redeployment, retraining and redundancy provisions or regulations made under the Public Sector Management Act 1994, workers can be redeployed and be forced to take a 20 per cent pay cut, which causes great concern in the public sector. Many people at the lower end of the pay scales in the public sector really cannot afford to take a 20 per cent pay cut. Who can? But that is the legal framework that this government applies to people on the front line. That will happen to a patient-care assistant earning \$50 000 a year or less. He or she will be redeployed and face a 20 per cent pay cut. Members opposite can say that is not going to happen, but it does happen. In my previous job at United Voice, I know we had people who had that happen to them. That is why, when we renegotiated our enterprise bargaining agreement during 2012, one of the provisions that we sought and bargained for were provisions in the EBAs to ensure that that sort of redeployment with the consequential pay cut did not occur. It is very disappointing that the industrial relations legislation that the Premier brought into this Parliament will override that provision.

What has happened to the salary of the former Under Treasurer when he became the Mental Health Commissioner? He is maintaining his much higher salary. This just fuels the view of many people in the public sector that this government has one set of rules for people who are doing particularly well, and another set that applies to most other people in the public sector. I will also make one other point about the issue of resources and priorities by saying something about the shark cull issue. Members might ask what on earth that has to do with mental health in this debate.

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A government member: What does that have to do with mental health!

Several members interjected.

Mr D.J. KELLY: I am glad members asked! I attended the first rally that was held at Cottesloe Beach. After that rally I spoke to some of the 4 000 people who showed up. There was a woman there who had had one of her children take her own life just the year before. She was standing there with a sign; I cannot remember exactly what it said, but it was basically: why is the government spending money on the shark cull when there is not enough money for mental health services? She was obviously still grieving for her child who had taken her life that year. However, one of the things that irked her about the shark issue was that the government had, in a climate of cost cutting, found an amount we now know is probably in excess of a million dollars to fund the shark cull. This is at a time when her daughter was going through some very dark times and when, as a family, they really struggled to get the services she felt her daughter needed. It is very much about priorities; it is very much a question about where the government wants to spend its money. The timing of the beginning of the shark cull was interesting. We kicked off the shark culling in January of this year. Also in January of this year, a report by the WA Ombudsman found that suicide amongst 13 to 17-year-olds is now the most common cause of sudden death in Western Australia. Of the 123 deaths of children of that age bracket, 39 per cent of youths had taken their own lives, 29 per cent had died in car crashes and 14 per cent had died from other medical conditions. Therefore, the most common cause of unexpected death for young people in Western Australia between 13 and 17 years of age is not shark attack, it is actually suicide. That is a terrible statistic. Most people will say that it is young people hooning around in their cars, taking drugs and doing all those sorts of ratbag things, but it is actually suicide.

Returning to the point that the woman at the rally was making, it is about questions of priority. It is interesting what the government spends its money on. A report into youth suicide is coming out in January and the government has announced that it will spend an extra million dollars on the shark cull. While I am on the issue of youth mental health—I am the shadow spokesperson for youth—I just wanted to make the point that mental health services need to be appropriate for young people. It is not the case that by making these services available anyone in the community will access them. Young people need specific services that cater for their needs. They need to be accessible through environments in which young people feel comfortable enough to participate. I acknowledge and thank the role that organisations such as the Youth Affairs Council of Western Australia play in advocating in this space. The CEO, Craig Comrie, and his staff do a really good job in this area. We very much need to be conscious of the fact that youth need services that meet their particular needs.

I move on to another issue that has taken up quite a bit of my time since I came to Parliament. At first blush, people might ask what that has to do with this debate. The issue is the two disability justice centres that will be built in my electorate. Prior to the state election, there was going to be one in Herne Hill and one in Kenwick. The government retreated from that plan very promptly after some community concerns were raised. The government and the minister said that they would re-look at it, that there would be more consultation and that they would revisit the sites. After the election, the minister chose to put both centres in the Lockridge area. Both centres are very close to Lockridge Primary School, Lockridge Senior High School and Good Shepherd Catholic School. There was no consultation whatsoever with the community. Members of the community just got a letter stating that it was going to happen. The reason that is relevant to this debate is that those centres are for people who have an intellectual disability, not a mental illness. If a person with an intellectual impairment is charged with an offence, they cannot go through the criminal justice system, so these centres are an alternative to prison or to release directly into the community.

[Member's time extended.]

[Quorum formed.]

Mr D.J. KELLY: As I was saying, the two disability justice centres that are planned for my electorate are for people with an intellectual impairment. The Mentally Impaired Accused Review Board, which makes decisions on whether someone meets the criteria to go into one of these centres, has said explicitly that it would like disability justice centres to be built for people who have a mental illness. Sixty-five per cent of the people who come before the Mentally Impaired Accused Review Board have a mental illness, so this government, to its credit, is building centres for people who have an intellectual impairment. The Mentally Impaired Accused Review Board wants similar centres for people with a mental illness. This is relevant to this debate because the government has made such a hash of locating suitable sites for the disability justice centres for people with an intellectual impairment that it is making it much more difficult in the future to locate centres for people who have a mental illness.

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These types of facilities will always have the potential to be controversial in the community. To minimise the controversy around these sorts of facilities, the government should have a rigorous process to identify suitable locations so that people do not feel as though their particular community is being singled out and awarded these types of facilities through politics rather than good policy processes. Everything the government has done on the disability justice centres in my electorate shows that the location choice was about politics, not process. The Minister for Planning shakes his head; I am glad to see that he is awake. Before the election, the government was going to put one centre in Kenwick and one in Herne Hill; they were going to be separated. Then the government said that it got it wrong and there was going to be consultation. After the election, there was no consultation and it announced that it would put both centres in one community, about one kilometre apart. All of a sudden when the government was asked about that, it said that it was absolutely necessary that they be close together so that staff could move between the two centres. Twelve months ago, one centre was going to be in Herne Hill and one was going to be in Kenwick. Now the centres have to be together. The government set criteria. The criteria basically required that the centres not be located next to residential areas or schools. Both these centres are in residential areas and are very close to schools. Members of the community are in uproar about it. They are doing everything they can to get the government to change its mind. There has been a lot of media about the issue. It just highlights to the community that these locations were chosen based on politics, not good policy.

Mr J.H.D. Day: The one that is currently going ahead is actually on a Disability Services Commission site that has been used for people with disabilities in the past. That is relevant.

Mr D.J. KELLY: Minister, that is absolutely correct. That facility has been there for a long time. The people in that community have accepted and welcomed that facility. The government is changing it from a centre for people who have an intellectual disability but who are quite safe to be in the community to a medium-security custodial facility—this is what the minister told me—for people who the Mentally Impaired Accused Review Board has determined pose such a threat that they cannot be released into the community. It is a very different use, minister. When the government asked where it should place these centres, the criteria required that they not be in residential areas and not be close to schools. The government knows that Lockridge Primary School, which is a fantastic primary school and one of the newest primary schools in the state, is 400 metres down the road. The people who live across the road from the centre are concerned enough, but the whole Lockridge Primary School community feels as though it has been disregarded. Just because the Disability Services Commission owns that site, it does not mean that the government can do anything it likes with that site. If it was such a great site, why was it not identified last year? The point I am making, minister, is that this government has made such a hash of locating these two facilities that —

Mr J.H.D. Day: So what is your suggestion?

Mr D.J. KELLY: My suggestion, minister, is that the government look at its own criteria and find sites that meet those criteria. It is as simple as that. I am not in government; I do not know all the land around Perth. I certainly think the Mount Henry Hospital site, which was on the list of sites identified as a possible location, would be worth considering. I do not know why the government disregarded that. There is a lovely site in Cottesloe that was identified by the Western Australian Planning Commission as a possible site. I do not know why that was taken off the list. If the government had gone through a proper process, come up with proper criteria and applied those criteria, I, as the local member, would be hard-pressed to argue against it. The fact is that it did not. Given that the government has not done that, it will be very difficult when the government gets around, as I hope it does at some stage, to building disability justice centres for people with mental illness. I think the government has made it very difficult for itself to identify a community that will accept the centres without a similar sort of controversy.

I turn to a couple of points that people have raised with me. Hopefully, the member for Kingsley will adequately address these in the debate. It has been raised with me that the definition that determines how someone can be deemed an “involuntary patient” has been broadened rather than tightened. It goes without saying that making someone an involuntary patient in the mental health system is an enormous step to take. The member for Armadale has referred to aspects of the bill that are unsatisfactory; the idea that someone could potentially become an involuntary patient for fear that they will otherwise damage their reputation seems a fairly unsatisfactory proposition. I would have thought that to be made an involuntary patient in the mental health system would have serious consequences for a person’s reputation. To be made an involuntary patient to protect someone’s reputation seems to be a pretty odd way of addressing whatever issues that person has. Our understanding was that questions of reputation would be removed from this bill, but that does not seem to have happened. The new criterion that someone must be in danger of causing serious harm to themselves seems to be broad enough to include damaging their reputation, so that is a concern to us. I have also been told that certainly on one reading of the definition, “causing serious harm” may also extend to other persons. Someone could by

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their behaviour, for example, damage the reputation of someone else. If that is the way that the definition works, it is a hugely concerning issue.

I also raise another definition issue in the bill. It has been raised with me that the definition of “psychiatrist” in clause 4 is of concern. Paragraph (a) is quite straightforward but people have questions about paragraph (c) —

psychiatrist means a medical practitioner —

- (a) who is a fellow of the Royal Australian and New Zealand College of Psychiatrists; or
- (b) who holds specialist registration under the Health Practitioner Regulation National Law (Western Australia) in the specialty of psychiatry; or
- (c) who holds limited registration under the Health Practitioner Regulation National Law (Western Australia) that enables the medical practitioner to practise in the specialty of psychiatry;

The concern raised with me is that someone who is not a psychiatrist can be defined as such in the bill under paragraph (c). People will read the bill and see that psychiatrists have all these powers over people’s lives, but when we look at the definition of “psychiatrist” in the bill, it does not mean someone who is a psychiatrist in the way that many people would understand. I ask for clarification from the member for Kingsley on that issue.

Lastly, I want to touch again on the issue of advocacy for people with mental illness. In my view, the Mental Health Law Centre does a fabulous job. It is absolutely imperative that that service continue to be funded well. There is no point in legislating for rights if people cannot exercise them. Specialist facilities and agencies such as the centre need to be supported by this government. I commend Sandra Boulter and her staff for the work they do and I urge the government to continue to support the centre.

MS M.M. QUIRK (Girrawheen) [5.15 pm]: In 1922, a royal commission into mental illness was called in Western Australia after accounts over many years of maltreatment, violence, misconduct and unsuitable conditions and overcrowding. This was partly due to the numbers in care being boosted significantly after servicemen returned from World War I. That royal commission’s report has the rather Pythonesque title of “Report and Appendices of the Royal Commission in Lunacy”, but it is worth referring to it. One of the conclusions of the royal commission that I particularly want to make note of is —

An emotionalism which has effected the judgment of many persons of ill-balanced mentality has resulted in the publication in the Press of incredible or distorted tales reflecting on the character of an institution and staff whose service presents difficulties wholly unintelligible to the average individual. The management, harassed by the inability to obtain supplies and effect repairs, often short-handed and fettered by demands for economy, has found its task one of extreme difficulty, and has not always succeeded in putting forth its best efforts, but no sense of dishonour attaches to it, and your Commissioners believe that if the majority of the suggestions which they submit for your approval are adopted, the difficulties of the management will practically disappear and the Department will take a deservedly high place in the estimation of the people of this State.

I hope that nowadays those patients would get a better hearing than they received in that royal commission, but I am saddened that the observations about the lack of staff and resources still have much resonance today. Moving on almost 100 years, I refer to the “Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia” prepared by Professor Bryant Stokes, AM, in July 2012. For the sake of economy that is referred to as the Stokes report. According to the Stokes report —

In Australia, one-third of the population experience mental illness at some time in their lives and mental illness ‘accounts for 13 per cent of the total burden of disease ... and it is the largest single cause of disability’ ... The illness affects all ages across a lifetime and is the greatest risk factor for suicide ... Mental illness has far-reaching effects on WA’s community. Currently, mental disorders rank fourth highest burden of disease for men after cancer, cardiovascular disease and neurological disorders and is predicted to rank third by 2016. In 2006, mental disorders ranked second highest for women after cancer. By 2016 these rankings are projected to be reversed, with mental disorders accounting for the greatest burden.

From these figures, Dr Stokes noted —

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 and carers.

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This act, in my view, will not make the role of those charged with the care and treatment of the mentally ill any easier. No doubt it will be frequently observed over the next few days how cumbersome and unfathomable an act it is. It comprises 583 sections, two schedules and over 400 pages, and also contemplates making regulations. It is hard to fathom that every prescription set out in this legislation is apparently not enough and there may well be regulations. There is ample repetition throughout the legislation and, I have to say, very annoying cross-referencing, which I will refer to later. There is also, annexed to the legislation, a charter of rights; I will also address that in more detail later. As a general principle legislation should enable those affected to understand how the law applies to them. I believe that the nature of the drafting of the bill will add to the burden of staff who want to ensure that they comply, and I will give some specific examples later. We have a situation in which the bill is highly prescriptive, whilst at the same time has a charter of patient rights that is supposed to act as an overriding aid to interpretation and legislative intent. What I call the unwieldiness of this legislation has in part been created by consultation. I certainly welcome the consultation process—this is an area in which many in the community have a very acute interest—but we have ended up with what is sometimes called “a camel is a horse designed by committee”.

It is impossible in the time allocated to address all of the issues and concerns that the opposition has with the 400-and-something provisions, so I will focus on what can loosely be called conferral of powers and accountability mechanisms. The first power I will look at is under clause 348, the creation of a Chief Mental Health Advocate. The Chief Mental Health Advocate is appointed by the minister and this has raised concerns in some quarters because, unlike other positions such as the Commissioner for Children and Young People, the Ombudsman, the Public Advocate, the Inspector of Custodial Services that are not ministerial appointments, this implies that there is a lack of the independence that the opposition believes there should be in a position like this one. Of course, the holders of the positions I referred to—the Ombudsman, the Public Advocate and the Inspector of Custodial Services—I think can only be removed by the Governor. I think that is a very important provision for maintaining independence and enabling the Chief Mental Health Advocate to act without fear or favour. In the same way, I think the Chief Mental Health Advocate should report directly to Parliament, as do the Ombudsman, the Inspector of Custodial Services and the Commissioner for Children and Young People. Another incursion into the independence of the Chief Mental Health Advocate is the power conferred on the minister and the chief executive officer of the Mental Health Commission to issue directions under clause 354. No doubt it will be argued that there is a level of transparency there because any such direction has to be tabled in Parliament. However, I think that is illusory rather than real independence and certainly the same issue was raised by Professor Stokes in the context of the role of the Chief Psychiatrist. In his report, Professor Stokes noted —

This Review is concerned with some aspects of the Mental Health Bill as follows:

- The Office of the Chief Psychiatrist (OCP) would benefit from being external to the Mental Health Commission and the Department of Health, acting independently and reporting directly to the Minister for Mental Health and the Minister for Health.

That is rather than being within the agency itself. Professor Stokes’ report continues —

This would empower the OCP to carry out the duties specified in the Bill without any conflicts of interest.

- Such independence would enable the OCP to develop guidelines, monitor continuous quantity improvement (particularly investigations of deaths and other incidents), patient advocacy and support to mental health staff from purchaser and provider associations. It is the Reviewer’s opinion that for the Chief Psychiatrist to report alone to the Mental Health Commission or the Department of Health raises major issues of conflicts of interest.

Although Professor Stokes talks about the Office of the Chief Psychiatrist reporting directly to the minister, he still raises the issue of the perception of independence and how it is important that officers such as the Chief Mental Health Advocate are conferred with a level of independence, so they can do their job without fear or favour. Not only does the provision in clause 354 compromise the perception of independence, it might also have the effect of, if you like, dragging the advocacy service into the vortex of the Mental Health Commission and the Department of Health’s much larger departmental procedures. It seems to me that the Chief Mental Health Advocate must be free to express from a consumer’s perspective concerns about the Mental Health Commission and the Department of Health, and if it is too closely aligned with these agencies that certainly hampers that role.

Another concern is that the Chief Mental Health Advocate does not cover voluntary patients other than those referred from an examination. This includes children who may have been inpatients for many months and could

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arguably be just as vulnerable. They will not be entitled to advocacy protection unless the minister so directs. I understand that this exclusion is about resources and money, and I think that it shows complete disregard for the vulnerability of many people in need of advocacy. It is my view that consideration should be given to extending advocacy services to voluntary patients in certain circumstances, for example, young people under the age of 18 irrespective of whether they are voluntary or involuntary. There is also another category of patients who are voluntary for a period and then involuntary and then voluntary and so on, and if the period spent as an inpatient is longer than four months, they should attract an advocate to act on their behalf. This is a major loophole; these patients are in the same conditions as involuntary patients much of the time and they should have the right to have their treatment reviewed and not wait the six months currently prescribed before they can have a review of their treatment.

There is also a group of people who might be voluntary per se, but, although they were admitted to hospital, that admission might have been made by their guardians because they have cognitive impairment. I think that this group should have the right to have advocates act on their behalf. Also, irrespective of the time that they are being treated, any inpatient who is physically or mechanically restrained and wants assistance to exercise their rights should have the capacity to do so. Similarly, inpatients who are on a ward, who have been secluded and who want assistance should be helped to exercise their rights in relation to seclusion.

The other category of patient who should have the right to and access to advocacy is inpatients on a ward for whom English is their second language. I am thinking mainly of people from culturally and linguistically diverse backgrounds and vulnerable Indigenous people. Those two categories are currently excluded if they are voluntary, even though they, themselves, are unable to articulate serious concerns about how they are being treated.

Submissions also suggest that the Chief Mental Health Advocate should have the function of educating people. That role is not included in the legislation, but it is important that it is included because this is complex legislation and it will be a major role for the Chief Mental Health Advocate. By not including that very important role in the legislation, one would presume that no budgetary allowance will be made for it. Likewise, I think there needs to be an explicit requirement in the legislation for mental health advocates to inspect hospital wards and hostels a specific number of times each year. I am extremely familiar with the regime operated by the Inspector of Custodial Services in prisons. I think a similar regime should apply here. It is a no-brainer that involuntarily detained patients should have the same level of protection afforded to prisoners. Inspection regimes of this kind are proactive and preventive, and they fix systemic problems.

I am well aware that the elephant in the corner of the room is the resources provided to public health advocates. At our briefing on the bill last year we could not get an indication from the bureaucrats of what resources are contemplated being given to mental health advocacy. In a way, we are debating this whole issue in a vacuum. The effectiveness of mental health advocacy will only be as good as the resources given to it.

The Optional Protocol to the Convention against Torture—commonly known as OPCAT—may also come into play at some stage. I am not sure that that has been considered. OPCAT is a treaty that Australia is contemplating acceding to. OPCAT requires an independent inspection service. The commonwealth government is moving towards ratification. This treaty aims to prevent the mistreatment of people in detention, including psychiatric institutions. OPCAT establishes a two-pronged process for inspecting places of detention: the first is periodic visits by the United Nations' Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment; the second is the creation of an independent domestic mechanism requiring regular visits to places of detention and monitoring of the treatment of people in such places.

[Member's time extended.]

Ms M.M. QUIRK: Learned researchers Professors Richard Harding and Neil Morgan noted, in the context of New Zealand—where OPCAT has been operating for some years—that the inspection regime under OPCAT disclosed some unexpected results; namely, that closed psychiatric institutions more than the expected areas of prisons and police lockups were the places where cruel, inhuman or degrading treatment was most commonly encountered.

In the context of transport orders, I note that this bill will in fact permit other persons to transport the mentally ill rather than the restricted conferral of those powers on police. Police have argued at length for many years that the use of police to transport persons with a mental illness is wasteful and time consuming. This bill permits other people to fulfil that role. But one would not be overly cynical to suspect that a company like Serco will get that role. I would like the parliamentary secretary, in response, to give an indication of who this bill contemplates will fulfil the role of transport officer. I have looked at the definitions in the legislation under clauses 4 and 147;

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it does not need to be a public servant subject to normal constraints and discipline. I think that in itself begs the question.

I will briefly look at some of the apprehension, search and seizure powers. Clause 156 of the Mental Health Bill 2013 is headed “Apprehension by police officer of person suspected of having mental illness”. I make the general point that although the provision requires the taking of a person as soon as practicable for assessment by a medical practitioner, I believe that police receive inadequate training to deal with not only people with mental illness but also in de-escalation. With the time and money police will save if they no longer have to transport persons with a mental illness, I believe that money should be redirected within police to invest in better training in this area so that police can deal more appropriately with people with mental illness generally.

Part 11 division II of the bill deals with search and seizure powers. It allows people other than police officers to conduct searches both of the person and anything seized from the person. Persons other than police are not authorised personally but as a class. I consider that either police officers alone should be allowed to exercise such powers—or should at least be present when such powers are exercised—or, worst-case scenario, the powers should be exercised by a named authorised person rather than a class of person. That way we can ensure that those people have proper training and know what their responsibilities are under the bill. Authorising whole classes of persons—especially transport officers, which I referred to previously—who may have another employer may mean that accountability lines start to get blurred, which is highly problematic. It also appears there is nothing in the bill to suggest that this part relating to search and seizure would not apply to children and people who do not have the capacity to understand. A separate clause should have been included along the lines of, “No child or person without capacity is to be searched or have property seized from them without a parent or guardian or other appropriate adult present, except in cases of imminent and serious harm to themselves or others.”

The provisions relating to the Mental Health Tribunal are relatively complex. I make the same observation I made about the Mental Health Bill generally: the Council of Official Visitors noted in its submission on the bill that the provisions relating to the Mental Health Tribunal remain complex. It has a number of concerns about the complexity and extent of patients’ rights to apply for a hearing and representation at Mental Health Tribunal hearings. In relation to the timing of hearings, the council’s submission is that the provisions are too complex with references to “prescribed number of days” making it more difficult to work out when a review is due. References to the person having been an involuntary or voluntary patient continuously creates loopholes for certain patients such that they might miss out on a review. The council notes that, adding to the complexity of working out people’s rights to a hearing, there are a number of patients who will regularly move backwards and forwards between voluntary and involuntary status while remaining in hospital. This blurs their entitlements and the time under which certain rights can be exercised. The Council of Official Visitors also considers there needs to be a separate provision allowing a mental health advocate or lawyer to make urgent application to the Mental Health Tribunal, and a reciprocal section requiring the Mental Health Tribunal to organise an urgent hearing when the advocate or lawyer has identified that the person may be detained illegally; for example detention orders may have expired or there has been an error made in the process of making the person “involuntary”.

In short, the council’s submission concludes that patients’ rights to apply for a review are considerably more complex and restrictive of patients’ rights than section 142 of the current act. Moreover, the bill no longer gives the patient an unfettered right to have legal representation in Mental Health Tribunal hearings. The Mental Health Tribunal has the power to exclude a person from a hearing. It is unclear whether this includes chosen representatives and the basis upon which such exclusion orders should be made.

I now revert to a matter I raised at the beginning—that is, the drafting of this legislation. The level of complexity is staggering and the use of cross-referencing is in epidemic proportions. In one subclause alone, clause 337(1), I found cross-references to 10 other clauses, and that was by no means an isolated incident. I also refer to the charter of patient rights, which I have to say again is full of language that verges on jargon and does not increase patient’s rights one iota. As I said, the charter of mental health care principles, at clause 11, is a rights-based set of principles that mental health services must make every effort to comply with when providing treatment, care and support to people experiencing mental illnesses. Then clause 12 states —

Compliance with Charter by mental health services

- (1) In this section —
mental health service includes a private psychiatric hostel.
- (2) A mental health service must make every effort to comply with the Charter of Mental Health Care Principles when providing treatment, care and support to patients.

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Clause 11 describes it as being a rights-based set of principles, but these rights are unenforceable. The charter is really no more than a motherhood statement or, in some cases, statements of the bleeding obvious. I am at a loss to understand why that charter is even annexed to the legislation. There has been a huge attempt to be prescriptive but that has been put in as a cover-all or aid to interpretation, when in fact it is probably an acknowledgement that most of the bill is totally incomprehensible and needs that assistance.

It is very difficult to cover all of the aspects of mental illness in the time available, but it would be remiss of me not to say that we have all had a considerable amount of correspondence concerning electroconvulsive therapy. I suspect that in the consideration in detail stage there will be a lot of discussion about that. I do not want to express an opinion on it because I am not a medical expert, but certainly the checks and balances need to be there.

I also note that on average there are 260 suicides in WA a year, many by young men, many Aboriginal, and it is my fervent hope that the resources that are directed towards the suicide strategy are not diverted to ensure the implementation of this bill. That should remain quarantined. As the member for Kimberley said, this is a burning issue and very important.

I make the general observation that this legislation will be of little utility if there are not the resources required to pay more than lip service to the charter. The resources of the Mirrabooka mental health service, for example, which my office deals with frequently, are so stretched that each case worker has a client load of 60 people. That is simply unacceptable. We will know if we have made progress with mental health in this state when we can pick up the 1922 royal commission report and not recognise issues as still being current today.

MR P. PAPALIA (Warnbro) [5.43 pm]: I rise to address the Mental Health Bill 2013. At the outset I make an admission that a large number of my comments will be drawn from the excellent submission to members of the WA Parliament from the Health Consumers' Council WA and its senior advocate, the former member for Bassendean Martin Whitely, who has put together a really good package. If members have not read it, they should. It is very detailed, concise nevertheless, and it also addresses some of the key issues that this debate should address. I will, therefore, refer repeatedly to it and I have a couple of things to add at the end. I may repeat some of the things that the member for Armadale has already put on the record, but it is worth noting, and I foreshadow that we will be very interested in these particular parts of the bill in the consideration in detail.

I turn first to the criteria for being made an involuntary patient. The point made by the Health Consumers' Council, almost inadvertently, judging by the Minister for Mental Health's comments on this particular subject, is that there has been an unintentional broadening of the criteria for involuntary patients. In an effort to reduce the number of criteria for which people can be made involuntary patients—reduce the complexity, I guess—they have gone from a much greater number of words but they have increased the capacity for someone to be deemed an involuntary patient. I assume it is an inadvertent outcome because, as the member for Armadale said, the minister's comments on radio would suggest that she thought the criteria had been reduced; however, what they have effectively done with the legislation is expand it by adding the phrase "a significant risk of serious harm to the person or another person" can be used as one of the criteria for an involuntary treatment order. That seems incredibly broad and to enable a flexible analysis whether someone could be deemed an involuntary patient one simply has to ask: what does serious harm mean? It is a very subjective phrase and could be applied liberally and result in more people becoming involuntary patients than under the former criteria. That is a reasonable question to ask of the legislation. The submission of the Health Consumers' Council was that we revert to the 1966 approach, specifying all the different types of criteria but remove the provisions relating to damage to reputation, for obvious reasons. It is a different time and we do not necessarily believe that is an appropriate criterion nowadays. The submission made by the council is reasonable and should be considered. I hope that the government, and at least the Parliamentary Secretary to the Minister for Mental Health, will provide a response specifically in relation to that one.

I will not cover all of the points made in the submission of the Health Consumers' Council, but I will now go to the powers of authorised mental health practitioners. The member for Armadale raised this matter very articulately, but I have to share my concerns about this. It is extraordinary that under the proposed legislation the Chief Psychiatrist can designate social workers, occupational therapists, registered nurses, midwives and psychologists as authorised mental health practitioners and then, through a series of other clauses and consequences of the bill, those people can cause someone to be detained for up to seven days in the metropolitan area and 10 days outside the metro area. Under the counterterrorism legislation a person can get 14 days maximum detention without trial. Under this legislation a person can get almost that for being a mentally ill person in Western Australia. It is worth considering whether this is too liberal an application of such powers. I share and agree with the Health Consumers' Council of WA's submission that there needs to be an automatic

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process of timely independent review. That makes sense. All of those types of people, of varying degrees of skill with respect to mental illness, should not be making decisions about people that could result in those people effectively being locked up without recourse to anyone and without some sort of oversight. There should be a process of timely independent review. The council's proposals sound reasonable to me. I will leave the amendments to the lead speaker from our side.

The next issue I want to talk about and expand on a little beyond the submission from the Health Consumers' Council is police powers. The council made a very good point that the police are empowered to do a lot of things, including enter premises, conduct body searches and seize virtually any article from the individual suspected of having a mental illness on the grounds that they are suspected of having a mental illness. The police will be doing that analysis. The individual can then be subjected to all those sorts of things. As was pointed out by the member for Armadale, someone who commits a crime in Western Australia has a lot more rights than that. It is reasonable to ask a lot more questions about police powers. I will go beyond this particular question from the Health Consumers' Council to talk about some concerns I have had for some time. I raised this matter as early as 2010 when it became apparent post the first 18 months of the Barnett government that there was an enormous increase in the prison population in Western Australia. In 18 months there was a 27 per cent growth in the prison muster, which is an extraordinary rate. It was clear at that time that a lot of people who were not serious criminals were contributing to that growth. The Chief Justice at the time said —

... if there are any general characteristics of the recent prison intake in Western Australia, they include psychiatric disability, economic disadvantage (evidenced through an inability to pay fines), Aboriginality and offending at the lower end of the spectrum.

Nothing has changed with respect to the reason for the vast majority of growth in the prison muster. There are record numbers in our prison system at the moment; there are more than 5 000 people. To put that into context, there are 5 000 people in our prison system, which is about the same number of people in Victoria's prisons, which has twice the population of our state. It is extraordinary that we can look at those statistics yet they garner no great debate in Western Australian society. Some perfunctory statements were made by the Minister for Corrective Services when he first got the job about trying to prevent people from going to prison in the first place by focusing on reducing recidivism. That is all laudable, although they only reflect comments I made four years ago. Nevertheless, it is nice that the minister read my speech and some of the papers I wrote and plagiarised the effort, because it reflects sanity. It indicates a serious concern, I hope, in government about the massive increase in the cost of the prison system due to the stupid policies that have resulted in this massive growth in prisoner numbers.

As indicated by the then Chief Justice, a large part of that 27 per cent increase in 18 months is attributable to people who suffer psychiatric illness. We have to ask: what happens when someone is suffering from a mental illness who may be in psychosis or whatever the case to such an extent that the police have been called by a family member, neighbours or a hospital with the intent of having the person transferred to a secure psychiatric facility? What happens to those people? I have asked how often that occurs. When I asked that in 2010, I was told it had occurred 382 times in the previous 12 months. That is more than one a day. I asked a number of other questions that flow from that. At that time it was topical because the government had introduced mandatory sentencing for assaults on police officers. I asked a question related to mentally ill people encountering police in these situations: after being called to conduct a mental illness escort to a secure facility, how often have the police been assaulted by the individual who was mentally ill, which resulted in a charge that could have subjected the individual to mandatory sentencing in the event the individual was charged and found guilty? The government could not tell me; it had no idea. The government's explanation, which it gave twice—I asked the question a couple of times over the years—was that police databases that indicate why police are called out and their role when they attend a task cannot talk to the database from health that might indicate a person has been called out for someone with a mental illness. Even two databases within WA Police—one for mental illness responses and one indicating why someone has been charged—do not talk to each other. In 2010 the police commissioner, therefore, was incapable of saying how many police officers had been assaulted by a mentally ill person when the only reason the person had come into contact with the police was that someone had called the police to escort the person for health treatment. I suspect that nothing has changed, although I have not asked again, but I should ask the same question I asked in 2010. Nothing has changed. It is timely that when we are debating this legislation we ask those sorts of questions. The submission by the Health Consumers' Council said —

Mandatory reporting to the Chief Mental Health Advocate (like that required in clause 145 described above) of instances where the Police use these powers would help to ensure that these powers are used responsibly.

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I can tell members that it might also help Western Australians find out how often people who are mentally ill encounter police for no other reason than someone has called the police to escort the person to a secure mental health facility and then there has been another consequence. It might point out the stupidity of some of our laws when they are applied to people suffering from a mental illness. I am not sure whether the amendment the Health Consumers' Council has proposed will be sufficient to cover that loophole. Either way, I want to place on the record that, in my view, it goes without saying that our mental health emergency response capacity is inadequately funded. People have to call the police most of the time and they are not necessarily well-trained police. That is not a criticism of the police, but they are not necessarily capable of dealing with the sorts of things they encounter. It goes without saying that our mental health emergency response needs better resourcing. It is true that under every government in history mental health has been under-resourced. That field of activity in which some critical response is required for transporting an individual who is often in psychosis or has a really serious mental issue, and the interaction with police and whether there is a better way of doing it or the response team is adequately resourced, is a key area.

The next part of the submission I want to focus on is the one that relates to the interaction of the Acts Amendment (Advance Health Care Planning) Act 2006. I thought a very good point was made by Mr Whitely and his council when he stated —

When they are well people who later become mentally ill have the same capacity as all individuals to determine the treatments they find acceptable and effective.

He is saying when we are well we should be given the capacity to lay down what sort of treatment we might receive, particularly in relation to some medications because some patients who have taken medications in the past have suffered serious consequences. They are the only ones who know that in detail and may be being treated by people who do not know that. It would be good if the same capacity that anyone else has with respect to their health applied to their mental health and if they had an advance health care plan that submitted that perhaps they should not be subjected to certain treatments or treated with certain types of drugs. The Health Consumers' Council is reasonable; it states —

In rare cases it may be necessary to overturn their wishes, however this should only occur after the need has been established via a rigorous independent process.

I share that. The council also made a submission about the State Administrative Tribunal and I commend that to the parliamentary secretary and hope she will consider that on behalf of the minister.

I also want to address the next point the council makes, which has been covered extensively by lawyers, so I will not go into it too much. As a lay person it seems extraordinary to me that the justification for excluding access to a lawyer might be that the lawyer could be threatened by the mentally ill person. Seriously, if a mentally ill person requires legal assistance and we cannot provide safety for the legal assistant, we certainly cannot provide it for all the other people around that person, so that is a fairly vacuous argument. It does not seem to hold water. In my mind it does not justify preventing a mentally ill person accessing legal advice. They should have that right just like anyone else. A very good point was made by Mr Whitely and his council and I ask that that be considered.

In his submission on behalf of the council, the point made by Mr Whitely on financial disclosures again makes a lot of sense. I cannot understand why the draft legislation for this bill, which was drafted in 2011, included the requirement for financial disclosure.

Sitting suspended from 6.00 to 7.00 pm

Mr P. PAPALIA: Returning to the submission from the Health Consumers' Council, Mr Whitely observed that clinicians need to disclose any financial interests. That is fundamental to fairness when anyone is treated, regardless of whether they are mentally ill. I ask the parliamentary secretary to provide an argument for why the wording regarding financial disclosure in the 2011 draft of the bill has been removed, unless the government is going to accept the proposal that those words should be reinstated. The submission made by Mr Whitely seems eminently reasonable to me. I cannot understand why those words would have been removed, other than to try to reduce the overall number of words in the document. In this case, I do not think that the removal is justified.

[Member's time extended.]

Mr P. PAPALIA: I will move on to a related point made by the Health Consumers' Council on the reporting of and parental veto of the use of off-label treatments for children. As the council pointed out, clauses 195(2)(b) and 208(2)(b) of the Mental Health Bill provide some protection by requiring approval of the Mental Health

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Tribunal for electroconvulsive therapy or psychosurgery, but there are other types of treatment that will be potentially far more frequently employed than those that are not subject to any sort of protection under the current draft of the bill. Mr Whitely referred to selective serotonin reuptake inhibitor antidepressants and antipsychotics, which have not been approved for use by children by the Therapeutic Goods Administration. That is a reasonable point. There is reason to be concerned that if we do not compel notification of the prescription of such drugs, there may be inappropriate prescription or over-prescription of them. As the council indicated in its submission, a consequence can be that some clinicians may be unusually frequent prescribers of these drugs, and that we would not know that unless we demanded that when these drugs are given to children, the system be notified.

We have experience in this state of one instance that illustrates that argument quite well. It involves the period from around 2003 to around 2008. In 2003, clinicians were compelled to provide notification in the event of prescribing to children drugs for the treatment of ADHD. I am not the expert that Mr Whitely is on this particular subject, but I recall being here in 2008 and hearing him speak about it. When that imposition was placed on clinicians, I recall that WA had one of the highest prescription rates, if not the highest prescription rate, for those drugs to children in not just Australia, but also the world. We then compelled clinicians to notify the prescription of those drugs to children and, by 2008, our prescription rate—I am trying to remember the correct terminology for the ratio of prescription rates; I think it was per capita of population—had halved. The only thing we did was say to clinicians that if they were going to prescribe this stuff to children, they had to notify us. That had the impact of halving the prescription rate. Interestingly, in the same period there was also a halving of the number of self-notifications by high school students of abuse of dexamphetamine, which suggested, not surprisingly or not inconceivably, that there was a direct link. It is difficult to prove, but clearly if the number of teenagers at high school who notified voluntarily that they were abusing this stuff halved in the same time frame that we told clinicians that they must notify when prescribing those drugs, there is reason to think there was a link. We have evidence that shows that if we get clinicians to notify when they provide drugs to children that may be harmful to them, we make it a little more difficult for people to inappropriately prescribe. That is a good thing.

The argument made by the Health Consumers' Council that there are circumstances in which it may be appropriate to exclude parents and guardians from decisions relating to a child's treatment, particularly if they have abused or severely neglected a child, is quite reasonable. That is undoubtedly true; obviously, that should be the case. But I do agree that parents should not be excluded from controversial off-label treatment decisions; such decisions should not be made unilaterally by the child's treating psychiatrist when that psychiatrist may, for whatever reason, be wedded to the use of those off-label drugs and see that as an acceptable practice when the parents may not. I therefore ask the parliamentary secretary to respond to that submission from the council and, if she does not agree, to put the case and explain why she does not agree. As has been outlined in the submission, the natural consequence of a couple of the other clauses may be that parents may be excluded from treatment decisions on the word of the treating psychiatrist.

The member for Armadale has already focused on psychosurgery and ECT, but I will add my commentary to the observations with regard to psychosurgery for children. I think it is outrageous that we would contemplate allowing such surgery on a child. In the original draft of the bill such surgery was going to be allowed for children aged from 14 years, but post the massive concern not just in Western Australia, but also right around the country, the minister and the department—whoever is advising the minister—conceded that that might be too young and shifted the age to 16. I do not see why the age requirement should not be 18 years. As the member for Armadale indicated, psychosurgery is irreversible; if they get it wrong, that is it. I do not think it is the right thing to do. Unless the parliamentary secretary has some incredibly powerful argument on behalf of the minister, I do not think she should walk this one into this place and expect people just to roll over and accept it. I want to see the extensive and conclusive justification for the need for 16-year-olds to be subjected to psychosurgery in Western Australia. If the parliamentary secretary cannot provide that justification, she should pull that provision out of the bill. That is pretty reasonable, actually. Any rhetoric around people being extremists or not representative I do not think applies in this case. It seems quite reasonable to me to ask the questions and, if the government cannot justify it, to not include it in the bill. As the member for Armadale said, at least electroconvulsive therapy is not irreversible. I understand that there is justification for subjecting some children to it. The opposition's position, as stated by the member for Armadale, is that the age at which a child can be subjected to this treatment should be extended to at least 16. I am pretty certain that the member for Armadale indicated that we would be moving an amendment in that regard. I will leave the amendments to him. We should err on the side of caution in these cases, particularly the controversial matters of psychosurgery and electroconvulsive therapy for children. I think that is reasonable. If the government feels that it is essential that children in Western Australia as young as 14 years can be given ECT, it should justify why that is so. The

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government cannot just say that it has been told by someone that that is a good idea; rather, it has to place on record in this place the justification and the arguments to support that case. That is not an unreasonable position.

As was indicated by the member for Armadale, it is our intention to propose amendments to improve the bill. I do not think he indicated that the opposition will oppose the bill. At this stage I add that the Minister for Mental Health and the government should be commended for tackling this significant challenge. One needs only to look at the size of the tome that will be amended to concede that it is a big job. It is good that the government is doing it, but that is not to say that there are not better ways of drafting some of the clauses so that they do not inadvertently lead to problems. I do not think it is the intent of the Minister for Mental Health or anyone else to bring about negative outcomes, but as has been indicated by the member for Armadale and others—hopefully, I have added weight to their argument—it is worth considering a significant number of points and whether the changes proposed in the bill will make the system worse. Perhaps we should amend those provisions a little to ensure that we are erring on the side of caution. I look forward to the rest of the debate, particularly to the consideration in detail stage and the parliamentary secretary's second reading reply.

DR G.G. JACOBS (Eyre) [7.13 pm]: I welcome the opportunity to talk about the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. The process of such bills in Western Australia has taken a long time, but I recognise the complexity of dealing with the very important subject of mental illness in the community. As a practitioner who is now a part-practising practitioner, I suggest that we keep the Mental Health Bill in context. Probably more than 300 000 people in Western Australia suffer some form of mental illness. One in five people in Western Australia suffer some form of mental illness. One in 20 people suffer a serious chronic relapsing mental illness, which is essentially the subject of this bill. The bill relates to between 5 000 and 6 000 people who obviously need inpatient treatment and community treatment orders. We need to talk about the treatment of voluntary patients, the involuntary status of patients and their rights and the involvement of carers. We need to deal with the responsibility of psychiatrists and mental health practitioners who treat people with mental illness and we need to involve carers and address the issue of who is advocating for people with mental illness. As I always say, by the grace of God any of us could go with a mental illness. We must address in a fair and balanced way the rights of a person with a mental illness. How do we as a government and a legislature look after vulnerable people in vulnerable situations or any of us at any time in a vulnerable situation?

I want to walk the house through what it would be like if I were a patient with a mental illness in my country home town. I want to walk the house through a day, a week and a month in the life of a person with a mental illness. I am Graeme and I have a mental illness. I have bipolar disorder. As a result of that bipolar disorder, I often have a manic phase and a very depressive low phase. Mostly when I am unwell, I am in my serious manic phase. The disorder in my brain means that during my manic phase, a lot of neurotransmitter chemicals in my brain make me agitated, hyperactive and manic. I become disruptive to my family. I drive my car at very high speeds. I harass and annoy not only my family members, but also my workmates and friends. I become disordered and dysfunctional. I cannot work nor can I function in my environment. I have had what the psychiatric space would term an "acute exacerbation". Under the criteria of the mental health legislation, I have an illness that needs treatment and/or I have an illness that provides a significant risk to not only my health and safety, but also the health and safety of others—my person or another person. Fortunately, I come to the attention of a very caring general practitioner. He is made aware by many methods—generally, the grapevine in a small town—that Graeme is not himself. Graeme is dysfunctional and manic and he needs treatment. If we let this condition go untreated and do not care for him, he will be a risk to himself or, indeed, to somebody else.

Graeme's GP writes a referral for an examination. He does so because in Graeme's home town there are no resident psychiatrists. A GP—or an authorised mental health practitioner if a community does not have a GP—can write a referral for an examination. The forms that are filled out authorise Graeme to be put in the care of a psychiatrist in an authorised place where his condition can be treated. An authorised mental health practitioner can be a psychologist, a registered nurse division 1, a social worker with appropriate training in mental health or an occupational therapist who has experience in treating people with a mental illness. The referral for examination to protect Graeme's right is enacted for 24 hours to a maximum of 72 hours. This recognises that if Graeme has an illness and needs treatment, it needs to be enacted, but the referral cannot remain for an unspecified time. Graeme lives in an area that is relatively isolated from an authorised hospital from which he can receive treatment, so a transport order is made. A transport order is live for only 72 hours, recognising again the rights of people with a mental illness and the system and that this bill, which will become an act, does not have an unending time frame in which these orders are made. Graeme is then taken to the facility by the best means possible for that to happen with the assistance of a policeman, policewoman or transport officer as an escort. Obviously, if Graeme is still quite disturbed, he might need a policeman. Obviously, Graeme's condition is somewhat controlled by his caring GP, who has given him some medication, then he might be able to be

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escorted safely—for him and for the escort—to Perth, in this case to an authorised facility, by a transport officer, who could be an appropriately trained ambulance officer in my home town.

Graeme is then transferred to an authorised hospital and then seen by a psychiatrist within a short time, which is prescribed in the bill, and an interim treatment order is made. The interim treatment order has a life of 21 days and Graeme has a maximum term in treatment of three months. For a child it is 14 days, with a maximum treatment time of 28 days before there is a significant review of the treatment of their condition. Graeme must be examined within 24 hours by the psychiatrist when he arrives at the authorised hospital. These matters are prescribed in this bill, which recognises the rights of Graeme, with a mental illness—in this case in a manic phase of his bipolar disorder—to get well and functional and back into the community. Indeed, there may be a need to search Graeme for intoxicants or an article of risk to his health or to anybody else in the hospital. These guidelines are very well described in the bill. However, Graeme might still be quite disturbed when he arrives at the authorised hospital, and might still be quite violent and upset. Graeme might need some seclusion or restraint—in this case, seclusion in a room that is safe and appropriately furnished. He needs 15-minute observation and every two hours a doctor must review his condition. Graeme must be provided with sufficient food and drink and adequate toilet facilities and anything else that may be needed for his relative comfort. When it comes to restraining Graeme, there may be some bodily or physical restraint or mechanical restraint and these are specifically prescribed in this bill. The bodily restraint may be needed in order for him to receive medication. Graeme might not want that injection, but he is an involuntary patient at risk to himself or somebody else. He has been deemed an involuntary patient in need of treatment, and in this case that bodily restraint for that particular administration is well prescribed in this bill. I will talk about some of the bodily constraints that are defined in the bill. Proposed section 227 states —

- (1) Bodily restraint is the physical or mechanical restraint of a person who is being provided with treatment or care at an authorised hospital.

Mechanical restraints do not include an appropriate use of medical or surgical appliances in the treatment of Graeme's physical illness and do not include the use of furniture that restricts a person's capacity to get off the furniture. Under the restraint component of this bill, a mental health practitioner or nurse must review and observe this patient every 30 minutes and every six hours he must be reviewed and examined by a psychiatrist. The authorised hospital cannot give Graeme deep sleep therapy, insulin coma therapy or insulin sub-coma therapy, which is outdated, draconian and dangerous. What if Graeme, who is suffering from a mental illness and who is taking the appropriate medication, is thought to require other therapy such as electroconvulsive therapy that is recommended for some conditions? Serious depression is one condition; occasional mania for bipolar disorder, in Graeme's case, is another; and a major depressive order of Graeme's condition is the depressive end of manic depression. Occasionally, Graeme has a mixture of a major depressive disorder and a psychotic disorder, such as the elements of schizophrenia. Graeme would know that in Western Australia in 2012 the total number of people treated with electroconvulsive therapy was 434. It is a procedure conducted under anaesthetic in medically controlled conditions. In 2012, some 68 involuntary patients, like Graeme, received ECT in Western Australia.

[Member's time extended.]

Dr G.G. JACOBS: It is not a common form of treatment, but it can be lifesaving for Graeme. When all other treatments are refractory—that is, the patient does not respond to other treatments—it can be lifesaving. Would there be a suggestion to Graeme, if he actually did not respond to electroconvulsive therapy and was refractive to medications, that he should receive some form of psychosurgery? Graeme would have to be reassured that psychosurgery did not mean a lobotomy as per *One Flew over the Cuckoo's Nest*, but in psychosurgery today, it means stimulatory electrotherapy. It is a treatment much like that received today for Parkinson's disease. In some patients, it has very good results.

Again, psychosurgery, in a minority of people who are refractory to every other modality in medicine, can produce positive results. Graeme would want to know why psychosurgery needs to be in this bill. It needs to be in this bill because it is not actually cutting out or ablating, but it is about stimulatory therapy. If we go back 10 years, the advancements in stimulatory therapy have been great. What will the next 10 or 20 years bring? Therefore, I think it is really important to have the psychosurgery modality recognised in this bill to take advantage of the potential advancements in psychosurgery and stimulatory cerebral therapy into the future. Graeme would want to know that there was an instrument that would review his case in assessing his involuntary status—namely, revoking his involuntary status and letting him go back as a functional person within his town and community. He would want to be assured that the Mental Health Review Board would conduct a review of his involuntary status with his psychiatrist or a psychiatrist present and that he would have a lawyer present.

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Graeme would be there as the patient and as the applicant, and, very importantly, he would want to know that he had a carer or an advocate—that is, a nominated person or a carer for him—present at the hearing. I think that is very important and that provision is described in this bill.

Graeme would want to know that his carer—his wife, his close friend or his nominated person—is to be kept in the loop. Graeme would want to know that his carer was informed. Graeme would want to know that when the Mental Health Review Board hearing was being held in his case, he had an opportunity for his wife or nominated person or advocate to attend that hearing. Graeme would want to know that his psychiatrist was keeping his carer—that is, his nominated person—informed of his treatment and his course. Graeme would want to know, when he was finally discharged from the hospital, that he had a comprehensive discharge plan; that his carer—his nominated person or wife—knew he was coming back to town. Graeme has had friends with the same condition or a similar condition who have been, for instance, treated at Graylands Hospital. They were put on a railway bus and sent back to town; however, neither the carer nor his treating GP knew that the patient, Graeme, was returning to town.

It is really important that we have communication about discharge planning and making carers aware. Graeme would just be thrilled to know that there was someone advocating for him in the state of Western Australia. He would be thrilled to know that there was a Chief Mental Health Advocate appointed in this state to not only stand up for his rights, but also keep all the standards of the institutions and the practice exemplary. That is in the way he was treated, the institution by which he was treated, the standard of treatment and of the institution as such. Graeme would be thrilled to know that there was someone standing up for him on those matters concerning the treatment and management of his condition. The Chief Mental Health Advocate, who is being appointed under this bill, which will become the act, has fairly prescriptive concerns and duties to which that appointed person should attend.

It is important that we introduce this bill in this house. I thank the members who have already spoken for their support. I hope members can see, through my walk with Graeme, who has a mental illness, that there are significant improvements. Members should pay particular attention to not only the patients' rights, but the possibility, once the involuntary status has been enacted, that it could be revoked. I am not saying necessarily that this is the dim, dark past. It is not about putting someone in an institution and basically throwing away the key or not addressing all the issues that we need to address in this very important area of treatment of people with mental illness. However, there are just a few other issues and concerns that have been brought up in the past. I suppose Graeme would want to know why, if his son or daughter were unfortunate to have a similar condition to his, they would need to have ECT or psychosurgery. The previous legislation, Graeme would recognise, says nothing about children; it is silent on those matters. Therefore, this bill has had to address some of those matters. The use of ECT in WA in children is a very rare event, but in certain situations when used in children, ECT can be lifesaving. ECT for Graeme's child under 16 is extremely rare. Under the age of 18, it is rare. No ECT has been given to under 18-year-olds in WA in 2011 or 2012.

People might ask why we do not just get rid of it. As I have said, it is very similar to psychosurgery. There are cases that are refractive to every other form of treatment. Under controlled conditions, this is a modality that can increase the neurotransmitters in the brain. People ask where this supposedly draconian practice ever came from. In the 1930s and even earlier, it was noticed that after people with epilepsy and depression had an epileptic seizure, their depression improved. The pathophysiology of that is that if a small seizure is induced under anaesthesia in a controlled environment, the neurotransmitters in the synaptic gap of the nerve fibres are increased and this improves the mood of the patient. That is where this has come from. As I said, it is very rare but I think the modality needs to be there for those very rare cases. There are checks and balances. Graeme's child will never have ECT without going through the Mental Health Review Board. The need for treatment will be comprehensively and rigorously explored before this treatment is ever implemented.

Today I received a letter from a psychiatrist in Queensland, who wrote about ECT in the Mental Health Bill. After a rather tortuous three paragraphs in which I really did not understand where my esteemed colleague was going, the last line said that Parliaments should impose more restrictions on ECT. He did not say that ECT should be banned. I think we have significant guidelines in the implementation of ECT. In the very rare case that it is needed in refractory patients, it could be lifesaving. I think there are enough basic restrictions. As the psychiatrist from Queensland says, this is a safe procedure and can be lifesaving for some. Graeme can be reassured in Western Australia that this bill will result in an improvement in his treatment. It will recognise his carer's role in his treatment and will recognise that psychiatrists will have a role in the patient's treatment to improve mental illness in Western Australia.

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MR C.J. TALLENTIRE (Gosnells) [7.43 pm]: I rise to speak to this cognate debate on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. I acknowledge the contributions of other members and their strong knowledge in this area. I want to add a perspective that is brought about by lessons that I have learnt from my constituents who work in this area of mental health care. Those people are in a rewarding and challenging profession. Two of my constituents—they are totally unconnected—have been victims of some form of assault. This just brings to this debate the reality that we are dealing with very difficult situations. The people who suffer from mental illness and have these various episodes need all the help that we can possibly give them. Where possible, we need to avoid people getting into a situation in which they become sufferers of some form of mental health complaint. I think of the opportunities that we have to deal with things such as substance abuse, methamphetamines and the like that can lead to someone having mental health problems later. We need to invest heavily so that we avoid the growing problem in our community of various substance abuses that lead to mental health problems.

I also want to say a little about the process that people have to go through when they present at the emergency ward of a hospital suffering from mental health symptoms. It is my observation, and the word I hear from those health professionals working in emergency wards, who do amazing work, that they are forced to make quite rapid triage decisions about where someone is best located in a hospital, what sort of treatment they need and what ailment they have. Those people are making those calls and people are also coming to them with mental health problems. I hear that all too often a person who presents at an emergency department is required to stay in that emergency area for an extended period. That is completely the wrong approach because there is all that coming and going—that fast, rapid action, that feeling of high adrenaline—in an emergency department. Some medical professionals who are there work best in that atmosphere. It is fast moving. That is not the right atmosphere for someone who is suffering mental health problems; it is the very wrong atmosphere. Just the thought of all those flashing lights, trolleys being wheeled around quickly, decisions being made and doctors, nurses and other health professionals rushing around is the wrong atmosphere for someone who is suffering a mental health episode, yet that is what people often encounter. I have even heard of situations—I do not know how frequent this is; I suspect it is all too frequent—in which somebody who has a mental health complaint and perhaps needs to go to a ward at Graylands Hospital is kept in that emergency ward until a bed is available for them. That can be for an extended period—perhaps one, two or even three days. Obviously, all kinds of damage can be done and there is a need to medicate the person so that the medical staff can deal with whatever mental health complaint that person has come in with and so that the person can then cope with the high-octane atmosphere of the emergency department with all the activity that goes on there. They are then medicated again, not just for the original mental health complaint but to calm them down after being affected by their surrounds. That is very worrying. Because we cannot find enough beds in mental health wards, we have to extra-medicate people to enable them to stay in this holding pattern in a temporary position in an emergency department. To me, that is completely wrong.

There are some real concerns and it comes back to resourcing. Likewise, resourcing is probably the reason that my constituents whom I mentioned earlier were put in these terrible situations in which they encountered assault. I will relate one situation involving Ms De-Ann Manning. She was called by the police to attend a situation in which a person—I will not name the person; there is no need—was being brought back to the Bentley mental health unit. This person—I will call her Ms B—was at her home but it was determined that she needed to be brought back to the mental health service. Police officers and my constituent attended her house. Initially, Ms B was against the idea of being taken back to the mental health unit; she did not want to go. She managed to lock the police officers and my constituent in a garage temporarily. She then ran down the street, and a strike was laid on my constituent and she suffered an injury, and there was also some spitting and all sorts of concerns about contamination. However it is essential that the police receive the necessary training about how to deal with a person who is going through this kind of mental health episode. It was a very unfortunate situation, because when this matter came before Magistrate Black in the Magistrates Court on 5 September 2008, the police prosecution failed to correctly identify my constituent, Ms Manning, as a public officer. As a consequence, even though my constituent had been the victim of an attack, the prosecution against her attacker—this person who was suffering from a mental health episode—failed. That has meant that my constituent, who has suffered all sorts of consequences since that incident, is not eligible to receive any compensation, even though she has been out of work for an extended period and has suffered serious financial loss. I put this case to the former Attorney General, Hon Christian Porter, and outlined why I believed there was a strong case for some sort of ex gratia payment to be made to my constituent. However, to my knowledge no such payment has been made. That is an indication of what can go wrong and the complexities surrounding the treatment of people with mental health issues.

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Another case that I want to mention is that of my constituent Mr Tim M'Intyre, who was a mental health nurse at Graylands Hospital. I have related this case to the house previously, and the Premier has been involved in correspondence about this matter. Tim was working in the high-security ward one evening when a patient went into a frenzy of violence and attacked him. There were insufficient nurses in the male section of the ward, although there were four nurses in the female section. That meant that no-one was available to back him up, and also there was a problem with access to keys, and that meant other people who might have wanted to help were not able to gain access. It was a dreadful shambles and a frightening situation, and my constituent has suffered a high degree of disability—I think 24 per cent disability—as a result of that attack, and also considerable psychological trauma.

That is another example of the inadequate resourcing for this very important mental health service that we must as a community provide. The consequences of that inadequate resourcing are felt by not only the people who are suffering, but also the people who are trying to look after them. That is a grossly unfair situation. It is also a frightening situation, because it will act as a discouragement to those who might be contemplating a career as a mental health professional. To be honest, I would find the idea of being a nurse on such a ward and having to deal with these situations quite frightening; it would be frightening to anyone. There is clearly a resourcing failure, and that is having dire consequences.

Other members have done an excellent job of presenting the facts about the seriousness of this situation across the state. When we hear of the number of suicides in this state, particularly youth suicides, that is a clear indication that much more work needs to be done. We need to address this situation as a community on many levels. We need to ensure that people are given the support that they require. We need to ensure also that people are given the opportunity to confide in others when necessary. We know that confiding in others is a legitimate part of our cultural expression, and we need to make it plain to people that help is available if they need it. We must help those who suffer from mental health episodes and ensure that they are given the best care possible. But we must make sure also that the people who work in the sector are given the resources that they need to do their job to best effect.

MR P.C. TINLEY (Willagee) [7.56 pm]: I rise to make a contribution to the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. Mental health as a general topic is a touchstone issue for every member of this house. It is not unlike some of the other issues that come before this house, in particular education and housing and those issues that each and every one of us has a personal connection with. There would not be many members in this house who have not had a direct, or even slightly removed, experience with mental health issues. Members may have experienced their own mental health issues, and I use that word in the broadest context, because this job and this career often cause us to feel emotional strain, which is obviously at the thin end of mental fitness and which can affect us all. Many of us have had to attend to constituents or family members who have mental health issues. My family is no different. We are not immune to it. I have a close relative who is bipolar and has all the attendant issues that come with that illness. I have lost a nephew through depression and then drug abuse.

That highlights a point that I want to make about mental health and this bill. We cannot look at this subject matter in isolation and expect that one act of Parliament, as voluminous as this bill is, and as exhaustively consulted on as this bill has been, will in isolation be the solution to the help that is required for the mentally ill in our community. I join with all members on this side to say that we support this bill. However, we question certain elements of it, and a lot of that will come out in consideration in detail. We on this side of the chamber often play an adversarial role in which accountability and scrutiny are part of the daily bump and grind of this place. However, I hope that the amendments that we have put forward and the considerations that we have undertaken on this bill will be seen as constructive. We are yet to see whether those amendments will be responded to in a meaningful way and whether they will be adopted or some accommodation can be made for them. However, we hope that there will be a reasonable level of bipartisan support for those amendments.

In the area of mental health, we should not tread lightly. We need to take a bold and strong position on this issue, for the betterment of our community. This bill is a strong step forward. I have read the report of the Mental Health Commission about the level of consultation that went on from the green bill and the hundreds of written submissions that it attended to. It is a commendable body of work.

I began by talking about the impact of mental health on our constituent bases. One of the things in the bill I am drawn to is police powers. As recently as two weeks ago I had to assist a strong supporter of mine, a great community worker in Willagee, whose own son had gone missing. He was affected by various substances as well as the intersecting aspect of mental health that he suffered from. She was moved to call the police to assist in locating her son. I have to say that in this circumstance the police were magnificent. They did not relent because they knew the background and authenticity of the constituent who raised the matter. The constituent did

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this on her own volition without my support. The police did not stop until they found her son and did, what is called in operational language, a welfare check and were themselves moved to use the power that exists under the current 1996 act that compels individuals to have an assessment and hopefully get the help they need. I look at these bills and see that the significant powers are, of course, transferred to the 2013 bill and its supporting legislation. I note that the circumstances under which the police can invoke some of its powers have been expanded.

The only concern I have with these bills is oversight and the capacity for potential abuse whether deliberate or inadvertent. As other members have said in here, I too hope and urge that there is some sort of amendment to or attendance around clause 242 to include the requirement that the information provided to the Chief Psychiatrist regarding incident restraint or seclusion is also provided to the Chief Mental Health Advocate. That would be an absolute tie-up so that if there are missteps, the capacity is there to learn a lesson. As they say, a lesson is never learnt until it is invoked. We can identify faults, problems and missteps but until we act on it and implement it, we do not really learn.

When talking about mental health, I would be remiss if I did not give at least some point of recognition to my previous tribe, that is, the Defence Force and the circumstances of mental health in Defence Force veterans in our community. This is particularly important even though members may wonder what this has to do with both of these bills and, more broadly, the jurisdiction of Western Australia. I inform the house that a significant number of veterans have separated from the Defence Force, more specifically from the Army, and are now living as normal, ordinary citizens in our community. Our country's veterans, who have been in multiple tours of both Afghanistan and Iraq, live in each and every one of our electorates. We know from the available statistics that since 2004 about 26 000 Australians have served in Afghanistan—not an insignificant number. It is the longest conflict this country has been involved in, with more troops than Iraq, where only 2 000 served, and Vietnam, where 58 000 served with 3 000 wounded and 521 dead. I will not go further back than that.

The death and wounding is only an indicator to the nature of the conflict and the subsequent trauma that will be visited upon these veterans in the years to come—long after they have pulled off the uniform. Indeed, in Afghanistan we had 219 wounded and I should point out, when I talk about wounded veterans, mental illness is very much included in the same vein. The number of wounded from the Afghanistan and Iraq campaigns will do nothing but increase over time as mental illness presents itself in the various cohorts of people. We know from global studies, certainly amongst the allied nations that have participated in conflicts since the First World War, that it is estimated that 10 per cent of Australian Defence Force personnel who served in combat roles in Iraq and Afghanistan will develop post-traumatic stress disorder. Will—not may or could; it is a known known. They will develop PTSD, and that means 2 600 veterans who served in Afghanistan since 2004 will present with PTSD. That in itself is one of the worst forms of PTSD. The correct terminology is frequent and recurrent severe depression.

One of the things that we need to understand about PTSD is that it is not necessarily related to direct combat conflict. That is certainly something that accentuates it and is a causal component of this sort of illness but the accumulation of fear that toxically builds in the body over a period of time is also causal. The simplest of operations such as driving from Kandahar airport through town to do some administrative work actually has a loading of implied threat or exposure. That in itself slowly accumulates so that time spent in the country is a contributing factor to this sort of stress.

A great deal of study has been done and there is a great deal more to be done. I say to the members of this chamber: be very, very clear about what is going on because 2 600 veterans who will suffer PTSD as a result of the conflicts in Afghanistan and Iraq has a far greater multiplier effect on their families and communities than just that 2 600 people. The Brain and Mind Research Institute in Sydney conducted a longitudinal research study of Vietnam veterans 36 years after the end of the conflict. It did an exhaustive study with 1 000 Vietnam veterans picked with the support of the Department of Defence, and under the tutelage of Professor Brian O'Toole, the director of the Brain and Mind Research Institute—part of the University of Sydney, which does some fantastic work—identified severe and recurrent depression in the selected sample followed in what was a very clear, qualitative and quantitatively exhaustive study. Severe and recurrent depression will present 40 times greater in veteran communities than in the general population. Imagine that—one group of people is 40 times more likely to contract severe, recurrent depression over a long period of time.

But, here's the rub: if a person lives with a veteran with these sorts of mental illnesses—such as wives, who were part of the second study conducted by the institute—they are represented 33 times greater than the general population for severe, recurrent depression themselves. But it does not stop there. Not only are veterans directly affected by this mental illness and then transferring it through various interactions over many years to their

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partners, but their children, who are the subjects of the current study being conducted by the Brain and Mind Research Institute, are also affected. The attempted and actual suicide rates of Vietnam veterans' children are three times greater than that of the general population.

For members, 2 600 veterans are directly affected by mental health and there is a multiplier effect to their families. Not just on the end of their service, not while they are in uniform, but 10 and 20 years after they have left service they can present with a range of symptoms and a range of problems. Unless they are diagnosed or red flagged as they exit the Defence Force with these particular problems or they have a recognised disability related to these problems, they themselves will just join the civil population and when, one day, it comes out vicariously through substance abuse—typically alcohol, the substance of choice for veterans—in domestic violence or abusive behaviour, they will present to the mental health architecture of this state. They will go down to Alma Street in Fremantle, maybe voluntarily but more likely involuntarily, to have a mandatory assessment, and be retained and restrained for a period of time—seven days—to have that assessment done. This is a fundamental problem and if we do not recognise it and if the government does not undertake to liaise very carefully with the government agencies working very hard in this area, I think we are letting that group of Western Australia citizens down by not being ready for when they start to present with these problems. This is not a maybe, this is not a potential, this is an actual. There is enough empirical evidence from the past to know what will happen. Those multiplier effects can inflict enormous damage on our community and I really urge the member for Kingsley, in her representative duties in this place, to convey that this bill is just the beginning. The legislation, the black-and-white verbiage, is just the beginning of what needs to occur to ensure we have a broad full-frontal approach to tackling what will be a significant problem in our community.

It might be noted, though, that I have just dwelled on PTSD or mental illness within our veterans' community, which is an increasingly legitimate part of our civilian community in Western Australia. We also need to understand that there are other attendant multifactor issues, if you like, that come with a veteran suffering from a mental health issue. I have already touched on substance abuse of some kind. Younger veterans are also turning to a range of drugs available, even drugs prescribed for other ailments. There are always those complicating issues because they tend to have physical disabilities or injuries accumulated over years of service. Do not forget that in this state the unit that has done the most tours of Afghanistan and Iraq holds a very special place—that is, the Special Air Service Regiment down at Swanbourne. Those guys have done five and six tours apiece. They have packed their bags, said goodbye to the family, got on a plane and flown into Afghanistan or Iraq or any other number of countries in relation to our commitments overseas and undertaken the job that they are paid well for, but that they also volunteered for. I come back to the point that the accumulative effect of multiple tours in a place like Afghanistan has what they call the capacity to fill a man's bottle. Once a man's bottle is full, it cannot be emptied, refreshed and recycled. Once it is full, it is full. I have led men in the Australian Army who have come to me quietly and said, "My bottle is full", by their own words. There is nothing that can be done about that but for it to be taken very seriously and attended to.

[Member's time extended.]

Mr P.C. TINLEY: I move on to another point. If we know all this stuff about veterans and the potential trouble a significant cohort of our population will go through—the veterans, their partners and their families—and the distributive effect of all of this stuff, we can ask what we know about PTSD amongst some of the other people in our community who serve us, and I of course directly turn to police officers. We cannot talk about police officers unless we talk about the other emergency services personnel who attend to a significant number of high-impact trauma events in the term of their careers; however, I turn to police officers to understand PTSD. If we know that PTSD accumulates amongst these sorts of groups, particularly those people confronted with a lot of trauma, and if we know that it has a multiplying effect—it affects families, it affects partners and the children of victims of PTSD—why would it not present itself in our police force? Sure, it would present at different numbers and at different intensities; it might not be recurrent and severe depression, although I am sure it is for a few. However, there is a significant number—over 6 000—of police officers, not to mention all the cohorts who have gone through and left the service having been exposed to high trauma, who would be suffering quietly in their homes with some undiagnosed PTSD or, at least at the emotional end of the psychology, some sort of disability that is causing them a problem. As recently as November last year the police commissioner and the minister jointly announced that 196 non-operational officers were to be offered a voluntary severance package in line with the government's public sector redundancy program. Some information, which I will not bore the house with, goes on to explain that those officers receiving the payout were deemed to be ill through physical and/or psychological injuries that preclude them from being operational on the front line. We know that some officers who are medically unfit are being discharged from the police service. We can understand that if it is physical

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because we can clearly see their inability to take the job, but there are also the invisible wounds, as they are called, that come from mental illness.

I note a question on notice from Hon Kate Doust in the other place to the Attorney General representing the Minister for Police that tries to understand from those figures how many of those officers fall in the mentally ill category. The response indicated that in the financial years from 2001 to 2012, 203 officers who were psychologically unfit to serve were discharged from the police service. This is a significant problem for us to try to understand as a lawmaking body, because when someone is medically retired as unfit for service, once they have had their payout, there is very little ongoing support. There is nothing like the Department of Veterans' Affairs that swings in behind with a significant architecture and machinery to attend to a problem when it presents itself. Once these guys and girls—these women—have been discharged from the service, they just wander off with a disability and have all those attendant problems. Again, these are the sorts of things that the bill cannot attend to—compensation and ongoing medical support for those who are separated from their service after many, many years. There is a consequence of that, and I have already outlined the University of Sydney's Brain and Mind Institute's research about the impact of that consequence in our community. What a waste. There are young men and women who were bright eyed, very keen, saw the poster, found the vocation, signed up to the service and went through the selection process, which is not insignificant. They went through the training process, which is not insignificant either, and undertook a career of various lengths, as much as 20 or 30 years. They accumulated a whole bunch of trauma scenes at the roadside or through domestic violence or through all the other things that happen on our streets, which we all know about too well and which we have raised in this house too many times, only to find out one night that they cannot get enough sleep, they are not eating well, they are irritable, they yell at their kids for no particular reason, they overreact to their partner's interactions, they overreact on the street, they overreact with their colleagues for no explainable reason and they are suddenly ambushed by this most insidious disease called PTSD, variously known as depression and a range of other things.

I want to finish—having made a case for the house to understand the impacts of one aspect of mental health—by saying that this bill will go a long way to starting a process to ensure that there are inclusive and equitable circumstances for those who serve us and who put themselves in harm's way. There is an absolute imperative to get it right. The point I want to finish on is the notion I started with: nobody presents with a mental health disorder in isolation. People do not bowl up clean to a counsellor or a mental health service with just straight post-traumatic stress disorder. It is clearly documented and clearly understood that they will have other conditions that are either causal or symptomatic aspects of PTSD. For example, a soldier, a police officer or a person with PTSD or a mental disorder—I will keep it really broad, as I am sure logically it extrapolates across the whole spectrum of mental disorders—is highly likely to have either as a precondition or a subsequent condition some sort of physical representation of the disorder. They will also potentially have some sort of substance reliance, if not substance abuse. They will have, created by or created from, a sense of dysfunctionality around their family unit. They will have a range of other conditions that potentially affect their housing. Their housing security will be impacted either as a result of their illness or as a precondition that has exacerbated their illness. We see it all the time. Anybody who deals with dysfunctionality knows there is never one issue, particularly members who visit homes of families in Department of Housing tenancies in their electorates; it is a multifactor issue and there are always other aspects. My criticism of the way we attend to these issues is that it is quite binary and narrow. For example, the pathway for a Homeswest tenant with antisocial behaviour is eviction. I do not want to revisit that issue from last week, but I make the point that if any member of this place has ever gone behind the scenes and seen what the issues are, they would realise that there are always other aspects. It is the same with mental illness; there are always multifactor issues.

In my research I noted something that I want to put on the record. The Victorian government of 2008 or 2009 identified this issue and introduced legislation. I am not an advocate of creating another law just for the sake of it just because we believe it will solve the issue; it will not. Victoria created the Human Services (Complex Needs) Act 2009, the purpose of which is to recognise the fact that nobody ever presents with a single issue and that when government is delivering human services, it must take into consideration and work on a total care package. The act provides for a new specialist, time-limited intervention that aims to stabilise housing, health, social connection and safety issues; provide a platform for long-term engagement in the service system; and pursue planned and consistent therapeutic goals for each client. It is therefore a holistic case management for somebody who presents with a mental illness. There is no point just detaining somebody and forcing them down a pathway with a community treatment order or to become an involuntary inpatient until we understand the other issues. The complex needs act instituted in Victoria is a very good example. An eligible person under the Victorian act is someone who has a mental disorder; an acquired brain injury; an intellectual impairment; is an alcoholic or drug-dependent person within the meaning of the alcoholics act; has exhibited violent and dangerous behaviour;

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or is in need of intensive supervision and support and would derive benefit from receiving coordinated services in accordance with the care plan under the act.

I have outlined in the time I have been on my feet the circumstances for why we cannot look at the issue of PTSD in isolation. A mental health issue that affects part of our community has a compounding and multiplying effect on the whole community. The PTSD issue for veterans is a good example. There is a lot of empirical knowledge now about those impacts on both spouses and families. I believe that knowledge also translates to the police service. Anybody exposed to trauma who has developed PTSD has an impact on their families and by extension their communities as a whole. We cannot look at this matter in isolation. I think there is strong bipartisan support for this issue, because we all have to deal with it. It is a personal issue that touches all of us in some form. Some people do not like to recognise it. These are visible wounds that must be the subject of compassion, comprehension and comprehensive service.

MR D.A. TEMPLEMAN (Mandurah) [8.25 pm]: I make a contribution tonight to the very important Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. It is significant that we are considering bills that have been mentioned by previous speakers as having been through considerable consultation. Indeed, the subject matter, the mental health and wellbeing of Western Australians, has attracted a great deal of attention, as it should, particularly given the statistics that we are aware of and have heard about from a number of speakers on the prevalence of mental health conditions in our communities.

As the previous speaker and many others so far in the second reading debate have said, mental health conditions and challenges know no bounds; there is no population or age that is immune from a mental health condition. All of us therefore in this place must recognise—I am sure we do—the ongoing importance of investing in services for people suffering from a mental health condition. We must also recognise the importance for us as a civilised community to look after, support and enhance the lives of those most vulnerable people. It is a sign of a civil society when people who need support and assistance get that support and assistance so that they can continue to participate in their community. It certainly falls upon all of us in this place to continue to advocate for the needs of people in the mental health area.

Some very, very important progress has been made in how mental health is regarded in the community. Some high-profile and not-so-high-profile people have shared their experiences, which may help us understand what it is like to suffer from a mental health condition. There are countless examples, and of course one only recently that ended in tragedy. None of us at all want to see that continue. I listened on a number of occasions to the impassioned pleas from the member for Kimberley about Indigenous youth in particular in her communities. I listened almost in despair as the member for Kimberley explained the impact that a young life lost to a mental health condition had and continues to endure on a community.

These bills being heard cognately obviously put in place a range of structures that, if members like, modernise the way we regard the treatment of mental health conditions and how they should be addressed into the future. But we must also never forget that a lot depends upon the funding of this very important area of government responsibility. I will share with the Parliament tonight the ongoing challenges in the area of mental health for my community in the Peel region. I start by acknowledging the staff of the Peel mental health team in Mandurah, which has operated for a number of decades now. Those very special staff work with people who present with mental health challenges in the community. I look on in awe at the complexity of the work they do and the complexity of the cases they are called upon to manage. However, in the Peel region, like in many other places, there are unfortunately gaps in services that need to be addressed by government. When someone presents in Peel there is a range of challenges. I was very interested to listen to the member for Eyre's contribution when he went through the process step by step, using the example of a person with a mental health condition and the sorts of challenges and impediments they may find within the system. I found that very interesting and enlightening.

In Peel we have a community mental health team that effectively still only operates on an hourly basis during daylight hours, and then there are some services provided after hours. It really was not that long ago that we did not have a mental health liaison nurse at Peel Health Campus. That has really been in place for only the past five years. But the problem of course is that we have a mental health liaison nurse who is there to assist people who present at the accident and emergency department at Peel Health Campus, which after hours is certainly the first port of call if a person is having an episode or experience of being under duress with regard to their mental health. But that is not a 24-hour service; that mental health liaison nurse is not there all the time. Indeed, if a number of presentations take place at once, that nurse's job is made even more difficult.

I was recently speaking to an accident and emergency nurse who works at Peel Health Campus and regularly does the Friday, Saturday and Sunday night sessions into the early hours of the morning. She relayed the experiences of people presenting and needing mental health assessment, and the difficulties sometimes of people

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being serviced immediately. Indeed, added to that are the problems that arise if people are assessed as needing acute care, which of course is not delivered in Mandurah or Peel, and their acute needs require them to be transported to an acute centre—usually Fremantle. Two police officers will often be taken off patrol to escort that person. On Friday the nurse relayed to me that there had been a number of occasions when there had been sometimes—in her words—“more police present in accident and emergency than actual nursing and medical staff.” Interestingly enough, one of the police said to her only recently, “If the crooks in the community knew we were at the hospital and not out on the beat, God help us.”

The need is growing, and the capacity to resource and deliver appropriate and timely services is stretched. One of the perennial problems with Mandurah for government is that we fall between the cracks. Many in this place and in government see us simply as a suburban southern fringe that can be serviced from Perth, but the reality is that they are wrong. We are a regional city with a growing population, with myriad economic and social challenges including increasing mental health needs. If members still have the view that Mandurah can simply be serviced from Perth, that view is wrong.

I want to acknowledge some of the community people; I will not name one of them because I do not think it is appropriate, but I will just call her “K”. K met me many, many years ago. She has been a wonderful advocate for people with mental health conditions. She has served on a variety of advisory boards and advisory and counselling advice mechanisms. She has been a stoic advocate for people with mental health needs. She is an amazing person who is very passionate, very forthright and gets stirred up quite often—I know she would not mind me saying that—but she absolutely has her heart and soul in the right place in terms of advocacy. I salute her. I also want to salute a fellow I have known for about 15 years—Alan Robinson; I know he will not mind me mentioning his full name. He is a remarkable man, and his son has had an almost lifelong mental health condition. The love that Alan and his wife, Lynne, have for their son is immeasurable and remarkable, despite their son, over a period of years, presenting a whole range of challenges for them as parents. But they—particularly Alan—have stoically stood by their son. Alan has never given up on making sure that his son gets the very best care he can find for him. Alan has battled bureaucrats, doctors, psychiatrists, community people and even staff who have been trying to assist his son. He is very well known to those in the mental health field, including Mr Bartnik and others, and ministers past and present. He is just a remarkable fellow. I salute him and K, and, on their behalf, all the other mums, dads and family members who know only too well the challenge that having a loved one with a mental health condition can bring. I salute them wholeheartedly because we do not give enough recognition to the families involved in assisting and trying to find a better life or journey for their loved ones.

I mentioned funding and the fact that Peel falls through the cracks in many areas, including mental health. I will give members one stark example. Last year in October, Heath Black, who many would know is a former Fremantle Dockers footballer and a man who suffered a whole range of challenges and has dealt with his own mental health and depression issues, came to Mandurah. Heath made a remarkable presentation to some 450 high school students from the Peel region—most of them were in years 10 and 11, from memory. The ability of Heath Black to cut through a whole range of impediments and stigma that mental health conditions and depression can bring and really zone in on these 450 students was quite remarkable. This program was presented by the Peel Youth Medical Service in Mandurah, which is supported by the GP down south organisation. There was a fantastic presentation from this man and some workshops were involved. Subjects such as youth suicide, which is so prevalent in our communities across Australia, were addressed by Heath and the other presenters. The response was remarkable. I want to very quickly read a couple of responses that give an example of the impact of this program. The responses are from people in places like Waroona. I will quote from a letter from the Waroona Community Resource Centre project officer and youth centre coordinator, Jo Fraser. Members need to remember that this program has a regional context. In the letter of support for the funding proposal, as a follow-up, Jo wrote —

Heath’s workshops are friendly, candid and confronting. Talking honestly about his own experiences allows the youth to feel connected and realise that mental health problems can happen to anyone, including them. The removal of the “aleness” of mental health is a major benefit. His comfort in discussing personal circumstances encourages the youth to engage and ask questions, enabling open non-judgemental dialogue to occur.

Members need to remember that one of the problems for young people living in towns like Waroona is the issue of isolation. That was mentioned in another letter from one of the participants, who spoke about the fact that he felt understood. This letter is from Brett—I will not mention his last name—who states —

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First of all I would like to say thank you for the time and the effort you went through on educating us about drugs, alcohol and everything in between. The presentation, how you approached things and the way you communicated with us was great! As you said for yourself you wanted us to approach you as a friend and not as a teacher so we felt comfortable and it worked!

[Member's time extended.]

Mr D.A. TEMPLEMAN: The letter continues —

Your story was quite compelling and touching with all your personal troubles and altercations and all your mental health problems and on what you've done to change everything and pretty much turned your life around. Some of it touched me close such as the anxiousness, getting out of routine and other things such as depression and stress.

I learnt a lot from the brief time you were here talking to us and I hope that you can come back and speak to us about some other topics, thankyou once again and I hope to be seeing you back here again

That is just one of a couple of comments from participants. This is a regional response; this program was delivered to a regional youth audience from not just Mandurah but also Pinjarra, Dwellingup and Waroona. There were 450 youth there. Catherine Shepherd, the principal of John Tonkin College, highlighted how important was this presentation and, indeed, the proposal that was put to government for an ongoing program in the Peel region. Dean Snashall, the senior sergeant from Mandurah Police Station, also supported the program that was presented and the funding proposal.

I want to go to the funding proposal for the youth mental health program to be delivered through the Peel Youth Medical Service. PYMS is funded by GP down south and specifically targets young people. Young people present to PYMS with myriad health concerns or questions, including mental health issues. After that event with Heath Black, the idea of having an ongoing program was considered so important that a funding proposal was formulated. It was a three-tier proposal. The first tier was for a global ambassador presentation, similar to the one Heath Black presented. The second tier would drill down to individual schools through the provision of workshops, and the third tier would be individual counselling sessions, particularly for young people who either presented for counselling or wished to seek further counselling. The proposal supported all the objectives for suicide prevention and in relation to addressing depression and health issues that particularly affect young people. It was supported by a range of groups and people, including the Mandurah police, high schools in the Peel education district, Pinjarra Senior High School chaplain Justin Hill, Catherine Shepherd from John Tonkin College, and the Palmerston Association, which has been in Mandurah for 20 years. The Palmerston Association works in the area of drugs and alcohol in particular and recognised the importance of the program that was being proposed over the next four years, which would fold in with the sort of work that it does with families in the Mandurah–Peel area. The chief executive of Primary Care WA also highlighted his support for the program, as did counselling and mediation groups and even primary school principals. All of them said that we need this program.

We have a massive youth population. This is the thing that people in this place must also understand; the Peel region and Mandurah are not just retirement villages where most of the people are in their 60s and older. That is now a myth. Yes, it was the case that a significant proportion of our population was once in the senior years, but now we have bulges at both ends of the demographic spectrum. The big bulges are in the age groups of zero to 15 and then 65 and beyond. A normal bell curve bulges in the middle; ours does not—it bulges at both ends of the demographic spectrum. That tells us that there is a growing number of young people in our region. What happened? A very good proposal was put to the Minister for Mental Health through the department and the commissioner for a very well researched and evidence-based program. The funding that was sought over a period of three years was \$393 000, which was broken down into the components—the three tiers—that I mentioned. I understand that only last week the government said no to that proposal. I do not know what one has to do to convince the government about the validity and value of a program. They did everything possible to highlight why this evidence-based program should be funded. I consistently stand in this place to highlight how my region misses out on royalties for regions funding. People get sick of me saying it, but this is another example of the government overlooking the Peel region, which is the fastest growing region in Western Australia. According to the government's own plans for population growth, the population of the Peel region will be equivalent to that of the south west by 2031. The government predicts the population will grow to 180 000 by 2031. The Peel region has grown 4.5 per cent annually over the last 15 years, much of it young families and children, yet the government cannot fund a \$398 000 program that is evidence based and will deliver outcomes over three years. I do not know what to say. It is not the fault of the parliamentary secretary, the member for Kingsley, but I ask that when she has a conversation with the Minister for Mental Health as a

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result of the contributions in the second reading debate to plead with the minister to look at the youth mental health funding proposal from the Peel Youth Medical Service that went before the minister and the Mental Health Commission. I reckon that a similar program would work in the Kimberley. This is the sort of program that will make a difference. I can give the parliamentary secretary every evidence of this. I can give the parliamentary secretary a copy of this, if she wants one. I ask why a program like this that is so well researched and evidence based, with so many willing participants and an eager audience, cannot get funded by this government. I plead with the parliamentary secretary to bang on the door of the minister tonight—I am sure she is still working—to ask what happened to the funding for the Peel mental health funding proposal. I hope the parliamentary secretary will do that.

I want to finish on a couple of other things that I think are important in the funding model of service delivery. Some of these things are a little out there, but in my view they are delivering results. One of these programs is the June O'Connor centres. I do not know whether anyone in this place has met June O'Connor. I always thought that she did not exist and that it was just a name, but one day, years ago, I met her. She is one of those remarkable people that we never forget. In fact, she does not let anyone forget her. More importantly, she does not let anyone forget the centres that she helped to establish; that is, the centres in her name in the metropolitan area. We fought, literally for years, to get a June O'Connor centre in Mandurah, and every year since we got it, it has been threatened with the removal of its funding. There is also one in Rockingham. The minister must realise that people with mental health needs want localised services. They want those services in Mandurah. Why should they not have them in Mandurah? They deserve to have them in Mandurah. They deserve to have these services delivered where they live, and where their family and supports are as well. I still drop into the June O'Connor Centre in Mandurah, but I am always fearful that I will hear about or get that phone call that says, "David, we are in trouble again", or something has happened. This is about treating Mandurah and Peel as a major centre of population with all the myriad needs that a local community has, wants and deserves. That goes for the area of mental health. I again highlight the importance of initiatives like the June O'Connor Centre and advocate very strongly for the June O'Connor Centre in Mandurah and would support any plans that ensure not only its continued existence but also its expansion into the future.

I will finish with one last point; it is an anecdotal experience. When I was an elected councillor at the City of Mandurah, I can always remember the council receiving a proposal for a house in central Mandurah to be used for what was then called a drop-in centre. Members should have heard all the negativity that came out of the community. I remember the city council meetings at which myriad people would tell us that the whole world would collapse if we approved this centre. There was one old gentleman who stood up on behalf of his son. He advocated so strongly that I reckon he convinced all the councillors why it was so important that we did not listen just to the not-in-my-backyarders but we recognise the need for support services for people. The centre went ahead, and the neighbours in and around that area ended up supporting it and becoming involved in the activities in that facility. Let us break down the barriers in mental health and the myths that might exist. Let us recognise that people of all persuasions and of all afflictions and disabilities deserve their place.

MR P. ABETZ (Southern River) [8.58 pm]: I would like to make a short contribution on the cognate debate on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. Our views on mental health issues are shaped by many different factors. The fact that psychiatry is not an exact science means that people have different experiences interacting with the mental health system. If anyone has a family member who has been mentally ill, or has been involved professionally, that shapes their perspective of the system. I have a sister-in-law who is a leading psychiatrist in Adelaide. Over the years, chatting with her at different times has helped to shape my views.

As a pastor for 25 years, I visited various people in psychiatric hospitals, clinics and in a home setting and I have counselled some at different times. One of the things that strikes me is that I saw some abysmal mental health care and I saw some excellent mental health care over the years. In fact, one case was very well handled and holistically managed by the Armadale-Kelmscott Memorial Hospital. They were brilliant, and the family was extremely appreciative of that, yet, in another case, a person was in a private clinic, which was a very different situation. This lady had been horrendously sexually abused in childhood and she struggled with a whole lot of issues because of that. Her family was incredibly supportive. Her husband and her kids, who are now grown up, wanted to help, but when they approached the psychiatrist treating her in this private clinic, they were told that they were not needed. I thought that did not sound right, so I made an approach to the psychiatrist and said that the family was really keen and wanted to know how they could help in this setting. I asked her how she thought I could best help the family as this lady's pastor. This psychiatrist puffed her chest out—she was one of the old-school psychiatrists and did not use the word "client"—and said, "I am quite capable of looking after my patient without the help of family or of you, thank you very much!" She got up from her desk and marched out to the ward. Needless to say, that lady struggled for years because this particular psychiatrist under whose care she was

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had this very arrogant attitude; she treated this patient's psychiatric problem as a purely medical problem. My experience certainly tells me that when mental health is treated purely as a medical issue, it rarely has good outcomes.

When the draft Mental Health Bill was released last year, there was a lot of feedback from the community. I certainly got plenty of feedback as well; in fact, I made a submission to the review of the act. I am more than satisfied that what is in the bill provides good safeguards, particularly regarding electroconvulsive therapy. I attended a briefing about it this morning. Electroconvulsive therapy is very rarely used in Western Australia, and the bill that is before the house will actually put far more restrictions on it than exist at this point in time. Certainly, there are psychiatrists who believe that electroconvulsive therapy is not a particularly useful therapy; others believe it has its place. I guess we need to leave the decision to the psychiatrists to figure it out amongst themselves, but we should allow people to make those choices about what treatment they want to pursue.

One of the highlights from the feedback that I received from the community was that people were shocked to learn that a person at the age of 14 could actually decide what sort of medical treatment he or she was going to get. They thought it was just not possible. However, the reality is that a child at the age of 14 can say, yes, he or she wants to have ECT and people will say that is terrible. Nonetheless, a girl at the age of 14 can decide to go on to contraception without having to inform her parents. She can have an abortion without involving the family or the parents at all. Again, a lot of people in my community were quite shocked about this provision, but that is part of our common law. It gives young people at that age the right to make a lot of decisions without consulting their parents. I do not know whether it is a good thing or not, but I think if parents are supportive then they should be involved. However, this is not the focus of the bill.

This bill is basically about what happens to people who have a serious mental illness. The nation's mental health budget runs into the millions. It is important that we treat mental health. It is important that we do not stigmatise it as being something worse than, say, cancer or some other physical illness. We need to ask questions that we ask about other medical conditions—that is, what can we actually do to reduce the incidence of mental illness? What can we do to reduce the incidence of diabetes? There are answers to those questions. Research shows very clearly that certain factors lead to a higher incidence of mental health problems. One of the interesting things is that the family, the context in which we grow up, has an enormous impact. I submitted a request for a parliamentary intern to do a report for me about this matter. It is titled "Impact of Family Type on Societal Outcomes of Children". Georgia Naughton-Watt from the University of Western Australia prepared the report. I will just read a little piece from her executive summary, which states —

Findings overwhelmingly suggest that the best environment for a child to grow up in is the traditional family; where the biological parents of the child/children are in a married relationship Children who have had experiences of parental divorce, and in some instances, parental remarriage, are at a significant disadvantage on a range of outcomes, including educational achievement, employment and financial security, when compared to those children who have grown up in a traditional family.

We need to ask ourselves as legislators what we can do to strengthen families, because that will make a significant difference.

In his book *The Conservative Revolution* Cory Bernardi cites research that basically says the same as what Georgia found in her research; namely, that the natural family of mum and dad in a married relationship provides the best outcome for kids. He posits the thesis that the traditional natural family is the gold standard. I am sure we all remember when Bill Shorten said, "As a stepfather, I am offended". Well might Bill Shorten be offended! But it does not change the undeniable evidence that the best context in which to raise children is the traditional family.

Let me give members a quote from a footnote from Cory Bernardi's book, which states —

We know the statistics—that children who grow up without a father are five times more likely to live in poverty and commit crime; nine times more likely to drop out of schools and twenty times more likely to end up in prison. They are more likely to have behavioural problems, or run away from home, or become teenage parents themselves. And the foundations of our community are weaker because of it.

Can I simply observe that for the sake of our society these things need to be said. Interestingly enough, this was not a quote of something that Cory Bernardi said himself. It is actually a quote that he took not from a religious-right fanatic, but from President Barack Obama's Father's Day address of 2008. That is not to say that some stepfamilies do not do well or there are not many brave single mums and dads doing a sterling job under difficult circumstances—there are. But as policymakers, if we want to reduce the incidence of mental health problems,

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reduce our prison population, improve educational outcomes for our young people, we need to look at what we can do to strengthen the traditional family.

Another issue that affects mental health in a very big way is illicit drugs. My estimate would be—from what I have read and from different research papers—that some 60 per cent of the people who have major mental health issues also have an illicit drug problem. I have a nephew who smoked marijuana just once. That first joint sent him into a psychotic episode. He has had ongoing mental health problems from that particular experience ever since. I find it absolutely appalling when people, who should know better, talk about so-called recreational drug use because there is no such thing as recreational drug use. Drug use so easily damages the brain. When people, who should know better, say that smoking marijuana is no different from having a glass of wine, I do not know anyone who, from one glass of wine or from one standard drink of beer, ended up having psychotic episodes for the rest of their lives.

Mr P.B. Watson: I think he might have had more than one puff!

Mr P. ABETZ: One joint, yes. If we want to reduce the incidence of mental health issues, we really need to address the illicit drug issue in our community. Whenever I hear anyone using the term “recreational drug use”, I always try and pull them up by saying that there is no such thing. It is an illegal drug. It is something that is damaging the body; people should not use it. We need to send a very clear message to people in our community that it is not something that ought to be done. The danger of using illicit drugs ought to be made very clear.

Another very significant contributor to mental health issues is sexual abuse. Childhood sexual abuse really damages the very soul of a child. The reality is that most people who have been sexually abused in childhood actually limp through life. Very few people fully overcome what has happened to them. We need to be very tough on this whole issue of sexual abuse. We should not tolerate it or condone it or be soft on it in any way, shape or form at all. One of the tragedies is that of the women who involve themselves in prostitution, the vast majority had been sexually abused in childhood. When we then look at women who have been in prostitution for any significant length of time, we see that 70 per cent suffer post-traumatic stress disorder; that puts a massive load onto our mental health system.

There are many things that we as a community and as legislators can and should do to reduce the incidence of mental health problems in our community. It is devastating for families when mental health problems strike. This afternoon I met with Karl and Pamela Walsh and Norman and Merrilan Bowring. Both of these families know all too well the impact of mental health issues. One of their sons committed suicide not that long ago. The pain of that is enormous. That pain is multiplied many times over in our community. The Walshes and the Bowrings, together with other people, including our former Speaker, the former member for Moore, have formed the Crossroads Healing Centre Inc. They are trying to provide a step-down facility for people aged between 13 and 18 because so often people have such severe mental health issues that they go into intensive care in a mental hospital.

Mr P.B. Watson: Member, what’s a step-down facility?

Mr P. ABETZ: If a patient in a hospital such as Graylands Hospital has recovered sufficiently not to need that kind of intensive care anymore but are not really ready to go home yet, they are referred to a step-down program where they have a bit more of a relaxed time in the setting. Crossroads Healing Centre Inc was set up and its founders wish to purchase the Christian Brothers Agricultural School in Tardun. The buildings would be eminently suited to such a step-down facility. It would cost millions of dollars to build the buildings that are there now. The Christian Brothers are willing to sell the school to the centre for the purpose of a step-down facility for \$550 000. The centre is struggling and wondering where it can find the money. Who can help them get this happening? They quite rightly say that often some of the issues within their community—this is particularly the case for Aboriginal people who have mental health problems—have contributed to the issue. If they come straight out of a mental health care facility and go back into their own community where nobody is checking on whether they are taking their medication and that kind of thing, it is a recipe for relapse. If they could go to a step-down facility such as this, it would be a great opportunity for them to continue on the path of recovery. One of the interesting things that the centre stressed is that mental health is not only a medical issue but also, as is illustrated by the diagram in its brochure, the body, mind and soul need to be looked at, and the centre believes it can do that well in that setting.

I will not ask for an extension of time. Unless we as a society really address some of the contributing factors to mental health problems, we will be faced with an ever-increasing burden of mental illness and we will be forever looking for bigger pots of gold in our state and federal budgets to fund this growing incidence of mental illness. I believe that we need to provide excellent mental health care facilities but we should also not forget to do those things that we know will help to reduce the incidence of mental health problems.

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MR M.P. MURRAY (Collie–Preston) [9.14 pm]: I rise to contribute to the cognate debate on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. I think the previous speaker oversimplified some of the issues that cause mental health. It is far deeper than just saying that it is a family issue; it is also about people's upbringing. We must be aware of that.

Mr P. Abetz: It is only part.

Mr M.P. MURRAY: I understand that it is only part of the problem but many people that we see in our jobs on a day-to-day basis have had an ongoing and long history of mental health problems. It is something that our staff have to deal with on a daily basis, more so in smaller country towns where people do not have that support. I recently attended a meeting with the Southern Country Health Service about mental health. To be quite honest, I went away confused and shocked. I had no answers, and nor did anyone else. When we sat down, we said that we were going to talk about mental health. We touched on only one slice of that—the medical condition. Mental health starts with whether one has accommodation, a job or access to training. Those parts were not picked up; they were picked up as one slice. We cannot do that. How can we help a person who comes into our office by saying to them that we have something for them and can help them if they do not have any accommodation and they have not had a shower for two or three weeks? This is the basis on which we must work to build that up. We need to do it across the board and make it all-inclusive, not part of something else. I went to another meeting with government agencies and there were 18 people in the room. Out of those 18 people, only five had met other service providers in that room. The approach is disjointed and needs to be coordinated.

The bill itself certainly addresses some issues but it does not address the underground services, the social issue and the funding that goes with that. It is very concerning. As we know very well, mental health has many faces. We have young people who have issues with jobs, depression, drugs and alcohol—all those things that are a part of growing up. Some people will get through that and others will never get out of the spiral that they are in. Then there are some of those awful things such as suicide. Suicide is far too common and something that is hidden in our community far too much. The press has the opinion that it is not going to report many suicides, if any at all. I spoke to some reporters during the Christmas drinks about that. They report everything else but they are scared about copycats. I think that is one of the problems: we are not facing up to the issue; we are hiding the issue of youth suicide and mental health issues.

Then we move on to seniors who at times feel bullied. They may not have a place to go when they get older. They might not have been provided with a place to go or the family has left and they are very lonely. Then they have the problems that go with that. Anyone who has been to an aged-care centre would have seen the terrible things that go on there and the condition of the people who live there, sitting in wheelchairs and not being able to function properly, and the wonderful people who look after them. That is another phase of mental health. Dementia has probably been addressed a bit more in recent times but it is still part of the mental health area. It goes across all areas. Then there is the issue of jobs. We read quite regularly about the depression that farmers suffer over years of having bad returns from their farm, the bank managers banging on the door, the breakdown of marriages and the kids who do not want to take over the farm. We hear that over and over again. Do we have services available to help them? Not really. We do a bit of lip service. Money has been spent in this area by the federal and state governments; there is no argument about that. Can a person walk in off the street and say, "I want to talk to you about this?" It is not there. In many country towns, that contributes to the problems of mental health.

There is also unemployment. That covers people of all ages. Recently a young lady came to see me. She had applied for 92 jobs. She was a bit of a mess. We can understand where that was headed and why depression had set in about how no-one in the world liked her and everyone was against her. Trying to sort that out on a one-by-one basis was certainly well beyond my capabilities. Trying to get a referral to a psychiatrist for that young lady was very difficult because of the lack of psychiatrists around the place and the reluctance in some cases for doctors to refer people. Doctors often say, "Here are some tablets; go home and take a couple of these and you'll be right." Another problem is that when people seek medical help, they are often filled up with pills and are unable to function properly. I should not do it, but many times I have told people to go home and throw their pills in the bin and try to start again without them. I do not know whether they have been successful in doing that. But because of the pressure that doctors are under, if the symptoms are there, it is often easier to just write out a prescription. However, the problem is that the person then does not function properly, their motor skills are terrible, and their thought processes are shocking. Therefore, instead of being a fix-it, it does not help the person at all.

Alcohol and drugs are often put together, but in many cases they do not mix well at all. Some of the young people in mining towns are very well paid. However, they often work 12-hour shifts, and they do not have time to socialise, or they do not have social skills, so they go home, and it starts off with a couple of cans, and over a

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period of time it becomes a very bad habit. I am hearing also that in some mining camps in the north, some people are staying in the camp on their days off, and we know what happens then—they are always sober and able to present for work when their roster comes on, but they spend their whole time being hermits in a way and drinking far too much and causing problems that are mental health-related. So we need to be very careful about what we do.

Often when people with mental health problems present at the hospital, they are sent away. We had what could have been a disastrous situation recently, when a person whom I have known for many years went to hospital, and the hospital sent him away, and we got a phone call from the police to say, “Look out; this guy with mental health problems is coming your way.” He managed to get to our office, but he was very compliant and quiet and easy to handle. But it could have been very different from that. He could have been stirred up or become agitated on his way to my office, and that could have caused huge problems for my staff. The problem is that there was nowhere for this person to go other than Mick Murray’s office, and even though my staff are very good at listening to and talking to these people, we do not have the facilities to help them. However, we cannot send these people back to their doctor, because their doctor will send them to hospital, and the hospital will send them away again. It is a cycle, and I am not sure how we can break that cycle to try to help these people. I hope that this bill will contribute to being able to break that cycle and get funding so that these people can be helped.

The funding of health services always needs to be at the front end of our medical system. It is not the job of the police to look after people with mental health problems. However, that is what happens. The police sometimes have to lock up people in a police van because they cannot find a doctor who is able to administer a sedative to slow these people down so that they can be placed in hospital. That is a tragedy for the person concerned, and it is also very hard on the police, because they are expected to act as a de facto psychiatrist, doctor and nurse, all in one, and then to also help in the community when a crime is committed. The police cop the abuse because they cannot get to the scene of a crime straightaway, because they have to babysit or look after a person with mental health problems. When the police are able to present these people to hospital, they go into a general ward, and they might scream and shout and be abusive to other people. We need to provide specialised facilities for these people. Sometimes when these people are admitted to hospital, there is no security, and once the police have dropped them off and gone out the door, they play up again and the nurses have to look after them. The many people that the hospitals in Bunbury and Collie have to deal with on weekends puts an extra load on those hospitals at times when they are trying to get through with a skeleton staff. The police do a wonderful job, but looking after people with mental health issues often goes well beyond their duties. The police are often underestimated within our community. Police officers may turn up at a house and have to sort out a domestic argument that is caused by mental health problems or drug addiction, and they have to deal with those people as though they were psychiatrists. That makes their job very difficult.

There has been a lot of lobbying about this bill over the past six or seven months. It is very confusing for a layman to look at that lobbying and work out what is right and what is wrong with the bill, what drugs should be given to which people, and which people should be looked after. But anyone who has been to Graylands Hospital would also be very confused. It is one of the worse places I have ever been to. I went there—not admitted, but I certainly went there—to visit people. I did not realise how close Graylands is to the movie *One Flew over the Cuckoo’s Nest*. People were walking around and around in the garden area and looking through me, not at me, because they were in a stupor from the drugs they had been given to slow them down. They had their own patch of turf and that was their spot; no-one else could sit there. People were begging for cigarettes. At the time I went to Graylands, there was a wire fence, and people were standing behind the fence and asking please could I give them a cigarette. I was shocked. It is not very often these days that I get that sort of eye-opener. The only way the people who work at Graylands can keep that number of people under control is by drugging them. That is exactly what it looked as though they were doing. These people were walking around and around in circles and talking absolute rubbish. There was not physical violence, but people were having arguments between themselves about where they could stand and whose chair or whose bit of ground they could sit on. That is how I envisaged Graylands would have been 50 years ago, and I came away from Graylands thinking that things have not changed much in the last 50 years. I would love to go back to Graylands one day and see that it was 10 times better, but I do not think it would be, because things are not changing quickly enough in my view.

There are huge variations in the opinions of psychiatrists and doctors, lobbyists and other people with an interest in this area. However, one issue that caught my eye and that concerns me is the age limits that have been placed in the bill for children to be given electroconvulsive therapy. I am glad to see that some of those age limits have been changed slightly.

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I read a book, the name of which I am trying very hard to remember, about a young person who went through life having convulsions and mental problems, and who had been through all the dark spaces of life—he moved out of home and lived on the streets, the whole lot. At about 21 something happened in his life and the convulsions stopped; his facial convulsions stopped and he became normal and moved on. That happened without drugs or electroconvulsive therapy. Even though in earlier times that person had had problems, he had changed and gone natural, I suppose, and around 21 or 22 years of age he was able to get on with his life and things became normal. According to this book, to this day doctors do not know why things changed. Therefore, I am very cautious about allowing operations like electric shocks and those sorts of things on young people. I think we have to be very, very cautious. Who knows what damage we are doing to a brain when we use those methods? It is something we should be very mindful of. I think the minimum age for electroconvulsive therapy is 16, but I believe it should be 18. Nurses who have witnessed that shock treatment have told me personally that it is one of the most horrific things that a person can see. My concerns are about younger people. Although we think we are doing the right thing at times, it is not always the case because sometimes nature will take its course with some help along the way.

In saying that, I support any move to help these people through updating the legislation. It looks at the issue of mental health from a slightly different angle, but I do not think it goes far enough and its overview is not far enough removed from the old legislation. However, in saying that, I support the bill. I hope it gives a bit more hope to those many, many people out there affected by mental illness.

MR P.B. WATSON (Albany) [9.32 pm]: I rise to speak on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. Mental health has been the elephant in the room since I have been a member of Parliament. It is probably my thirteenth year now and the issue has just grown and grown. Everyone just seems to want to push the issue a bit further away, because no-one wants to be involved with mental health. People do not want to have the stigma associated with mental health problems and it has become a real issue, not only in my electorate, but I think in electorates all over the state. Mental health issues cover all areas of the community. I have seen young people who have issues with drugs, whose parents have maybe brought them to me, and I have also seen older people with mental health issues. I see a lot of older people when I am out doorknocking. They might be people who are sitting around who have been put off work, probably in their 40s or 50s, and who had the same job for 20 or 30 years. All of a sudden they are at home and have lost the contact and stimulation that they had when they used to go to work. They were used to having people around them and all of a sudden they are at home alone. When I talk to these people while doorknocking, especially some of the older ones, I cannot get out of their house because they just want to talk to someone; they just want to discuss what is happening in the world or around town. We have to find ways of getting these people out into the community again because there will be more and more people in this case.

Unfortunately, there are no pathways forward for people in the early stages of mental illness. We have young children who have attention deficit hyperactivity disorder and we tend to fill them full of pills because we think they have issues. I see young people like that now who have the same characteristics I had at school, they cannot pay attention, they look out the window all the time and they are probably little bit cheeky—I have got over that over the years!—and those sorts of things, and now we just put pills into the kids without giving them a chance to develop. All of these things build up along the way.

One of the worst things I see is parents with children who just do not fit in and who are not eligible for funding to get a helper at school because they slip through the cracks. They might fit three out of four criteria that would qualify them for funding, but they do not fit the fourth thing, so they do not get any funding. These kids are at school causing trouble and it does not help them or the other kids.

I congratulate the government because we now have a very good mental health service at the hospital in Albany. It is probably one of the best in the state for regional areas, and I do not know about the whole of Australia, but it is very good system and it is up there. The problem is getting people there and getting them diagnosed properly. I know police have a real problem with this. Some people get out on the grog and the amphetamines, and they have to go to G ward because they are going crazy. I think we only have two police cars on the streets in Albany at the weekend and police tell me that a lot of their time is taken up by sitting at a hospital waiting to get a person processed. They cannot let that person go until they have been admitted, medicated and staff taken out of danger.

I turn to suicides. The member for Collie–Preston was talking about something I have been pushing for quite a while. Should suicides be reported in the media? People say there are copycats. Between Albany and Esperance is the highest youth suicide rate in Australia. It is not something we are proud of, but it is there. There are also a lot of farmers —

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Mr J.M. Francis: What age demographic?

Mr P.B. WATSON: They are aged up to 18—probably 12 to 18. I think it is one of the highest suicide rates in Australia or at least it was last time I checked.

Mr J.M. Francis: Where did you find that information?

Mr P.B. WATSON: It came out of a survey that was done about four or five years and I do not think things have got any better since then. Should suicides be reported? There are two instances of young people I know committing suicide. There were two guys who had break-ups with their girlfriends. They drove up the hill somewhere in town and hanged themselves. I will not say where it is because the tree where it occurred has been chopped down. One boy hanged himself because he had a fight with his girlfriend and the other one did exactly the same thing when he broke up with his girlfriend. It was not publicised that it happened at that spot. I do not want to get away from the fact that I was saying we should not publicise suicides, but we have to let people know about the consequences of suicide. Kids think it is a quick fix and think, “I will teach her”, but we have to educate them that when they die, they die. They will not make anyone else feel better, they will just make all their friends, family and loved ones feel worse. I have been to some funerals and I know.

There is also the issue of depression. So many young people who were victims of abuse at the Katanning hostel, four or five, committed suicide because of things that happened to them that were not brought out earlier, which led to depression, alcoholism and all these sorts of things. These things should never happen. We cannot bring back the past, but we have to make sure that it does not happen again in the future.

There are also issues such as dementia. There is the new Hawthorn House in Albany. I congratulate the state and federal governments for building a new Hawthorn House; the staff do a tremendous job. They had a building in McLeod Street that was getting a bit old, so we managed to get them new premises through the former Leader of the National Party when he was Minister for Lands; he gave us some land near Oyster Harbour. We have a real issue there at the moment. Apparently we cannot get telephone lines in there or the internet and it is going to cost another \$75 000. We will probably be coming cap in hand to get royalties for regions for something like that as it is a huge issue.

Funding for accommodation for people with mental health issues is a big problem. I have people who come to see me who are all right when they are on their medicine. One person does not get on his meds and we have put a ban on him coming to the office but it does not make any difference. We had five policemen there with Tasers one day because he did not take his meds and wanted to smash up my office, my staff and me. The five police there asked him to move on and he said no, so they had to handcuff him and take him away. Country areas are a little bit different. When people have an issue, they go to their local member. However, I am more concerned for my staff when these types of people come in and they have not taken their meds. I have forgotten the electorate of the member who spoke about the step-down program before the member for Collie–Preston spoke.

Mr J.M. Francis: It was the member for Southern River.

Mr P.B. WATSON: Yes, it was the member for Southern River. He talked about a step-down program for people who come out of a hospital or mental health facility. Currently people just get released. They do not have a taxi fare or anything; they are just released at the front of the hospital and that is it. It would be great if we had a step-down facility because then we would be sure that they got into the process and took their medicine on a regular basis. I do feel, though, that we over-medicate. I know it is easy for hospitals and for mental health staff, but if we are going to over-medicate people, we have to make sure we wean them off over a period. Some of the people I have problems with are continuously on the same meds. When they are feeling good, they will come to me and say, “I got flown up to Graylands because I had an episode. The police came and got me. Next thing I know is they stick a needle in my backside and I wake up in Graylands Hospital.” They then have to find their way back to Albany. There must be a better system for people like that. They do not want to be like they are but if they do not take their medicine, they misbehave and sometimes it is not their fault but more of a chemical reaction or something that happens.

I just want to get back for a moment to the issue of depression. We have seen in the media high-profile sportsmen who finish their sport and get depression. I probably went through a bit of that myself. When people are running, they are training seven days a week and preparing themselves for big races. There is not much glamour or anything like that; it is hard work. But then all of a sudden they stop and they do not have the adrenalin going through them and they miss their body not doing the things it did before. Depression affects a lot of people. I had a close friend who I once sat up all night with and talked out of committing suicide. He had gotten to the stage at which he just did not think there was any other way out. This was a person who members would never ever believe would want to commit suicide. He had everything, but had nothing. In his own mind he

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thought he just did not have anything. When he rang me, I just could not believe what he was telling me he was going to do. We got him help and he is on medication now, but it is scary that it can happen to anybody—just anybody. It can be sportsmen and it can be children.

We put pressures on young people today by saying that they have to compete and do this and do that. We just have to let people enjoy their life a bit more. I am involved in a fair bit of sport and it really scares me to see the pressure that parents put on their kids by saying, “You’ve got to win, you’ve got to beat that person.” One of the worst things I have seen in sport was at a Little Athletics event when I was presenting trophies and I saw a young kid run his heart out. He was probably half the size of the guy who beat him, and the guy just beat him on the line. His dad came up afterwards and grabbed the kid by the ear and said, “How dare you let so-and-so’s son beat you.” I went up to the bloke and said, “You are an absolute disgrace.” He took a swing at me, so it probably was not the best thing to say. However, we cannot keep putting this sort of pressure on these young people, because then they get all these problems down the track.

I know that royalties for regions is not supposed to pay for everything. However, the Lions Community Care Centre in Albany provides respite for families who have people with mental issues, dementia and all those conditions. I know that it got state and federal funding but it will run out of its funding at the end of the financial year. This organisation in Albany probably saves a lot of marriages and maybe some lives, and that is what I think royalties for regions should be for. People in Perth have a lot more facilities for respite but this is the only one we have in Albany and it is going to close because it is running out of money. A constituent who came to see me recently has a daughter who is bipolar. She might go one or two years without having an issue but then she needs to be admitted to hospital when she has one. They cannot get a psychiatrist to admit her to hospital. The only way she can go there is to front up at Royal Perth Hospital or Bentley Hospital. She went to Bentley and she got better, so she went home. Sometimes she will go home and go to bed for a day and it all passes but when she had the next incident, she went to the hospital and was told that the hospital had deactivated her because she had not been there for a certain time, and the hospital would not tell her how she could be activated again. This girl, who lives very close to Bentley Hospital, has to now get someone to take her to Royal Perth Hospital, which refers her back to Bentley and then Bentley refers her back to Royal Perth Hospital, because she has been deactivated. There must be a better system. One of the major issues is finding a psychiatrist who will admit her to hospital.

I want to talk about some groups in Albany. Kids Central Great Southern mental health centre is a support service for kids from three to 14 years old and their families. It is a not-for-profit organisation and the staff there do a tremendous job, which is to strengthen the mental health and wellbeing of children. Headspace Albany does a tremendous job with young people in Albany. The Men’s Resource Centre in Albany does a tremendous job, and I congratulate the Minister for Health who has twice now provided funding for that centre. The staff go out into the community and educate people, especially men. Men are not like women—I have to be careful how I say this—because men hold everything in. Women will talk about issues to their friends, whereas men will not. The staff go out and talk to men and let them know about the facilities that are available for them. As I say, women will seek help and will talk to their friends.

Working fly in, fly out is a real issue. We lost a young boy from Albany last year. I think he was away up north for three weeks on and one week off. When he came home for the one week, no-one picked up that he had an issue but obviously he had issues up there. He was lonely and the FIFO system did not suit him, but he wanted to make money and, unfortunately, he committed suicide up there. It is very hard to pick something like that when someone works away, but I think there should be more education in schools to tell people that when they get down, there is —

Mrs G.J. Godfrey interjected.

Mr P.B. WATSON: Does the member for Belmont want me to get an extension?

Mrs G.J. Godfrey: If you want.

Mr P.B. WATSON: No, but I thank the member anyway. We just have to encourage that education at school.

I am concerned about psychosurgery for children. I think it is very dangerous that we have this surgical technique that is banned in New South Wales for all ages, but now they want to enable it to be done on children from the age of 14; I think it should be changed to 18. As the member for Collie-Preston said, we do not want to be messing around with young people’s brains. So many changes are happening in the medical system, and I think messing around with kids’ brains when they are in that age group is not right, and it is banned in New South Wales. I support this bill, but I am really concerned about psychosurgery for children. I think I will

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be talking about that another time. I think something has to be done, and I think this bill goes a fair way towards it.

MR J.R. QUIGLEY (Butler) [9.51 pm]: I, too, rise to support the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013, and to make some comments on the state of mental health treatment in Western Australia. The comments I will make this evening are largely informed by discussions had with a friend of mine—a contemporary from university days back in the 1970s—who for many years now has sat on the Western Australian committee of the college of psychiatrists.

Before turning to those comments, informed by my good friend the doctor, I would like to refer to the anecdotes told this evening in the chamber about the sufferings of people known to members. Having been brought up in the 1960s, that was a time when mental health really did carry a heavy stigma and people would talk about it only in hushed voices, and disparaging words such as “loony” were used, which increased the stigma. Since then, of course, especially in the past 10 years or 15 years, there has been a real awakening throughout the community around how this illness—because it is an illness—can afflict so many people who would otherwise look to be functioning members of the community but who go on a cyclical process during their decline. We have all heard about the recent tragedy of the late Charlotte Dawson, who only last Friday was a panellist on Fox television—I saw her while I was walking in the gym—and appeared to be bright, up and functioning, and then within a short space of time it appears she was so depressed that she took her own life. Who would have picked it?

In my own electorate there is the tragic situation of a woman who came to see me. She is a lovely lady in her late 30s who is a physiotherapist involved in rehabilitation work—getting people back to work—and she had been remarried for about 15 months. She has two daughters, the oldest being 15, and she married a physiotherapist who has a son aged 26 who was schizophrenic and had been in Graylands Hospital and discharged to home care, which throws the burden on the parents. The woman saw the son at home perving or eyeing her oldest daughter and became disturbed about that, and it was agreed they would move him into a flat by himself in Maylands and try to support him from there. But during further decline he became unruly in that block of flats, to the point that he could not continue with his tenancy. The father, lovingly and dutifully, went to assist the son’s move with a trailer and was taking loads down to it. While taking one of these loads to the trailer, his son jumped him from behind and drew a carving knife across his throat, ear to ear. The father grasped his throat and ran to a laundromat across the road, where he collapsed. The father did not die, but he tragically lost so much oxygen and suffered hypoxia during this process that he became very debilitated and unable to work. There was the woman, 15 months after her marriage, now the full-time carer for her new husband who had suffered hypoxia. The son was charged with attempted murder, which he was found not guilty of on the grounds of insanity; he was then committed under the jurisdiction of the Mental Health Review Board.

I think those two stories touch upon two things. Firstly, that mental illness is not always obvious to families or the community, and a person can be affected without us knowing. We have heard of footballers who have come out—I do not want to mention particular names—such as the Collingwood player who came out last year and said he had been struggling with mental illness or severe depression since coming to Australia some years ago; others have come out and talked about their struggle with mental illness. Of course, it has been destigmatised by these people coming out, and in no small measure by the ongoing and sustained efforts of the former Premier of Victoria Mr Kennett in destigmatising this illness over the past maybe 15 years. He has never given up, and all credit to Mr Kennett. I notice the organisation he leads, beyondblue, is now to tour Australia with the big blue bus to further highlight the problem and help destigmatise it.

The first time I really turned my mind to the problem of the treatment of mental illness was in Adelaide, where the WA Police Union had sent me to appear at an inquest into the assassination of a Western Australian police officer who was working with the National Crime Authority in Adelaide—the late Detective Sergeant Geoffrey Bowen. I was over there for about six months appearing before the former coroner His Honour Judge Wayne Chivell. Because it was not litigation as such, I had the opportunity to spend several evening meals with him. He was concurrently working on a case not dissimilar to the case I described to members earlier this evening about the schizophrenic boy, in which a schizophrenic person had been discharged from an Adelaide institution. The parents found their son was noncompliant with his medication. Often the parents who are looking after these people are getting on. This man, who was in his mid-20s, was bulked up and quite strong and had become unruly at home, so his parents called the police. When the police arrived, their son charged down the corridor with a knife and the policemen shot him dead on the spot.

It was during one of these evening meals with the coroner, when he was lamenting to me, that I first started thinking about this. This is going back to 1997. The advent of the deinstitutionalisation of many mental patients,

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the disbanding of what we then knew as asylums, and pushing these people out into home care and throwing the responsibility onto families, in many cases, has had some unfortunate consequences for society. I discussed this with my friend, the doctor who is on the committee of the college of psychiatrists in Western Australia. He agreed that the advantages of asylums—we are not talking about Victorian asylums or places of detention—is that they are places of safe harbour in which people under duress of mental illness could go and be safe and be looked after and be subject to their medication regimes. That fell by the wayside in the 1980s when it was decided to move a lot of these people out into the community or into smaller institutions. The good doctor informs me that from the college's point of view, it believes the shortage of beds in Western Australia for acute mental patients to be as high as 700. He looked at Graylands Hospital, which is a very old hospital now. He explained that for health and safety reasons some of the wards on the second floor, such as the Fortescue ward, have had to be closed because of fire risk. He said that one of the big failings of the treatment system in Western Australia is that, unlike the other states, we do not have step-down beds; that is, when an acute patient has become subacute but not ready for discharge there is no step-down bed, such as might be found in some institutions where they could be looked after but not in an acute bed. He said that these subacute patients cannot be discharged and therefore they remain in an acute bed. This creates a backlog, because new acute patients cannot be admitted.

He pointed out that the new Fiona Stanley Hospital will have 24 beds in the mental health section to accommodate acute patients and that of those 24 beds, eight will be set aside for eating disorders because there is no eating disorder clinic for adults. There are good eating disorder situations at Princess Margaret Hospital for Children, but once they are not eligible for treatment at PMH, people are stranded. That leaves 16 beds. He said that because Fiona Stanley Hospital is a quaternary hospital, like a consulting hospital, it will have priority over all other hospitals in terms of discharge to other institutions. As my colleague and friend from Mandurah pointed out, there is no capacity to treat acute patients in Mandurah so they have to be sent to Fremantle Hospital. If they are assessed in Fremantle Hospital and it wants to refer them, for example, to the Alma Street clinic, but the Fiona Stanley Hospital consultant rings up and says they want to discharge into Alma Street clinic, Fiona Stanley has priority and the Fremantle patient gets bumped and cannot be admitted. That is because Fiona Stanley needs to keep beds free for new acute patients. He said that the problem with beds in Western Australia for acute patients is at breaking point and the accommodation for subacute patients is dismal.

I turn to the bill. I support the bill and I have been through various parts of the bill with the good doctor. We noticed that the bill before the chamber this evening contains a lot of checks and balances with admissions, including involuntary admissions and treatment modalities. Although all members in this chamber laud the bill and agree that these are good moves, we have to recognise, as he has pointed out to me, that this puts a lot of extra work on the admitting doctors; however, there is not a commensurate increase in resources within the public sector. I am told that psychiatrists within the public sector are already at their wits' end. No one is railing against the safeguards. How are they going to catch their breath? They are working so hard at the moment, how are they going to cope with the administrative requirements with the existing resources? We have at least two issues arising out of these comments, and they both come back to funding of the mental health system, both in the resources for the practitioners in this area, given the new requirements contained in this bill, and resourcing for the hospitals and institutions that are going to deal with this, because it is clear we are not resourcing them sufficiently at the moment. We cannot look only at the anecdotal evidence we have heard this evening from members who have known people who have suffered; we have all known those people.

[Member's time extended.]

Mr J.R. QUIGLEY: Not the least of this problem is in the regions amongst our Indigenous population. We have all heard of—the member for Kimberley has spoken to me about this—the incidence of foetal alcohol syndrome amongst Indigenous populations in the east Kimberley. Those children will carry the burden of mental infirmity throughout their life. There will be no recovery because the damage has been done during gestation. All those people are more than likely to become customers, clients or users of the services over which the Minister for Corrective Services sits. We know that the rate of mental infirmity amongst prisoners is very, very high.

There is a convergence of pressures upon mental health patients at the moment. We know from the comments of His Honour Judge Heaney, who sits on the magistrates' bench in Perth, that on declining to make an antisocial behaviour order against a Perth resident, he said that person is so infirm he would not even know what street he is in and whatever order he made, it would be broken because he would only end up in prison because of his mental infirmity. He declined to make the order. I will not go back into the debate about antisocial behaviour orders now other than to observe that a very large proportion of those people who are the subject of those applications are labouring under some type of mental infirmity. Indeed, the first one was a chap in Geraldton against whom an order was being sought to keep him five kilometres, I think, from the central post office in

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Geraldton. It was observed that he could not get in to get his pills from the chemist to treat his condition. When we talk about antisocial people and a lot of low-grade crime throughout the state, a lot of it is being committed by people who are suffering from some infirmity. The resources that we have to deal with it are meagre in terms of the size of the problem that I have described here this evening.

As my friend the doctor says, these people present at various times in their life to a forensic institution—that is, prison—to a psychiatric institution or to a drug rehabilitation program. Of those, the best funded at the moment is probably the prison system. But that is the last stop. We would like to avoid them going to prison and treat them in the community. As I have said, the treatment model and the treatment modalities within the community need far closer critical examination by this Parliament, or perhaps a committee of this Parliament, than this bill does itself because the bill is not a bad bill. I wish to draw an analogy for a moment. If we looked at other pieces of legislation that go through this Parliament, when we look at them objectively and analytically in this chamber, we would say, “That is not a bad piece of legislation”, but when we put it into practice, sometimes things are not what we thought they would be when we debated the bill.

The Corruption and Crime Commission is a prime example, although perhaps that was because of teething problems, but those teething problems went on for a number of years, in fact to the point at which there has not been a commissioner of that organisation who has ever served a full term. They have all thrown away their bat and gloves before their terms have expired. It was true of the first commissioner, Judge Hammond; it was true of the second commissioner, Mr Len Roberts-Smith; and it was true of the third commissioner, Mr Roger Macknay, QC. I note that there has not been a rush of applicants to fill the chair, but cabinet would know more of that than I do. When we look at the CCC bill, we can say that that was a good bill, and it passed through Parliament, but when we look at some of the ways in which it has been put into operation, we would have to say that it has been very disappointing. If we look at the Mental Health Bill, we would say that it is not a bad bill. It introduces new safeguards. It introduces a Chief Mental Health Advocate. It does a lot of things. Once the bill passes through Parliament, it will then get down to the treatment of these people, how we are going to treat them, where we are going to treat them and where the beds will be to treat them. As my friend the doctor says, “When you scatter it all over Perth into smaller institutions, you would be surprised at the amount of time I spend driving from place to place and I’m not treating anyone; I’m going from one small place to another small place, and in that trip I could have seen three or four people on a ward.” I do not know the answer. At the end of the day, we can distil it down to money—how much we can spend on the proper places of treatment. That is very difficult. As I said, the decision started to be taken in, I think, the late 1980s, but it certainly got going in the early 1990s, when the thinking was to deinstitutionalise all these people and get them out into the community.

I note that the honourable minister from the other place has taken a seat behind you, Mr Speaker, so I will recount one more story of a friend of mine who has a child who suffered a closed head injury at the age of six from which he will never recover. He was awarded \$11 million, but it took until, I think, the end of 2012 or the beginning of 2013 for that award to be made. His parents could then afford to buy a house and engage a company to give him the 24/7 care that he needed. There are not too many mental patients who could have those sorts of resources. By that stage, he had assaulted people. They were serious assaults of police who were trying to arrest him, but, thankfully, no-one was too badly hurt. He has also assaulted carers. There is a real problem with how to deal with these people. He is in his own little institution now, but that is because he got a huge award from a motor vehicle damages claim. As I said, he was an infant in the car when he suffered this horrendous event.

There are scores of people in the public system. As I have said, because there are no step-down beds and people are occupying acute beds, the system, according to my friend on the WA committee of the college, is in a gridlocked position.

I note that the former Under Treasurer, Mr Marney, has moved into the mental health field. I hope that with his knowledge of the budgetary process and his deep commitment to improving the treatment of people in this state with mental health issues, he will make some progress on behalf of all patients and on behalf of the profession.

I will be in the chamber to look at this bill when it is examined on a clause-by-clause basis. We will be supporting the bill, with some comments. I hope that the Parliament and the committees of the Parliament will look beyond the bill to what will be done after we pass this legislation to assist in the treatment of the mentally infirm. I worry about what progress will be made in that regard in the forthcoming budgetary process, and I will be very interested in that. I conclude my remarks by thanking members very much for their time.

Debate adjourned, on motion by **Mr J.H.D. Day (Leader of the House)**.

House adjourned at 10.21 pm

Extract from *Hansard*

[ASSEMBLY — Tuesday, 25 February 2014]

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Ms Andrea Mitchell; Dr Tony Buti; Mr Roger Cook; Mr Dave Kelly; Ms Margaret Quirk; Mr Paul Papalia; Dr
Graham Jacobs; Mr Chris Tallentire; Mr Peter Tinley; Mr David Templeman; Mr Peter Abetz; Mr Mick Murray;
Mr Peter Watson; Mr John Quigley
