MENTAL HEALTH REFORM

Motion

HON HELEN MORTON (East Metropolitan) [2.03 pm]: I move -

> That this house applauds the Australian government for contributing $1.8 billion of new funding to a five-year plan and a commitment to reform mental health in Australia, and calls upon the state government to match the commitment and outline its new funding contribution for mental health reform in areas of state responsibility.

It was the report, "Not for Service: Experiences of injustice and despair in mental health care in Australia", released by the Mental Health Council of Australia last October that finally dragged most of Australia into widespread mental health reform. The "Not for Service" report detailed shocking experiences of pain, injustices, a sense of pervading hopelessness and despair in the mental health system in the most graphic detail. For those people who have worked in the mental health area, the descriptions in the report were well recognised as part of an ongoing institutionalised culture of acceptance of the systemic failure and lack of accountability of our mental health system. The "Not for Service" report also outlined recent attempts to bring about reform in mental health.

In 1992, all Australian governments initiated the national mental health strategy to try to correct decades of neglect and assure the rights of people with mental illness. In 1993, the Human Rights and Equal Opportunity Commission released the Burdekin report of the "National Inquiry into the Human Rights of People with Mental Illness", which exposed the devastating personal consequences of grossly inadequate mental health and welfare services in Australia. Despite 12 years of national effort, the "Not for Service" report captures the persisting, distressing and daily experiences of inadequate mental health and community care. It details personal stories of people with mental illness and their family and carers from all parts of Australia. It is a qualitative work and includes the strong views of doctors, nurses, psychologists and other professionals who provide mental health services in Australia.

It is important that those members who want an insight into what people with mental illnesses and their families have to deal with read the "Not for Service" report. The report outlines 12 issues that were listed by consumers and their family and carers as priorities. These priorities are -

i) access to professional care, particularly in emergency and other acute care settings;

ii) treatment with dignity and concern for the individual irrespective of location of care;

iii) prioritisation of safe and high quality services;

iv) an emphasis on clinical care, rather than 'containment' -

The ongoing containment in mental health is something that these people are fed up with. The priorities continue -

v) earliest possible access to professional care in acute and non-acute circumstances;

"Earliest possible" are the key words in that item -

vi) response to individual needs, including recognition of the complexity of comorbid substance abuse, personality dysfunction or socio-economic deprivation;

vii) coordination of health, welfare and related community support services;

viii) access to programs and support to live independently and work;

ix) respect for the legitimate interests of family and carers in accessing care and participating in ongoing treatment decisions;

x) support for those who provide direct clinical services;

xi) provision of appropriate community housing options; and,

xii) access to appropriate medical as well as psychological services.

The "Not for Service" report is compelling reading for anyone who has an interest in mental health services.

Mental health reform in Australia is not only about funding, resources and much-needed bricks and mortar. I will talk further on this subject. The reform is much more than that. It is about reforming an inappropriate and outdated culture in mental health that is, unfortunately, alive and strong in Western Australia. The culture extends from the top down and reaches across the entire breadth of mental health services, and I hope to be able to give members some insight into that.

Without a change in the institutional culture of mental health services in Western Australia, all the funding, resources and bricks and mortar that is being invested in this area will not correct the injustice, distressing neglect and despair; it will merely accommodate it better and enable it to become further entrenched. I am sad to say that there is evidence to indicate that it has already started in Western Australia.

Before I refer to the cultural issues, I wish to highlight this state's poor commitment to new funding for mental health reform. The recent announcement of the national mental health action plan by the Council of Australian Governments meeting that was held in the past month was a positive step in addressing the mental health crisis facing Australia. There is serious concern about the level of spending by state governments in mental health. If we compare the collective state government mental health commitments to what should have been committed to equal the commonwealth's funding input - I am talking about new funding - the states collectively have reneged on $1 billion. The states are contributing $835 million, whilst the commonwealth is contributing $1.85 billion over five years. The Western Australian government has committed to spending $128 million, but if it were to equal the commonwealth share, it should have contributed $185 million. This government has short-changed the mental health system and reneged on the COAG agreement by nearly $60 million over five years. Worse than that, the government is counting old money in that $128 million; that is, money that was previously committed to mental health. It is not all new money. In fact, I am not sure whether any of it is new money. The Western Australian government allocated $173.4 million in additional funding over three years as part of the "Mental Health Strategy 2004-2007". If the total commitment to 2010 is $252 million, WA's commitment to new funding is only $79.1 million. However, this may be just the out-year costs of the new services that have already been identified in the 2004 strategy. If that is so, this government has not committed any new funding under the national mental health action plan. Not only that; it will count this money a third time. Money not spent in one year, such as the $14 million underspent in last year's mental health budget, will be counted again when it is rolled over into the next year without the base funding being increased by that amount.

The minister likes to say that WA spends more per capita on mental health in WA than do the other states, but he does not say that this does not mean that people in WA get more services. In fact, they get fewer. WA has the least number of mental health services provided by the private sector, so the state funds services in WA that in other states are funded by the commonwealth and private and not-for-profit organisations. WA's mental health system is very inward looking, lacks innovation and suffers from a lack of privatisation. The minister needs to look at ways of encouraging more private practices to specialise in mental health, and one of the ways to do that is to ensure that private practitioners can access the public services on a shared-care basis for their patients. This rarely happens in WA.

The response by the states to the commonwealth's funding strategy showed the poor leadership on this issue by the WA Premier compared with that of, say, Mr Bracks in Victoria. WA's main response was to express a concern that the new federal funds being made available through Medicare, of about $600 million, will disadvantage people in WA because they will be channelled through items for clinical psychologists and Australian Divisions of General Practice, and WA will fail to get its fair share of the funding on a population basis because of the lack of such health professionals, as well as psychiatrists, in many parts of the state, especially outside the metropolitan area. What did the Premier want? He wanted more funds to maintain the status quo. No; we need a strategy in WA to move more patients into primary care, managed outside the rather closed, inward-looking public mental health system.

WA currently has the lowest level of Medicare expenditure on services provided by private psychiatrists of any state in Australia. Our Premier wanted to be compensated for this. Of even more concern is that WA has gone backwards in the total number of psychiatrists and psychiatrists in training per 100 000 people, while the nation as a whole has moved forward. I have visited many services that are unable to get registrars to fill their registrar training positions for psychiatrists. Surely the minister can see that this is an issue that needs reform - a remedy rather than compensation. WA would be better served by a minister who can understand how mental health reforms can create dramatic savings for the national economy through reduced absenteeism and productivity in the work force. Increased services to catch people who fall between the cracks into a downward spiral will dramatically reduce costs associated with unemployment, family breakdown, violence, suicide or serious crime. The Victorian government reported that mental illness costs the nation in the vicinity of $21 billion a year, and at least half the people in that downward spiral are not receiving any mental health services at all. The Victorian Premier went on to say that access issues for those people are unlikely to be resolved until both levels of government recognise the problems and take joint action.

I will talk a little about commonwealth and state cooperation. The commonwealth and state governments, the private sector and the non-government organisations provide care and support for people with mental illness. The responsibilities for action are not always clear. Services can overlap, and this often results in fragmentation and poor connections between them. This has a detrimental impact on people who need to access services, and it is costly and inefficient. The "National Action Plan on Mental Health 2006-2011" outlines where the

commonwealth and state and territory governments will significantly expand and improve their mental health services. I would like members to remember that the requirement is to significantly expand and improve their mental health services and access to them. It also outlines opportunities for improved collaboration between the governments. The states and the commonwealth are to commit to new improvements or expanded services in promotion, prevention and early intervention; integration and improvement of the health care system; participation in the community and in employment, which includes accommodation; coordinating care; and increasing work force capacity.

The commonwealth's section of the national action plan is contained in a Council of Australian Governments document. I will briefly mention some of the areas that that deals with. They include expanding suicide prevention programs, at a cost of $62.4 million; alerting the community to links between illicit drugs and mental illness, $21.6 million; new early intervention services for parents, children and young people, $28.1 million; community-based programs to help families coping with mental illness, $45.2 million; increased funding for the Mental Health Council of Australia, $1 million; better access to psychiatrists, psychologists and general practitioners through the Medicare benefits scheme, $538 million; new funding for mental health nurses, $191.6 million; mental health services in rural and remote areas, $51.7 million; and improved services for people with drug and alcohol problems and mental illness, $73.9 million. It goes on. I do not think that people will want me to read it all out. However, there is a substantial commitment by the federal government to new funding and improved services for people with mental illness.

An e-mail that I received from a participant in the COAG process sums up my feelings about the lazy, lacklustre effort of WA. According to my notes, the e-mail reads -

> I thought you may be interested to see the first article in this . . . It seems the Victoria Premier is serious . . . The WA Premier's leadership has been very inept and weak by comparison - even non-existent

I will outline why this is a correct summation of the WA effort. WA has produced nothing new, just more of the same. It is re-counting already committed dollars, and there has been a pathetic, inept and dishonest participation in the COAG process.

Point of Order

Hon KIM CHANCE: Would the honourable member cite the document that she is quoting from?

Hon HELEN MORTON: I have reproduced the words of an e-mail onto pieces of paper that I have with me in the house today.

Hon KIM CHANCE: Can I ask a question, Mr President?

The PRESIDENT: Does the Leader of the House want some clarification?

Hon KIM CHANCE: On the point of order.

The PRESIDENT: Yes.

Hon KIM CHANCE: In a circumstance such as this, when a member is citing a particular document, but is using the words from that in his or her own notes, is the original document a document that can then be tabled?

The PRESIDENT: As I understand it, Hon Helen Morton is referring to a document that is contained in her notes. She has been asked to identify the document, and she has identified the document as being contained in her notes, and in the honourable member's notes there is a reference to words. I think that is where the matter lies.

Debate Resumed

Hon HELEN MORTON: Thank you, Mr President. For the leader's benefit, I mention that it was an e-mail I received from a very senior mental health participant in the COAG meetings that took place. In case the Leader of the House did not quite catch what I said, I will repeat what his e-mail to me states, according to my notes -

> I thought you may be interested to see the first article in this . . . It seems the Victorian Premier is serious . . . The WA Premier's leadership has been very inept and weak by comparison - even non-existent.

Hon Kim Chance: The only reason I asked was to establish the provenance of the email. Anybody could have written that email. For it to have any significance -

Hon HELEN MORTON: I know the Leader of the House would like to know who sent it to me.

Hon Kim Chance: You can tell us if you wish, but I just wanted to know that it wasn't coming from your electorate office.

Hon HELEN MORTON: Absolutely not; this is a person who operates at an Australian level in mental health. I will outline why this is a correct summation. The first document is entitled "Delivering a Healthy WA: Western Australia's Mental Health Strategy 2004-2007". I think one can assume that it was written or thought about in 2003. The second document is the "Individual Implementation Plan on Mental Health" put out by the state government as part of the "National Action Plan on Mental Health 2006-2011". Not one item on this plan is not already covered in the first document. I direct members' attention to headings such as "Multi-systemic Therapy for Adolescents". The government says it will spend $10.5 million. Under the mental health strategy plan, action 1 of part b of key initiative 3 reads -

> Development of two MultiSystemic Therapy (MST) teams for young people aged 12-16 years at risk of developing mental illness in the south and the north metropolitan areas.

The national implementation plan reads -

> This initiative will provide two Multi-systemic Therapy (MST) Teams for young people aged 12-16 years at risk of developing mental illness in the south and north metropolitan areas.

Every single item on the Western Australian component of the new national action plan has already been identified and costed into the state's Delivering a Healthy WA strategy. It is no wonder that, according to my notes, the person who sent me that email stated -

> . . . very inept and weak by comparison - even non-existent.

Hon Sue Ellery: Who was it? Are you prepared to name the person who spoke with such authority?

Hon HELEN MORTON: I will ask the person, and if that person is happy for me to divulge the source, I shall. Who does the minister and the Premier think they are fooling? Certainly not those people who are monitoring the state's contributions. An article from *The Weekend Australian* dated Saturday, 15 July 2006 states -

> States 'flunk' mental health needs
>
> . . .
>
> Despite the COAG meeting announcing a $2.1 billion contribution from the states towards the new $4 billion, five-year National Action Plan on mental health, some experts believe much of the states' funding came from existing money.

I have already demonstrated to members that the entire amount from Western Australia was money that was already committed -

> Chairman of the national depression initiative beyondblue Jeff Kennett said the combined state contribution could be as much as $1 billion less than the $1.9 billion required to match the commonwealth. As the matching funds were "desperately needed" to pay for extra accommodation for mentally ill patients, the shortfall would "particularly impede the care, treatment and return to good health of thousands of Australians"
>
> . . .
>
> "Suicide numbers will remain too high, as there is overwhelming evidence that many suicides occur when people are discharged too early from treatment facilities because of the demand for beds . . ."

He goes on to talk about the very poor situation in state mental health funding. So concerned was the Mental Health Council - it was the Mental Health Council's document, "Not For Service", that created the progression of mental health reform - that it published a follow-up report entitled "Time For Service: Solving Australia's Mental Health Crisis" that outlined areas of priority. An article in *The Weekend Australian* of Saturday, 10 June 2006 claims that mental health experts -

> . . . are now getting jittery that momentum is being lost.

The Mental Health Council has become incredibly concerned about the lack of or poor commitment being shown by the states to new funding and new services. The article continues -

> MHCA board member and prominent psychiatrist Ian Hickie admits the council was becoming "concerned that the COAG process is proceeding without a clear roadmap, without clear goals, without clear intentions . . ."

He also went on to talk about the concerns that the Mental Health Council had about targets, being able to monitor progress and the sort of accountability that would be put in place to ensure that the states actually followed through on the things they said they would do. Professor Hickie talked about where he believed the emphasis should be. The article continues -

> Hickie says one such preconception is that patients should recover from their mental health issue before social services are provided.
>
> "But in the mental health area, often it's a very important part of the health system that the accommodation, the rehabilitation, the return to work actually happens,"
>
> . . .
>
> "Those things are actually health interventions. If people are back at work, back at school, their mental health improves in those situations. We have to get over the notion that you have to get well before you bring into play these social and other services.
>
> "With physical disabilities like wheelchairs, you put in the lifts and the ramps, you put in the structures that enable people to return to work and to function, without them having to have got over their illness or their disability."
>
> Currently, too great a proportion of available resources in mental health is spent on in-hospital acute care services, Hickie says, with some use also of longer-term care . . .

He is saying that we need to put more emphasis on enabling people to get back to work. The article continues -

> "What we've never had is early intervention . . . (which) as a concept has never taken off in mental health. We're an acute care and palliative care system. Early intervention remains only something happening in highly specialised services . . .

Hon Louise Pratt: Historically, it is not a national responsibility. It has always been a state responsibility.

Hon HELEN MORTON: The article continues -

> . . . because the health system doesn't work that way.

In other words, he is saying - I support him entirely - it is about time that mental health was taken out of the health field and put in alongside disabilities services or something of that nature.

The Mental Health Council has expressed its concern about the lacklustre approach of the states and the tokenism displayed in the states' attempts to try to match the federal government's approach to mental health reform. The area that I am perhaps most concerned about is the independent system of accountability. I have worked in that part of the system; I have actually managed the area of health in Western Australia that accounts to the commonwealth for expenditure on matched grants etc. I can tell members that it is a very inexact process. A lot of creativity goes into trying to demonstrate to the commonwealth the Western Australian commitment to health funding. I have asked the Western Australian government to give me the 2006 baseline data for the 12 performance measures that will be used to monitor the progress of the national action plan. Interestingly, it is one of the many questions I have asked for which I have not received an answer. For the interest of members, the 12 performance measures that will be used to ensure that the state is progressing and is being accountable will include: the prevalence of mental illness in the community; the rate of suicide in the community; the rates of use of illicit drugs that contribute to mental illness in young people; the rates of substance abuse; the percentage of people with a mental illness who receive mental health care; mental health outcomes of people who have received treatment from state and territory services and the private hospital system; the rates of community follow-up for people within the first seven days of discharge from hospital, which in Western Australia is currently about 65 per cent; the number of readmissions to hospital within 28 days of discharge - that is another question I have asked; participation rates by people with mental illness of working age in employment; participation rates by young people aged 16 to 30 with mental illness in education and employment; prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities; and prevalence of mental illness among homeless populations. Those are the measures that will be used to determine whether the state is moving forwards or backwards with mental health services.

I refer now to leadership issues in mental health in Western Australia. I refer generally to the lack of leadership, which obviously led to the rather embarrassingly poor performance of WA at the Council of Australian Governments meeting on mental health. I refer to our part-time Minister for Health, who is also the no-time minister for mental health. Even in this article he blatantly says, "I can do more." Do members remember the article in the newspaper quoting the minister saying that? He did not think that being part-time Minister for Health and part-time Attorney General would take up enough of his time. He can do even more as long as he does not have to roll up his sleeves and do anything substantial. This Minister for Health skates across the surface of health, making announcements about capital expenditure. He loves talking about capital expenditure because that produces something that he can open and cut ribbons for to gain lots of political kudos. It is the really tough stuff such as the culture in the health system that he cannot understand. He makes announcements about capital expenditure but avoids the difficult issues being raised with him by the public and leaves the real

considerations and mind exercises to the bureaucrats. He does not understand and is barely interested in mental health reform. I ask the government to please give us a minister for mental health as other states have.

Hon Sue Ellery: You should be embarrassed by what you are saying.

Hon HELEN MORTON: Hon Sue Ellery would make a good minister for mental health. I congratulate the South Australian government, which has appointed a Minister for Mental Health and Substance Abuse. The Senate Select Committee on Mental Health produced a report in April this year called "A national approach to mental health - from crisis to community". Recommendation 5 was that state and territory governments agree to recognise mental health as a designated ministerial responsibility in federal, state and territory departments of health. Minister McGinty should talk to his Labor colleagues who were members of the committee and who agreed with that recommendation; namely, Senators Ruth Webber, Claire Moore and Michael Forshaw. It is a good recommendation. The current minister could not care less. I think he agrees with the federal opposition health spokesperson, Julia Gillard, that mental health is all too difficult and should be handed over to the federal government to manage.

What did the Minister for Health say when asked by *The West Australian* about suicidal Western Australians hearing an answering service when they called the state's only 24-hour counselling hotline earlier this month? His response was, "Leave it to the feds to fix, don't bother me". He could not care less. So far this year, two directors have left the Office of Mental Health and the appointment of a third is imminent. What hope is there for mental health in a large bureaucracy such as the Department of Health if it cannot find someone to stay in the top job? What reforms are being implemented for mental health leadership in WA?

Another aspect of mental health that requires urgent reform is accountability. The Victorian government engaged the Boston Consulting Group to lay out a vision for reform in mental health services over the next 10 years. Its vision is in a report called "The Next Wave of Reform". The reforms outlined come from a completely different angle from those in WA. The vision takes a holistic view of mental health and not only incorporates the high clinical needs of some people but also closes the gap in service delivery for people with non-clinical needs. It describes the problems with governments and accountability, the lack of coordination between state and commonwealth, the fragmentation of service delivery at the local level and the lack of alignment around a shared set of mental health outcome measures. Most importantly, it pinpoints the need to refocus services around the patient or the consumer. They call it a consumer-centric mental health care system, which refers to empowering consumers through consumer-based funding. It is a bit like the disability services model. This is in contrast to what is happening in WA. To demonstrate this, I will read the opening passages of a program titled "Delivering a Healthy WA: Western Australia's Mental Health Strategy 2004-2007". I am comparing the approach of the Victorian government, which supports a consumer-centric mental health care system with consumer-based funding, with what is provided in WA. This government supports a mental health system that is in place to serve the system. The mental health reform initiatives outlined in the strategy aim to increase the capacity of mental health services to meet the increase in demand. It says nothing about responding to patients' needs. It states that the focus will be on relieving pressures in the mental health system especially where this impacts on other parts of the system such as the emergency departments. That is indicative of the way the mental health system in WA works; it works for the system. It states that, specifically, the mental health strategy will address five main areas in the health system where targeted interventions have the capacity to immediately and significantly increase access to mental health services and reduce demand on acute hospital beds. This is a mental health strategy that is designed to look after the system first, and says nothing about reform or consumer-centric mental health care.

Our mental health system is a long way from the sort of reforms taking place in Victoria. That is because the Minister for Health is interested in only one thing: new buildings - bricks and mortar - which he can open and use to promote his own political status. "This minister has reached new depths of political self-interest." That is not my opinion; it was stated in an article in *The West Australian* on Thursday, 22 June. It refers to new depths in politics of self-interest. It states -

> If anyone can be said to embody all that is hateful about contemporary politics, it is Electoral Affairs minister Jim McGinty. He has a well-deserved reputation for being a fixer for the Labor Party. But his undeniable effectiveness in serving the party's interests - as distinct from the public's - derives from the deviousness and cynicism of the tactics that honourable people find appalling.

I find him appalling.

Hon Ken Travers: Stick to the issue.

Hon HELEN MORTON: That is from this article in *The West Australian*.

Hon Ken Travers: You just said that you find him appalling.

Hon HELEN MORTON: I find him appalling and I will tell members why.

Hon Ken Travers: Have the courage of your convictions once you say something; don't backtrack.

Hon HELEN MORTON: The article continues -

> But perhaps the most appalling characteristic of the McGinty political style is his insulting assumption that people are gullible fools ready to swallow any fanciful line he chooses to use.

And he uses them non-stop.

Do members know that he abolished all the hospital boards and is now the direct employer of all staff in all the hospitals and health services in the state? He is the direct employer; they are his employees. We now have a situation in WA in which the minister is the direct employer of all health staff. I thought that a minister's job was to represent the community's interests but how can he do that impartially if he is the employer? As any good employer, does he look after the interests of the employees first and foremost? If we need an example of this, we need look no further than the situation earlier this year that involved the staff at Swan District Hospital. I refer to various questions on notice.

Hon Ljiljanna Ravlich interjected.

Hon HELEN MORTON: This is very interesting. First of all, in letters and answers to questions on notice on this issue, the Minister for Health uses interesting words such as "had to be transferred to another hospital for a higher level of care" or something like that. When I asked why that person could not be admitted to Swan District Hospital, I was told that it was because no mental health beds were available. I asked whether he was assessed in the emergency department. The answer was, yes, he was assessed in the emergency department. I asked: was he assessed by a psychiatric registrar and a psychiatric nurse. Yes, he was. I then asked whether he was assessed as being at risk of doing harm to himself and to others. Yes, he was assessed as being at risk of doing harm to himself and to others. I then asked, if that was the case, why he was put in a taxi, without an escort or any support, and sent to another hospital. On the way to that hospital, this man, who was assessed as being at risk of doing harm to himself and to others, jumped out of the taxi and seriously injured not only himself but also the taxidriver. I then asked the minister, as the employer of the people who had assessed this man as being a risk to himself and to others but had allowed him to get into a taxi and be sent to another hospital, whether he would take responsibility for the actions of these people. The minister's response was along the lines that this was a clinical decision. I then asked the minister whether he was responsible, as the employer of these people, for the clinical decisions these people had made, and he said yes, he was. The minister's final response was along the lines that the North Metropolitan Area Health Service does not believe the assessment and management of this case was inappropriate. The minister is the employer, but he will not take responsibility for what his staff are doing! The complication of having the minister as the employer -

Hon Ken Travers: Enlighten us! Tell us what you would have done!

Hon HELEN MORTON: The minister should not be the employer of the staff. If he wants to represent the community -

Hon Ken Travers: What would you have done? If the clinical decision had been made by the clinical staff, would you have asked the board to sack them all? What are you saying? What is your point?

Hon HELEN MORTON: If I can take this a bit further, I will tell the member my point. From whom does the part-time Minister for Health, no-time minister for mental health, get his advice about whether to accept liability for a case such as this? The minister gets his advice from the Attorney General. However, that is the same man! The minister gets advice from the Attorney General's department about whether he should accept liability for a case such as this! The minister is asking himself "Should I take advice on this, or should I take responsibility for this?", and his response is, "No, I do not think I should"!

Hon Sue Ellery: Did you not say that he is also the Attorney General?

Hon HELEN MORTON: I said: from whom does the part-time Minister for Health, no-time minister for mental health, get his advice about whether to accept liability for a case such as this? He gets it from himself - the part-time Attorney General!

Hon Sue Ellery: Do you understand how the Attorney General obtains legal advice?

Hon HELEN MORTON: I assure the parliamentary secretary that all is not rosy when it comes to accountability and transparency in the mental health sector. The parliamentary secretary should read the "Not for Service" report; or, if the parliamentary secretary wants something closer to home, she should read the latest annual report of the Council of Official Visitors. That report cites incidents of patients being cold, embarrassed and humiliated as a result of being nursed naked for punitive reasons. Mr McGinty tried to let the report of the Council of Official Visitors slip under the radar at the end of last year in this Parliament. I will be raising some

of the more serious concerns that are cited in that report, and others, such as patients being pulled along a passageway by their arms and family members being intimidated and possibly seriously abused by staff for demanding services. However, despite the fact that these issues are known, little responsibility is meted out to staff, and absolutely none to the minister. If these things were happening in any other aspect of human service delivery, it would result in a scurry of litigation. However, that is not the case for this extremely disempowered group of patients. Since July 1997 - in the past nearly 10 years - 684 medical treatment liability claims have been lodged against the Department of Health. Only 23 of those claims, or less than three per cent, related to mental health. Eleven to 12 per cent of all outpatient and inpatient services relate to mental health. A total of 197 claims were made, resulting in payments totalling $26 million. Only four of those 197 claims were for mental health, resulting in payments totalling $1 million. If the minister is the employer of health workers and is also the Attorney General, who is looking after the interests of patients, their families and the community?

The Mental Health Review Board is appointed by the minister. For the benefit of those members who may not understand, the Mental Health Review Board is required to review all the decisions that are made for involuntary patients in hospitals or patients on community treatment orders. Murray Allen, the president of the Mental Health Review Board, was appointed by the minister in 2005. The position was not advertised. The board is not required to produce annual reports or budgets, and its funding arrangements are not made public. The board's funding is via the State Administrative Tribunal and is recouped from the health budget. The board shares an office and some administrative functions with the State Administrative Tribunal. Any appeals that are made by patients against the decisions of the Mental Health Review Board go to the State Administrative Tribunal, which is just along the corridor in the same building! The minister's review board reviews the decisions that are made by the minister's employees; and if patients do not like those decisions, they can appeal to SAT, which is just along the corridor in the same building!

Hon Sue Ellery: What does that mean? What are you saying?

Hon HELEN MORTON: It is in the same building, just along the corridor!

Hon Sue Ellery: What does that mean? What point are you making?

Hon HELEN MORTON: They have a cup of tea together!

Hon Sue Ellery: So what?

Hon HELEN MORTON: The parliamentary secretary can work that out.

I turn now to the Council of Official Visitors. Appointments to the council are made by the minister. The head of the council is Dr Judyth Watson, a former Labor minister! I am not sure whether this position was advertised. I think it was. The minister is required to table the annual report of the Council of Official Visitors in the Parliament. The minister can do that quietly at the end of the year. There is no requirement that the minister must respond publicly to the report.

I turn now to the Mental Health Law Centre. The Mental Health Law Centre is funded by the Legal Aid Commission, I think, and its function is to represent mental health patients in a variety of places, including hearings of the Mental Health Review Board. Only 47 per cent of involuntary patients retained in a hospital who requested a review of their involuntary status had any form of representation at their review. The level of representation dropped to 32 per cent for people on community treatment orders. Other than requested reviews, only 12.5 per cent of people in a hospital, and 15.7 per cent of people on community treatment orders, were represented in their initial review. When I asked the Mental Health Law Centre about its appalling lack of representation, its response was that it does not have the funding and resources to provide greater representation. Apart from the problems associated with obtaining forensic reports from hospital-based doctors for patients who go to court, the lawyers from the Mental Health Law Centre do not have the resources to meet the demands of all the people who request its assistance. There are significant problems with accountability and transparency within the mental health system. This government has done very little to address that issue and achieve reform.

I turn now to the general culture in the mental health system in Western Australia. People with a mental illness who access public services are frequently confronted by an inappropriate and outdated culture that pervades most aspects of the mental health system that I have worked in and have visited recently. This culture is evident from the top to the bottom of public mental health services. However, I am pleased to say that there are some exceptions. Mental health reform requires a major cultural shift. It requires a change in focus from protecting the system to recognising and protecting the patients and their families; that is, to becoming health consumer-centric. I have found the system self-protecting; intimidating to patients and their families; punitive to anyone who steps out of line, including staff, patients and their families; disempowering to patients and their families, rather than empowering them to work toward recovery; mean-spirited and miserly; and, worse of all, paying only lip-service to achieving the national mental health standards of normalisation, destigmatisation and integration.

I will remind members about the questions I have asked in the Parliament about SouthWest24. SouthWest24 is a mental health crisis call service for people in the south west. It is based in Perth most of the time. However, it reverts to Sydney after hours. It could have been based totally in Perth, but it is cheaper to allow it to revert to Sydney after hours. That is another lot of questions I have asked in this house that have not been answered. What was the cost said to have been saved through the action? I know that the reason the questions are not answered is that the government did not want me to have the answer before today. When patients and their families raised their concerns about this, and a question was raised in this house about the appropriateness of it, the minister decided to attack me personally and initiated, through his staff in the south west, a witch-hunt to find the name of the family that spoke to me. I might add, the family was petrified that I would not maintain their confidence.

Hon Sue Ellery: How are we to follow up specific problems when we do not know who they involve?

Hon HELEN MORTON: The issue is whether the service was diverted to Sydney after hours. They were not concerned for themselves, but about the potential recriminations for their son.

Hon Sue Ellery: It is convenient for you not to give us the name, so we can't track it and we can't tell whether your allegation is true or not.

Hon HELEN MORTON: The allegation is that the service diverted to Sydney after hours, and the parliamentary secretary would never say that it did. I had to find out myself by going and visiting.

Hon Sue Ellery: You made allegations about a person threatening to kill himself.

Hon HELEN MORTON: That is true.

Hon Sue Ellery: How could we track whether that was true?

Hon HELEN MORTON: They did not want the minister to track that; that was not the point of it.

Hon Sue Ellery: You should not make the allegation if you will not let us investigate it.

Hon HELEN MORTON: The point was that the Sydney-based service could not do what it was meant to be doing.

Hon Sue Ellery: You cannot substantiate what you are saying.

Hon HELEN MORTON: I can; the parliamentary secretary cannot.

Hon Ken Travers: So we should just trust you?

Hon HELEN MORTON: The member should. Why could the minister not focus on the issue instead of the messenger, unless it was to intimidate other families who wish to complain about services?

Another lady also does not want her name used, and the rest of her family does not want the name used because of the potential backlash to them and their family member who is in receipt of ongoing mental health services. She has provided the following evidence of intimidation. I witnessed the intimidation first-hand with this lady when I accompanied her on a visit to Bentley Hospital. Because I am sure that the parliamentary secretary will ask me to table the paper, I have tried to black out anything that would identify the people concerned. The document reads -

> To Whom It May Concern,
>
> My name is . . . and I am a Lecturer at . . . Curtin University. I have a degree in . . . and a Graduate Certificate . . .
>
> I have known . . . and her son . . . since 1996. Over the last couple of years I have accompanied . . . on three visits to the Bentley Hospital. On two of those occasions there have been incidents that have caused me to be alarmed, which I feel I have a moral obligation to mention.
>
> I am alarmed that people (like . . . are often the object of frustration, as a result of the effects of a necessary institutional treatment of a family member, and I am alarmed that people are treated with disrespect and dis-guarded in relation to their concerns for their loved ones. People who have sick members of their family are already suffering enough in silence and don't need any added humiliation to their already burden of pain. All I ask is that they are treated with respect.
>
> On both occasions I was distressed at the aggressive behavior towards . . . by staff at the Bentley Hospital. On both occasions I felt myself intimidated at the overwhelming aggressive authorative manner in which . . . was spoken to and treated with.
>
> On the first occasion . . . was very submissive while I accompanied her to see a doctor by the name of Elizabeth Moore. (For example, at one point the doctor said to . . . "That's not what I said . . .", . . . said

> something like "I'm sorry I made you angry doctor and the doctor replied, "I think you meant it . . .") This type of behavior in my mind is like a role-play and it's not about real people - why do they refer to each other personally by calling each other constantly by their name? For . . . to call the doctor, Doctor in every occasion in my mind is a form of control, and obedience, and I don't think it's necessary. I have never witnessed this type of behavior before except in movies. I told the doctor that I was upset at how . . . spirit and well being had deteriorated, and that this had upset me. The doctor spoke down to . . . and I cannot find words to express my disgust at what was happening and being said to . . .
>
> The second occasion was yesterday (. . . February 2006, about 5.00pm), when I accompanied . . . to see her son . . . A male nurse by the name of Trevor G spoke to . . . He appeared to be the nurse in charge. He pointed and waved his finger at . . . and spoke in a tone that was unacceptable and inappropriate. He used the words. . . you were told" . . .and that's no way to talk to a learned person, which I consider . . . to be.
>
> I cannot believe, that staff at a hospital that are placed in positions to care for other fellow human beings, can be so demanding, controlling, intimidating and down right rude to say the least. I stood there appalled, and I cannot even express how humiliated I felt at . . . and her son's treatment.
>
> From my perspective as an educator, I was wondering if a little training wouldn't go astray for staff that work at Bentley Hospital and deal with patients that have specific needs. I've also had a number of years experience working in human resources and worked with training and educational packages. Staff at the hospital probably get training at the onset - but a little up-skilling wouldn't go astray from time to time to reinforce staff commitment in regards to the human relationship aspects of their positions. Organisation and agency practice should be reflected in the everyday work of its employees . . .

She goes on to talk about some form of code of conduct. The next document is one that I have put together. It is a composite of letters from a private psychiatrist who has some concerns about a patient as well. I have put together some of the bits and pieces of her words; they are not all my words. I have inserted different names again to protect the people concerned. The document I have compiled reads -

> Mary is the 55-year-old mother of Ben, a young man diagnosed with paranoid schizophrenia with a history of substance abuse.
>
> . . .
>
> Mary's story is about the extent to which, as a mother, she continues to seek help and compassion for her son, and assurance he has the correct support in place to be able to live a dignified and respectable life despite his mental illness. It is the desperate story being lived by many parents of young people disabled by mental illness.
>
> However, Mary's story is all the more poignant because of her courage, determination and perseverance in the face of an onslaught against her personally by the public health system. Repetitively humiliated and shamed in front of neighbours and friends, possibly treated punitively with intramuscular medication by the public health system,

She was admitted involuntarily to hospital herself three times without evidence of hallucinations, psychosis or any other reason for such an admission. It continues -

> and being humiliated, embarrassed, intimidated and shamed as a means of discouraging her constant demands for better service for her son has left her angry, distressed and completely distrusting of the mental health system she is reliant on for her son's future. To say she has been traumatised is an understatement.

An eminent private psychiatrist says that this lady does -

> experience severe post traumatic stress from her treatment at Bentley. She is distressed, ashamed and humiliated when she recalls what has occurred. She has experienced firsthand the stigma of those with mental illness. She has been assaulted by neighbours and apprehended by police because of her -

So-called -

> "known psychiatric illness". She has become reluctant to assert herself - with one exception. . . . continues to be the (appropriately) complaining mother of a difficult patient - her son . . .
>
> She has had many occasions to legitimately question the decisions taken by Bentley Hospital in respect to her son. They have knowingly put him in danger and she has expressed her unhappiness about the lack of appropriate treatment and responsibility for his welfare. They have projected their resentment onto her for the difficulties of managing . . . She is to be commended for her courage and commitment as a mother to . . .

> I personally observed similar behaviour when accompanying this lady to a family conference (held at my request) to enable all agencies involved in . . . discharge plans, to meet and discuss their collective plans for making his discharge as successful as possible.
>
> The psychiatrist present made an offhand remark to this lady about "not being afraid to come and visit . . , because we won't lock you up here". This was even more bizarre as it was said whilst I was present. The psychiatrist subsequently told me, as I passed my business card to him, that he would be glad to be rid of the family.

This lady's story is most descriptive. It is about 12 pages long and it relates to intimidation. I have tried to condense it. She merely wants to be assured that her son is well cared for by the system and that she, as his mother and the person to whom he comes when the system breaks down, is kept informed of changes. She will not sit back and accept that he has to fail before he receives necessary support, and she wants her name cleared. She said that because of her postcode she had no choice; she had to use this service. If she wanted to go somewhere else to use another service, she would have to sell her house and move.

I do not think that people really understand how bad this is. I received another e-mail from a lady whom I have never met in my life. It states -

> Dear Helen:
>
> I spoke with your Electorate Officer, Karen, several weeks ago about an issue concerning my daughter whilst she was a patient in Bentley Hospital's psychiatric wing. She suggested that I put my concerns in writing to you, in your capacity as Opposition Spokesperson on Mental Health Issues.
>
> . . . I thought I would let you know my daughter's experience in Bentley Hospital in case you have opportunity to ask questions in Parliament or through some other avenue which might eventually lead to improvements in the mental health system.
>
> My eldest daughter . . . graduated from ECU with a Batchelor of Science in . . . -

I am trying to protect the names of these people -

> several years ago and took up her first graduate position in . . . working for a Government department. Unfortunately, after six months there, she suffered a major mental breakdown and was subsequently diagnosed with Bi-Polar Disorder.
>
> After the breakdown, she returned to Perth for family support and has since been hospitalised for short periods on several occasions - once in Ward D20 at Sir Charles Gairdner Hospital, where the treatment was nothing short of fantastic - and twice at Bentley Hospital.
>
> The last occasion she was admitted to Bentley Hospital was on . . . 2006, whilst my husband and I were in Alice Springs at a Conference. There is no doubt that she needed to be in hospital and that she was angry when she discovered that her so-called voluntary admission had become non-voluntary and she was in fact in a locked ward. How many of us would happily acquiesce to being locked up in a psychiatric hospital, after all.
>
> The duty staff obviously decided she need to calm down and should be placed in a Quiet Room - not sure of the correct terminology, but you will probably know what I'm referring to - it's along the lines of an empty, padded cell which is used to allow patients to calm down over half an hour or so. As her parents, we have no gripe with this treatment.
>
> However, what disturbed us was the method used to move . . . to the Quiet Room. Three male nurses were apparently involved, with two of them taking her by the arms and dragging her - ON HER STOMACH - along the corridor floor to the Quiet Room.
>
> When . . . came out of hospital, she said something that went right through my heart: "Mum, you wouldn't treat a dog like that!" And you know, when I actually thought about it, I was horrified. Most of us wouldn't mete out that kind of treatment to an animal, much less a human being. Yes, she was in a manic state. Yes, she was angry. Yes, she was probably abusive. But that doesn't excuse this disgustingly unprofessional treatment by psychiatric nurses, who should know better. This is an everyday occurrence to them and they are supposed to be trained professionals. I shudder to think who knows how many people with mental illness may also be receiving similar treatment at Bentley.
>
> I'm sure there would be an approved method for moving people to the Quiet Room - in . . . case, two male nurses taking her by each elbow and marching her to that room should have sufficed. She's not that big a girl!
>
> Abuse like this must be stopped. Psychiatric nurses are not a law unto themselves - they are just as accountable for their actions as the rest of society. When a patient is a non-voluntary patient, and

> already in a distressed state, they feel totally powerless and it's very hard to retain any dignity in that sort of situation, let alone the worthlessness you would feel in being treated so basely by the very staff who are supposed to help you. I also believe that the abuse she suffered worsened her condition and caused a longer stay in hospital for her.
>
> I did seek . . . permission before writing this letter - she wants to see the system improved, but there is still the fear of retribution, should she be hospitalised in Bentley again in the future - one which I also share. Helen, if you do decide to take the matter further, is there any way you can do so without divulging her name or identity, please?
>
> I'm hoping you can use this information to shine the spotlight on abusive practices such as that suffered by my daughter.

There are many, many examples like that. I also refer to an involuntary patient at Graylands Hospital highlighted by the Council of Official Visitors. It was decided that he would be charged a fee as a means of deterring him from coming near the hospital again. When I speak to non-government agencies, they refer to concerns about the range of services and they talk about their inability to have good dialogue with some of the services, but they also say that if they complain, they are at risk of losing their funding. Therefore, they also keep quiet. Carers groups say the same thing. They talk about token involvement and disempowerment and they say that WA has the worst record in Australia. That was borne out by the national mental health report of 2005. When I question people about why carers and carers groups are not used more openly in mental health planning, it was explained to me that it is not policy in WA to involve carers. Some carers had not been paid. Carers who participate in these areas are supposed to get paid and some of them had not been paid for six months and then they would get it all in one hit. However, because that affected their pensions, in the end they said that it was too difficult and too problematic and so they decided to not get paid anymore because it was not worth it.

I have asked a couple of private psychiatrists with whom I have spoken whether they are prepared to talk openly about these issues. They said that Perth is a very small town and they are reliant on their public sector colleagues. They say that they admit and understand that the culture exists within mental health, but they will not go on the public record and talk about it. I attended a public forum recently that was held specifically for the media on how they might report mental health matters more appropriately. I was surprised to hear the director of the South Metropolitan Mental Health Service say that it would not be a good idea to publish any bad stories about the system and that the media should not publish anything negative because all it would do is drive away the already scarce work force.

I have demonstrated to some degree how the needs of families are being ignored, neglected and trivialised. One of the most needed areas for reform in mental health in WA is the culture of ignoring, neglecting or trivialising the needs of families of people with mental illness. I have mentioned already the intimidation experienced by some families. I am also concerned about the lack of a mechanism within the mental health system whereby families of people with a serious mental illness can be kept informed of changes to the family member's mental health status, treatment and support. The family members are often the only other people who have regular visits and regular telephone contact with the patient and it is they, more than anyone else, who continue to seek help and assurance that the correct support is in place for these people with an illness so that they can live dignified and respectable lives. When these people go home from hospital, it is mostly the family to whom they turn when the rest of the mental health support system breaks down or is not available. As an example, an elderly gentleman whose wife was in Armadale-Kelmscott Memorial Hospital had been to visit her on a number of occasions. He knew she was not ready for discharge and yet he was petrified because the hospital was absolutely intent on discharging her. He called for my help and I went and had a family conference once again at the hospital. By the time I got there, his wife's position had been reassessed and it was decided that she would stay in hospital for another month. Had I not become involved, he would have been left with the management of that very ill lady. Similarly, I have talked about the family conference at Bentley Hospital.

I now refer to the emergency department at Armadale hospital from which a chap was discharged. Apparently he was to be followed up by a non-government organisation. However, that non-government organisation had a five-week waiting list. A parent had to take time off work to be with her son while the non-government organisation became available. This lady said -

> I was wondering if you could pass this information on to Hon Helen Morton.
>
> My son . . . was taken to Armadale emergency on Monday night . . . 2006 As he was depressed, as result of substance abuse. He put a knife in his wrists to harm himself.
>
> Interestingly after attending the public meeting about self harm and hearing what the govt have put in place in emergency dept's in WA metro. I can assure you it is not happening.

> We waited in emergency for 3 hours before being seen by the doctor, there was no psychiatric assessment by the mental health team at Armadale. The doctor in emergency asked -

She refers to her son -

> if he would harm himself again -

She said that her son's answer was, "No." The e-mail continues -

> I said to the doctor that is what he tells you, I also told them that I didn't feel safe with -

She again refers to her son

> as my husband was in Canberra on business. . . . There answer was we can't baby sit him. . . I stated I was concerned about his self harm risk.
>
> He was given a lecture . . . and told to go home. I contacted the mead centre the next day and they told me the same thing they can't baby sit him for me and that I should take time out and leave him at home on his on. I stated to them . . . I was immediately concerned about . . . the self harm risk. They again stated I needed time out away from -

She again refers to her son.

> And that they would not change their arrangements they will visit . . . on the following Thursday as usual.
>
> The system is totally none existent as far as I am concerned, it just gets worst.
>
> I have found a place for . . . to live through St Vincent De Paul I had an application form that needed to be filled out by the community nurse at Armadale immediately and faxed back the on Monday . . . February. This house is just what . . . needed to help get his life back on track and he agreed that this was a positive move as the house had a supervisor to help deal with his problems and ensure he was taking his medication and attending his appointments . . .
>
> But, guess what, . . . normally community health nurse was on holiday so the mead centre decided to wait until he returned from leave before filling out the application. As they said they didn't know . . . well enough, . . . So hear we are again let down by the system, and possible . . . will miss out on the house available.
>
> . . . was admitted to Armadale on . . . February with a relapse with suicidal thoughts yet the week before he wasn't suicidal.
>
> Where is this system going and what about the people who don't have support in their life?

I have to keep raising these issues because I am concerned that members do not understand the seriousness of the situation. The following appeared in *The West Australian* on Saturday, 19 August -

> My youngest son is now mentally impaired and I've been crying out for help since he was 16. "There is nothing you can do" is the common catchcry from all government departments. He has to break the law first. Many times I was told this. Police, politicians, doctors and lawyers all have their say but parents have no say.
>
> Families must be allowed to intervene. Just as the grandparents of little Wade Scale should have been allowed to intervene. The politicians and bureaucrats run when any suggestion is made that the law be changed for family intervention.
>
> The cost to my family has been extreme in our own mental health and family dysfunction. Thousands of dollars have been spent on my son over the years, but the Government just doesn't see it.
>
> Here was a family prepared to put their money where their mouth is and sell the house to try something new - anything. We asked for co-ordination between the various departments he came into contact with, but we were told that would be breaching privacy laws.
>
> We watched our son descend into madness. It is likely he will now need government support for the rest of his life. We were ignored, just like the despairing grandparents of little Wade Scale.
>
> Shame is too slight a word to express the resistance to change that would allow families to intervene. In my eyes it is criminal.

I have just one more article that is headed, "Dad pays the price for mentor ban" and reads -

> A Perth father has quit his $50 000-a-year job to join his mentally ill son at school after being refused help to get his son educated.

In this case the family had actually gone to Swan TAFE, which has a mentoring service, and asked for a mentor for their son. When the family was unable to get the mentoring service for the son, the father said that he would be the mentor. Swan TAFE told him that they do not take on family members as mentors. The father quit his job and enrolled in the same course as his son, so that he could be with his son day in, day out to help him get an education.

The needs of families in the consultative process for the community-supported residential units has probably been the most recent and stark evidence of the minister's contempt for involving families appropriately. The minister's suggestion that these people did not want community residential units because of a not-in-my-backyard attitude was insulting to the majority of well-meaning families, both those living in the neighbourhood and families of residents who were to live in the proposed houses. I have been to three or four of these community group meetings. There are always one or two people who have a stereotypical approach to people with mental illness, but by far the majority of people at those meetings have wanted to have some meaningful input into how community-supported residential units can operate well within their communities. It was an absolute insult to them and others when the minister commented that the prevailing attitude was "not in my backyard". That is not the prevailing attitude.

The service model across a large section of the inpatient or residential care services in mental health is characterised by the insidious culture of institutionalised care. Unfortunately, most of the staff involved in this care are unable to recognise and acknowledge their institutionalised model of service delivery. Some care is so institutionalised that the people with mental illness who use these services lose the skills required for daily living, and that makes it difficult for them to resume a normal lifestyle.

The Council of Official Visitors raised many examples in its latest report. The same examples have been raised in its reports over the past three years. The examples included patients being treated like prisoners, overcrowding and patients not being told what is going on. It reported a situation in which a patient had to wait 19 days to find out that her community treatment order had been lifted. Simple things are being denied patients without good reason; for example, not being able to have fresh milk, drinks at night or read at night, unless they have their own lamp. The worst thing is the expectation that these people will have communal underwear. Is any member in this house prepared to wear communal underwear? The council's latest annual report is full of examples of how the statutory rights of people with mental illness are too often breached and how the rights to privacy, dignity and bodily integrity are not met. The most recent example of this was the extent to which the institutionalisation is embedded in the culture of the public mental health system in the government's attempt to move people with manageable mental illness into community-supported residential units.

I am fully in support of people with mental illness moving into community-supported accommodation. However, it is the model that I question. In most cases this cluster-type accommodation caters for 25 residents, and is located on hospital sites in Albany, Armadale, Bentley, Kalamunda, Osborne Park and Peel. The cluster-type accommodation that is not located on hospital sites can be found in Stratton, Bunbury and Busselton. The minister has taken the quick, cheap and easy option. He is not meeting national mental health standards. These standards require community living for people with manageable mental illness to be as normal as possible, without stigma, and to be integrated within the community. Twenty-five people living in one cluster will be institutionalised and that will ensure that they are stigmatised. Smaller groups interspersed within the communities would be more appropriate, and the community would be in a better position to understand their situation and assist them where possible. Cluster accommodation on a hospital site will prevent integration and lead to institutionalised living.

I can assure members that before long the gardening and home maintenance services required by these people will be provided by the hospital's home maintenance service. It will not be long before the linen is taken to the hospital's linen service. It will not be long before some of the meal preparation is done by the hospital. It will not be long before these 25-bed clusters on hospital sites will become institutionalised. Would members like to make their home for the rest of their life in a unit on a hospital site? The only reason this is being done is because it is cheaper to operate on a recurrent basis - 25 people to one carer. Why do the physically disabled and intellectually disabled people have carer ratios on a small scale, but people with mental disability do not? In my street is a house that has been purpose-built for physically and intellectually disabled people. Three or four chaps live there. They have a carer 24 hours a day on a roster system. At some times of the day, two or three people care for those disabled people. Why is it that people with an intellectual or a physical disability can access that kind of carer situation but people with a mental illness cannot? The stigmatisation of people with a mental illness goes right through the system.

Of equal concern to me was the manner in which this project was initiated. It should have been consumer-centric, starting with a futures plan being developed for individual persons identified for possible relocation out of the acute hospital system. A futures plan involves the resident, the family, the carers, the staff, the guardians

and the advocates, as well as professional carers. I have been involved in futures planning for many people with long-term mental illness. Families from all over the state may need to be involved. Consent and competency issues need to be looked at. Lifestyle issues and future lifestyle interests need to be considered. Guardianship hearings may need to be held. Advocates for those without families may need to be found. Education and counselling need to be provided for residents, families and staff. Residents need to become aware of their options and given a chance to try them and consider which options might best suit them. Formal assessments need to be undertaken. Residents' needs and support requirements need profiling, and compatibility considerations need to be taken into account. Only when all that is completed will it be known how many places are needed and in which locations.

The department has gone about this in completely the opposite manner. It determines how many places it will build and where, and then looks for the residents. It has not identified at this stage which people will move into which of these 25 clusters. When it does identify those people, they will be told how good it will be for them. This is institutionalised mental health services at their worst. It facilitates learned helplessness in the residents. It is the opposite of empowering residents. When I took up this issue with the director of mental health services, the comment to me was something along the lines, "It is better than what they have currently. We will start identifying residents now and do some transitional planning with them." Unfortunately, institutionalisation and stigmatisation are alive and well in mental health, and they are promulgated from the top down.

However, it gets worse. The department is trying to pull the wool over the eyes of the community. I have been out and about among groups of people in which this community-supported residential units issue is being discussed. On some days, the department talks about it as residential services, and on other days it talks about it as rehabilitation services. The department is confused. If it were a residential service, which I understand it is meant to be, it would be a home for life for these people. If it were a rehabilitation home - I am not getting confused with Hawthorn House; I know the difference between Hawthorn House and community-supported residential units - it would be a different concept altogether, and it would have a different staff base. The department talks about acute stay versus a home for life. The psychiatrists at Mandurah think that their community-supported accommodation units will be used for acute care stays on the hospital site. They are completely confused; they do not know what this model is about. When I spoke to the chief psychiatrist at Graylands Hospital, he talked about it as a rehabilitation service, but he also talked about these people having failed in psychiatric hostels with minimal care, and yet we are talking about a staff ratio of one to 25 people.

Probably one of the worst things that I saw in the way this is being promulgated was some recent information that was sent out in which it was said that the community-supported residential unit model is a proven model. I looked up the three models that were given as examples of that. In the New South Wales model, not one has 25 units in one place. The majority have them in groups of four and five, and the people are in separate homes. They are not in clusters in the one location. In Victoria, which has the so-called proven model, the community care units have on-site clinical services. They are clearly more like step-down facilities such as Hawthorn House. The department, in trying to spread the story about this proven model, has pulled bits out of three different models and put them together as its own model, and is now prepared to say that it is a proven model. It is not proven; it is not even ideal.

I will talk a little about crisis and emergency care. I cannot go through all the reforms that the government could have addressed, and did not, without raising the issue of crisis and emergency care. Sir Charles Gairdner Hospital, which has the busiest emergency department in the state, does not have one secure bed for a mental health patient. Patients are kept sedated in the emergency department for, on average, three to five days, and up to one week, while they wait for a secure bed somewhere else. The situation at Royal Perth Hospital is the same. Once again, questions which I have asked but which have not been answered will, I am sure, when they are answered, tell me that RPH's record is even worse than that of Sir Charles Gairdner Hospital. The Joondalup Health Campus has a secure unit, but it is full. People are looking for beds there also. Some people wait at that hospital for up to nine days. I do not know whether members understand what waiting in an emergency department is like, or whether they have ever stood in an emergency department and imagined being there for nine days waiting for a secure bed in a hospital somewhere in Perth. People wait up to nine days at Joondalup. When I was there I stood in the emergency department. Kids were screaming and people were rushing around. People are sedated for nine days in the emergency department waiting for a bed. Although those people are sedated, they must be brought out of that sedation to have their fluids and to eat. They are then sedated again. It goes on. That happens not only in Perth, but also in the Kimberley and the Pilbara. People wait up to a week for the Royal Flying Doctor Service to pick them up, because there is not one secure mental health bed north of Perth. The RFDS gets to those people when it can. They are sedated, and normally have a guard with them. They get significant respiratory complications because of their sedated state.

The Murchison ward at Graylands Hospital is closed to male patients - that is the secure ward at Graylands - because it now has a waiting list that is too long. It will not take any more patients onto its waiting list; it is

closed. It is more than two years for males, and it is two years for females. Can members imagine the outcry if any other type of patient was kept in an emergency department drugged up and waiting for a week to go to a ward? I do not understand why that is not seen as an issue that requires urgent attention in Western Australia.

We have talked about how bad it is that ambulances are ramping outside EDs for general health services. Ramping is now being experienced in mental health. As I have mentioned, the locked wards, or the secure wards, are blocked. The unblocked wards for voluntary patients are 50 per cent full of people seeking secure beds, and they are being "specialled" or they have security guards with them. In emergency departments, people are being held sedated for up to nine days. In the community clinics, there are people on community treatment orders. These are involuntary patients who are still living in the community. A man was sent from Northam to Graylands - people contacted me about this - four times this year and was sent back despite it being known that he is a risk to himself, the staff and the community. Last month, out of desperation, the staff called in WorkSafe. WorkSafe slapped some work orders on the services, which have not been addressed yet. In Northam, there is a community clinic that has both child and adolescent clients, as well as adults. It is very inappropriate for that man to be seen in that clinic. I will talk a little more about that when I deal with country services. At present, individuals and families who could once get their family members into the clinics now cannot do so; they are managing them at home in severely deteriorated situations.

The number of people with mental illness who have been transferred from the Kimberley by the Royal Flying Doctor Service has nearly doubled in two years. In the past five years the number across the whole of the country area has doubled. The figures do not include people transferred by road ambulance. There are no inpatient facilities for involuntary mental health patients north of Perth. To transfer someone from the Kimberley to Perth is very expensive and costs $20 000 a flight, and that is just the cost of the trip. Apart from that, it is socially disruptive and culturally inappropriate to send patients from those remote areas to Graylands Hospital when there is nothing to stop a secure mental health facility being built in Broome. Worse than that, the revolving-door issue takes on a new significance when these people are discharged a few days later, sent back with minimal support and re-present for assistance three days later. I have referred to a man in Northam who went to Graylands four times this year. The issue in Northam was the poor design of a facility he was attending as an outpatient. As I said, it combines a child and adolescent service with an adult outpatient clinic. The man needs regular weekly or fortnightly injections - I cannot remember which - but he cannot be given them at the clinic because it is attached to the child and adolescent service. Consequently, he was asked to turn up at the hospital emergency department, but that department could not handle him so he was asked to turn up at the police station. The police said that they would not take him. The arrangement is now that the police will take him to the emergency department at the hospital. Unfortunately, the patient missed the last couple of treatments. As a result, a staff member went to see him where he was staying with a friend, and the staff member was seriously assaulted. This sort of person would usually be in a hospital, but his treatment is being managed at home under a community treatment order because he cannot be placed in a hospital or anywhere else.

One psychiatrist services the whole of the Kimberley and the Pilbara. Where is the mental health reform for the north west of WA? No commitment has been made to a psychiatric facility in Broome. Current treatment for involuntary patients in those areas is barbaric, but it is no worse than what is happening at Royal Perth and Sir Charles Gairdner Hospitals. Patients are sedated and held for up to a week. Patients brought into general country hospitals are being chemically restrained, or sedated, while they await transport with the RFDS. Despite $100 million being allocated to health infrastructure across the Kimberley over the next five years, not one cent has been allocated to mental health. Not one community-supported residential unit has been built in the Pilbara or the Kimberley. Mental health staff do a wonderful job with the available resources but work under enormous pressure. They are understaffed and face the challenge of travelling for up to five hours a day to see patients, and suffer dreadful housing and recruitment shortages. On one occasion they could not recruit anyone for a position because the person had to wait 19 months for a house. The cost to rent the house is $450 a week. On another occasion in Broome it took six weeks after a person had been interviewed and deemed the successful applicant before the person received the approval letter from the health corporate network.

There is a fantastically designed and built respite centre for people with mental illness in Kununurra. However, it is empty because the Department of Health cannot get any staff to work in it. Remote communities are suffering an epidemic of permanent mental health damage caused by the combined use of alcohol and marijuana. Where is the mental health reform policy for this problem? The SouthWest24 crisis call service switches to Sydney after hours for people in the non-metropolitan area. The service for the rest of country WA is run from Perth. The system is ridiculous and confusing.

I have not yet started talking about the problems of suicide in rural and remote WA. Suffice to say, people there talk about suicide as though it is a normal part of life. It is not. When I was travelling through the Kimberley recently, people in those communities would talk to me about their suicide rate and then move onto the next subject such as the weather. They seem to have an incredible acceptance of the suicide rate as part of life in

those communities. Something is very wrong with a system that does not let people know that suicide is not all right. It reflects a situation in which there is a part-time Minister for Health and a no-time minister for mental health who "can do more". Members are probably wishing that I would get to the end of my speech because it does not contain good news, and I understand that. The issue of youth should have been discussed at the beginning of my remarks because all the evidence shows that in the medium and long term, investment should be directed at early intervention for children in particular.

Hon Ljiljanna Ravlich interjected.

Hon Norman Moore: You should be listening to this and taking notice.

Hon Ljiljanna Ravlich interjected.

The DEPUTY PRESIDENT (Hon Ken Travers): Order! The Minister for Education and Training will come to order. Hon Helen Morton has the call. The time for debate is limited. I urge members not to interject and prolong the debate any longer so that we can allow other members who wish to participate to do so.

Hon HELEN MORTON: As I say, the issue of youth should have been talked about at the outset. All the evidence to hand today tells us that if we invest in people with mental illness at an early age, it is possible to provide preventive intervention, particularly for children. What do members think is happening in WA? The absolute opposite. A smaller percentage of children with mental illness is being treated than was treated in the past. About seven per cent of children with a mental illness were being treated but the rate has now declined to 0.9 per cent. Funding for child and adolescent health services relative to the total population and to mental health services for adults and the elderly has gone backwards in WA. There are huge waitlists, which include children at serious risk of harm. Despite evidence about the effectiveness of early intervention in WA, children under 12 years of age are unlikely to be treated. There are easily identifiable early predictors of mental illness in children as young as two years of age. Other countries such as the United Kingdom, Canada and the United States are now focusing on this preventive approach. Mental health reform in WA should include a comprehensive plan for the mental health of infants and children. It needs to span the health, education, welfare and justice departments. It must move away from the current silo mentality. The two initiatives in the Western Australian section of the national action plan are the initiatives outlined in the 2004-07 mental health strategy and are operational. I have visited them. They are needed but they are nowhere near enough. A 1997 survey on mental health and wellbeing showed that the highest prevalence of mental disorders - 27 per cent - was in young adults aged 18 to 24 years. The Victorian government is establishing a specialist youth service in the public mental health system for this group. The commonwealth government has established the National Youth Mental Health Foundation with an advisory board to consider how better to support the nation's young people who are suffering mental illness and associated drug and alcohol problems. Its membership comprises people such as Grant Hackett; Trisha Broadbridge; Divonne Homes à Court; McDonald's chief executive officer; Paul Ramsay of Ramsay Health Care; former Premier of South Australia Hon Dean Brown; Ryan Stokes, a prominent member of the Channel Seven staff and son of Kerry Stokes; and others. The commonwealth has committed $69 million to support initiatives in youth mental health. Where is the WA commitment to significantly increase services for the 18 to 24-year-olds?

In conclusion, I take my hat off to Hon Christopher Pyne, MP, from South Australia, the parliamentary secretary to the federal Minister for Health and Ageing. He is the main person at the federal level pushing mental health reforms. I am looking for the same level of understanding about the dire need for mental health reform - not just more of the same outdated models of care in WA - and a commitment from the parliamentary secretary for health in WA, Hon Sue Ellery, for new funding rather than a recount of the funds that have already been committed.

HON LOUISE PRATT (East Metropolitan) [3.40 pm]: I very much welcome this debate because it is an important opportunity to discuss a very serious issue. However, Hon Helen Morton's motion is a complete nonsense. Sure, it is terrific to applaud the federal government for introducing $1.8 billion in new funding. However, in calling upon the state government to match this commitment, is she asking it to match the $1.8 billion or the amount that should come through as part of the Western Australian component?

Hon Helen Morton: The Western Australian component.

Hon LOUISE PRATT: The simple fact is that Western Australia will struggle to receive the proportion it deserves from that $1.8 billion.

Some of that funding will provide, for example, Medicare numbers for different forms of health services. Those services are urgently needed in rural and regional Western Australia. The honourable member has already highlighted some of the needs in those areas, yet because in Western Australia there are not enough people in those professions in those areas, we will not attract the proportion of that $1.8 billion in funding that Western Australia deserves. We have already matched that level of funding this year. In 2001, when the Gallop

government came to office, $208 million was being spent on mental health, and the Labor government has since increased that spending by 50 per cent. There is absolutely no doubt that it is now the federal Howard government that is playing catch-up on this issue. That is made clear in a media release by the Mental Health Council of Australia welcoming the national announcements. It states -

> "To put the investment into perspective, today's CoAG announcement will lift mental health's share of total health expenditure in Australia from 7% to 8%. It is a good start but still looks a long way from the 12% the council has called for,"

Yes, Western Australia also aspires in the long term to increase its mental health spending. However, the simple fact is that our spending is already at nine per cent and we are already ahead of the rest of the nation. Nine per cent of the total health expenditure is significantly greater than what any other state government or the federal government has committed to mental health. The internal logic of Hon Helen Morton's motion is completely inconsistent. She has asked us to match the federal commitment and outline the government's new funding contribution to mental health; we have done that. The state Labor government has done that, and it was way ahead of the game when it started the Western Australian mental health strategy in 2004. The member will recall the debate in the community in 2004 about significant levels of unmet need in Australia. It is a debate that has been raging across the nation. That debate was happening in Western Australia back in 2004 and it has continued to rage at a national level because of the lack of action.

To some extent, I believe mental health organisations and groups were very successful in highlighting their needs and issues to the Western Australian government in 2004. I think that consumer groups and advocacy groups learnt a lesson from that, have become well organised and have brought the issue to the national agenda. A Senate committee report into mental health was recently published. The report has a wide range of recommendations relevant to both federal and state governments. However, the federal government's recent commitment to mental health is only 50 per cent of what the Senate committee identified as unmet need. The Senate committee raised a range of issues for the attention of state and territory governments. Many of these recommendations are already part of the state's mental health strategy. They include more respite step-up, step-down accommodation options; long-stay patient facilities; a safe environment for consumers in acute long-stay and emergency settings; more long-term supported accommodation community-based housing; and an increased level of consumer involvement in mental health services. Those are just some of the issues pertaining to the Senate report that the Western Australian state government is already actively engaged in.

Western Australia's mental health strategy has outlined the need for an increase in the number of adult inpatient beds for people with severe mental illnesses. I have some statistics and information relevant to my electorate that highlight some of the accommodation services and beds that will be available. I will get to that later in my speech. I turn now to community mental health services for adults and for young people. The objective of mental health services for adults is to improve clinical outcomes for people with mental illnesses through the provision of accessible community services to encourage early identification, intervention and recovery. This is something which the government set in motion in 2004 and with which the federal government is now playing catch-up. The federal government is finally coming to grips with the need for primary mental health services. The government has a vision of enhancing mental health services for young people to encourage accessibility and to provide a whole-of-government service and approach to ensure that young people with mental health problems are given the best opportunities for early intervention. There are a wide range of important initiatives in the government's mental health strategy.

I turn now to community-supported accommodation, which was one of the significant issues raised by the Senate committee report and, indeed, raised by the Western Australian Health Consumers' Council in 2004. I will quickly discuss some of the issues in my electorate, the East Metropolitan Region. Some of the key initiatives include a 25-bed community-supported residential unit in Armadale and a 25-bed community-supported residential unit in Kalamunda. Hon Helen Morton will recall that a major realignment of services is under way at Kalamunda District Community Hospital. That includes some quite controversial things such as shifting maternity services. There has been wide-ranging community debate about those issues. The state government seeks to align the services that are required at a local level in that community hospital. That realignment includes the provision of more residential mental health units. There is also a 25-bed community-supported residential unit in the Swan area and a six-bed group home in redevelopment at Whitby Falls, south of Armadale. There is also an eight-bed facility for community options in Kelmscott. These initiatives come under the Department of Housing and Works. This government has provided more than $8 million worth of capital works funding to underpin housing for people with mental health issues in the East Metropolitan Region.

I turn now to clinical and community services. A key project is the expansion of mental health liaison nurses in Swan and Armadale. There has also been an expansion of on-duty registrars in Swan and Armadale. If we include Bentley, which of course falls outside our electorate, there has been an increase of $1.6 million in those

staffing areas. The number of inpatient beds in Armadale has been increased to eight, to the tune of $650 000. Prior to September 2004 there had already been an increase of 11 beds in Armadale.

Hon Helen Morton: That is all bricks and mortar. Is anything positive happening at the cultural level?

Hon LOUISE PRATT: That is not just bricks and mortar. It includes staffing as well as the number of beds available.

A number of clinical community initiatives have been implemented. These include adult and child and adolescent community teams, and the expansion of day therapy services at places such as the Bentley Health Service. Work has been completed on the Bentley transition unit for adolescents aged between 12 and 18. That will provide additional partial hospitalisation-style treatment and support to twice as many patients as can be catered for currently; that is, 80 patients.

To go back for a moment to supported accommodation, I have mentioned Whitby Falls. Whitby Falls has been the subject of ongoing debate within political and community circles. The previous government attempted to close Whitby Falls. It then found itself in a position in which it had to close Whitby Falls because it had deteriorated to a significant degree and was unsuitable for housing. A six-bed group home will now be built so that the existing residents can be relocated to a purpose-built facility. That facility is scheduled to be completed by the Department of Housing and Works in February 2007.

I turn now to inpatient services at Armadale. The Armadale mental health unit is now fully operational to its 25-bed capacity. The Armadale eight-bed adult inpatient unit was commissioned on 27 July 2006 and is also operational. There are significant planned redevelopments in the Swan and Midland hospitals and health services. That includes provision for 15 adult acute mental health inpatient beds and the construction of the new facility, which is scheduled for completion in 2011-12, at a capital cost of $181 million.

Hon Helen Morton: We are talking about something that is six years away. What will be happening in the six years between now and then?

Hon LOUISE PRATT: I have outlined previously an expansion in beds and services, some of which has already come into effect, and some of which will be rolled out in the near future. That is ongoing. We have improved funding for the emergency departments at Armadale and Swan District hospitals. That will enable people who present at hospital emergency departments with a psychiatric illness to be quickly assessed and treated by specialist mental health staff. Additional funds have also been provided to enhance the mental health triage service at Bentley Health Service. To answer the member's question, $2 million has also been invested to provide an enhanced south metropolitan community mental health emergency response service. This will greatly improve access to community emergency services in our electorate. That $2 million is additional to the mental health strategy funds that I have already referred to. That is an outline of some of the progress that is being made within the East Metropolitan Region that will build on this government's mental health strategy.

I turn now to some of the other initiatives that have been taken by this government. We have implemented a scholarship program to provide an extra 120 mental health nurses for the Western Australian health system over the next four years. It is all very well to ask what we are doing right now. We need to have people in the system and ensure those people are trained. We have been doing that on an ongoing basis. We have been expanding the number of places and positions, and we will continue to do so. It goes without saying that the 50 per cent increase in the mental health budget has meant that a large number of new people have been employed. That has required a large number of people to be trained in the mental health area. The state government has allocated $2.8 million to establish a postgraduate diploma in mental health and nursing. This new course will enable fully qualified registered nurses to register as mental health nurses. I hope that will help make nursing a more popular career choice. I pay tribute to the mental health nurses who work in the front line of our system and provide support to patients and general practitioners, psychiatrists, social workers, psychologists and other health professionals in coordinating care. The scholarship program will fund that one-year postgraduate course for nurses. The course will include 1 000 hours of clinical education in a mental health facility. That is just one example of the kinds of things the state government has put in place to respond to the growing need in the mental health area. In fact it has been an existing need in mental health that we have failed to recognise as a community for a long time. As I have said, the expansion of the mental health budget by 50 per cent since 2001 has created a strong demand for mental health nurses.

Some innovative things are also taking place. A good example is the creative expression centre for arts therapy at Graylands Hospital. It has been shown at Graylands and throughout the world that arts therapy can reduce hospitalisation and relapses for mental health patients and is helpful in treating depression, abuse-related trauma and schizophrenia.

Hon Helen Morton: Did you know that they put a "Health" logo on the arts therapy centre in Northbridge? I am serious! They had to fight to get the "Health" logo off it!

Hon LOUISE PRATT: That is probably taking government badging a bit too far, but I am sure some artist will in the future seek to create some appropriate humour from that.

This government has spent $185 000 on upgrading the arts studio. We have also allocated an additional $300 000 a year towards the operational costs. That is just one small part of the $173 million health strategy that the government launched initially. The amount of funding is now considerably more than that.

I will now comment briefly on a report which came out some time ago and which has been very much at the forefront of putting pressure on the federal government to increase funding for mental health in Australia. That was the Mental Health Council of Australia's "Not for Service" report. That report highlighted many tragic stories of a similar nature to the one outlined by Hon Helen Morton. One of the issues that has been highlighted by Dr Sev Ozdowski, human rights commissioner and acting disability discrimination commissioner for the Human Rights and Equal Opportunity Commission, is the stories that were raised during the consultations that suggest that in Australia the process of deinstitutionalisation has unfortunately not been accompanied by a corresponding level of support to enable mentally ill people to live in the community. This has meant that many people with serious illnesses have been left without the help that they deserve. He said, further, that Australia has some way to go before the ideas in the national mental health strategy translate into a mental health care system that delivers the highest attainable standard of health care in Australia. I agree with him, and we have a long way to go, but the government is going gang busters on this issue at the state level. We are very firmly committed to improving mental health in Western Australia. I do not think that the record of any other state can match ours. The member's comments directed at the Minister for Health are entirely unfair.

An example of the state government addressing the process of deinstitutionalisation is community-supported housing. I have made some mention of this already in my speech this afternoon, but I would like to talk about an initiative in supported accommodation at the Stratton community in Midland.

Hon Helen Morton: Are you saying that 25-bed units are deinstitutionalised?

Hon LOUISE PRATT: No; some mental health conditions require institutionalisation, and we have an objective of deinstitutionalisation. I am about to talk about the Stratton community-supported accommodation residential units. We will remember that in September 2004 the Minister for Health announced the mental health strategy, which included additional community-based accommodation for people with mental illnesses. As part of this strategy, the Department of Health intends to construct new community-supported residential units for people with manageable mental illnesses at Stratton, in my own electorate. I am not sure whether the member is aware that the state government is currently undertaking this kind of project, but these facilities will be a cluster of new one, two and three-bedroom units providing permanent homes for 25 residents, as well as on-site staff. The residents are living in the community in a variety of settings but, as we have already highlighted, in deinstitutionalising people we did not provide proper accommodation and support. The strategy is now about taking, as a good local example, those 25 residents who are living in a variety of settings in that region and who are not adequately supported, and bringing them into these units in Stratton.

Hon Helen Morton: That is actually institutionalising them out of other accommodation.

Hon LOUISE PRATT: No, it is not. These will be small community-style houses.

Hon Helen Morton: But they will be all together in one place.

Hon LOUISE PRATT: Listen to me! They will be a cluster of new one, two and three-bedroom home units. They will provide permanent homes for 25 residents as well as for on-site staff. The units will be supported by the staff, who will be on site 24 hours a day, and the local community mental health nurse.

Hon Helen Morton: Why doesn't the Disability Services Commission use that model anymore? It is stigmatising the people concerned.

Hon LOUISE PRATT: Would the member like to tell me what her model is?

The DEPUTY PRESIDENT (Hon Ken Travers): Order! Hon Helen Morton will come to order. Hon Louise Pratt has the call. As I have reminded members, this debate is limited to four hours and 15 minutes. Interjections prolong the debate and prevent other members who may wish to participate in the debate from having a say. Hon Helen Morton has interjected a number of times when Hon Louise Pratt has not sought her interjections. Hon Helen Morton might limit her interjections to those that Hon Louise Pratt wants to take, and not the many she has been making that the member does not wish to reply to.

Hon LOUISE PRATT: I do not wish to talk for too much longer because the time for this debate is limited; it is a significant issue and I know other members want to contribute. In her speech, Hon Helen Morton made an allegation about the integration of mental health housing into the community. I am not very clear about what the honourable member said, but with these units at Stratton, the Department of Health is undertaking a consultation

program with the local community on how best to properly integrate the units into the local community. This will include personal briefings with neighbours, local schools and mental health stakeholders.

Hon Simon O'Brien: They tried doing that in Hilton, but then abandoned the idea.

Hon LOUISE PRATT: It is hard work doing this. We must talk face-to-face with the community to make it aware of the issues. We must work very hard with the local community to get its support for introducing these kinds of facilities.

Several members interjected.

The DEPUTY PRESIDENT: Order! Hon Louise Pratt has the call. Members on my left will remain silent, and the members on my right will stop encouraging them.

Hon LOUISE PRATT: A fantastic example of this is the Boronia Pre-release Centre for Women, which shows that the state government has the capacity to be at the forefront in introducing properly integrated community housing for people with mental health conditions.

I will not speak for too much longer because, as the Deputy President has indicated, this is indeed a significant debate and many other members will want to contribute. I conclude by reminding the house how much of a nonsense the motion we are debating actually is. It calls on the state government to match the commonwealth government's $1.8 billion in funding. It does not state explicitly whether it applies only to the proportion of that amount that comes to Western Australia but, as I have highlighted in my speech, it is unlikely that Western Australia will get its fair share of that money in any case. Mental health is an issue that I take very seriously, and I know the Minister for Health also takes it very seriously. The state government takes the issue very seriously. We have led the nation with our mental health strategy and we lead the nation in funding this area. I am very proud of the government's record, but, of course, there is more work to do. Mental health has been a long-neglected issue in this country, but I am very proud to stand by the record of the state government, and I oppose the motion.

HON SUE ELLERY (South Metropolitan - Parliamentary Secretary) [4.08 pm]: We need to take a deep breath and step back a bit from some of the aggression and the partisan nature that characterised the opening contribution to this debate. It is the government's position that it applauds and congratulates the Australian government for its announcement of $1.8 billion of new funding for mental health. Indeed, the Western Australian government has written to the Prime Minister welcoming the announcement and making a commitment to be an enthusiastic participant in the Council of Australian Governments process. We look forward to working with the commonwealth government on the plans to roll out the expenditure that has been announced.

However, we need to recognise that governments of both persuasions cannot come to this debate with clean hands. The reasons Australian governments are now having to make very significant funding resources available is to address the crisis in mental health that both sides of politics oversaw in the recent past. Both sides of politics must acknowledge that no governments, until very recently, treated mental health with the seriousness we now know it needs. If that is the case, we should recognise the good that both jurisdictions are doing, and that is indeed what the leaders of the COAG process have done. I draw the attention of members to the foreword of the COAG document "National Action Plan on Mental Health 2006-2011" dated 14 July 2006. It reads, in part -

> COAG recognises that it will take time to strengthen the capacity of our mental health services. This National Action Plan outlines a series of initiatives that will be implemented over the five-year period, comprising a significant investment from all governments. The value of the measures covered in the Individual Implementation Plans totals approximately $4 billion over five years. All governments have agreed to continued investment in the area after this time.

The Western Australian government and the commonwealth government have the opportunity now to commit significant resources to lifting the bar for mental health services and to work together, which they are doing. We are happy to congratulate the Australian government for the contribution that it is making. However, there has to be real recognition, as there has been, by the Prime Minister and the other partners in the COAG process that WA is also taking big strides forward.

One of the issues that have been raised in the debate to date has been the approach that has been taken on disability services. One of the things that characterises the history of disability services, at least in Western Australia, since the 1980s is the bipartisan approach that has been taken to the significant issues around disability services. Therefore, we should be able to learn from that in our approach to mental health services and recognise the good that both jurisdictions are doing. In doing that we have to seek the best for Western Australia's circumstances and recognise that the plans that have been announced by both jurisdictions will take time to roll out.

Amendment to Motion

Hon SUE ELLERY: I move -

To delete all words after "Australia," and insert instead -

applauds the WA government for boosting funding of the WA mental health strategy in 2004 with an increase of $173 million and for allocating $300 million to mental health this financial year, and notes the distribution of the Australian government's mental health funds through Medicare payments directly disadvantages areas where there are fewer GPs and psychiatrists, like WA and, in particular, regional and rural WA, and calls on the Australian government to distribute these funds in an equitable way.

The Prime Minister has announced an allocation of $1.8 billion over the next four years for the national mental health service reforms. That includes a $1.5 billion increase to mental health services provided through the commonwealth medical benefits scheme, which increase was announced by the commonwealth Minister for Health on 22 March 2006. The recent Senate committee report on mental health that has been referred to by both speakers who have contributed to this debate so far recommended an increase in commonwealth funding of between 50 and 100 per cent by 2012. The $1.8 billion that has been announced by the commonwealth is about half of what was recommended by the Senate report. Much was made in the contribution by Hon Helen Morton about that being a bipartisan Senate committee report. I think that is worth noting. It should also be noted that the states were not consulted on the detail of the plan before the announcement was made. Although we have publicly, and by way of letter to the Prime Minister, welcomed the contribution, attention and priority that has been given to mental health services, we have some concerns about how that plan will roll out in Western Australia and, in particular, how it will take account of the low number of general practitioners and psychiatrists in WA, particularly in rural and regional WA. The emphasis by the commonwealth government on that money being made available through Medicare will cause real problems for us in Western Australia. That money will not be spent if there are no GPs and psychiatrists to deliver the services or to take advantage of the provisions that have been made available through Medicare. Patients in need of good primary mental health care through a GP will not be able to access those services because of the shortage of GPs in Western Australia. Therefore, we need to work with the Australian government to make sure that the equity issue is properly addressed, otherwise we will not get the benefits from the significant funding that was announced by the Australian government.

Like those with physical conditions, the likelihood is that people in need of treatment for mental illness may find that their condition will deteriorate if they do not have access to a GP.

Debate interrupted, pursuant to sessional orders.

Sitting suspended from 4.15 to 4.30 pm