MENTAL HEALTH BILL 2013

Consideration in Detail

Resumed from 13 March.

Clause 42: Providing information contained in referral to person referred —

Debate was adjourned on the following amendment moved by **Dr A.D. Buti** —

> Page 36, after line 21 —To insert —
>
> (2A) Any information provided to the practitioner under subsection (2) must be notified to the Chief Mental Health Advocate.

Dr A.D. BUTI: Mr Acting Speaker (Mr P. Abetz), can you jog my memory? Was I on my feet when we reported progress? I cannot remember. Did I move that amendment?

Ms A.R. Mitchell: Yes, you did.

The ACTING SPEAKER: According to the notes I have been provided as Acting Speaker, the amendment was moved by you.

Dr A.D. BUTI: That is very good. I think I spoke about it previously so the parliamentary secretary might have a comment.

Ms A.R. MITCHELL: I have responded on a couple of occasions but I will clarify for members that at this time the clause is only about referral. Nobody will have been examined to see whether they should become an involuntary patient; therefore, the involvement of the Chief Mental Health Advocate is not appropriate at this stage.

Amendment put and negatived.

Clause put and passed.

Clauses 43 and 44 put and passed.

Clause 45: Extending referral made outside metropolitan area —

Dr A.D. BUTI: Can the parliamentary secretary please inform me whether the referral to be made outside the metropolitan area could be 72 hours, plus 72 hours, plus 72 hours? That is how I understand clause 45(4), but I may be reading it wrongly.

Ms A.R. MITCHELL: No, it can be extended for one lot of time but the maximum is 144 hours.

Dr A.D. BUTI: From my understanding, someone can be held for 72 hours. Subclause (4) reads —

> The referral may be extended for a further period of 72 hours from the time when the 72-hour period referred to in section 44 ends.

That is fine. Subclause (3) reads —

> The practitioner or person responsible may extend the referral if satisfied that the referral is likely to expire before the person is received into the authorised hospital or other place.

Can the parliamentary secretary tell me where there is a definition of "other place"? I cannot find it anywhere. It is probably there, but I have not been able to find it.

Ms A.R. MITCHELL: The Chief Psychiatrist will have a list of those "other places" that may be required. It will be part of his guidelines.

Dr A.D. BUTI: Can the parliamentary secretary please tell me where in the legislation it provides that the Chief Psychiatrist has a list of other places? Should we not know through the legislation where these other places are? We are being asked to vote on the Chief Psychiatrist having a list, the contents of which—these "other places"—we do not know. They could be completely inappropriate places for someone to be referred to and in effect detained for up to 144 hours. Where in the bill is there provision for the Chief Psychiatrist to a have list of other places?

Ms A.R. MITCHELL: I refer the member to clause 543 on page 358, which states —

> (1) The Chief Psychiatrist must publish guidelines for each of these purposes —
>
> …

(b) making decisions under section 26(3)(a) about whether or not a place that is not an authorised hospital is an appropriate place to conduct an examination;

Dr A.D. BUTI: Does Parliament not have the ability to scrutinise what these other places are? We can just imagine that in times of urgent need when the budget does not allow the government mental health facilities and authorised hospitals, we may be in a desperate situation and we will allow a person, without the scrutiny of Parliament, to declare somewhere as an appropriate other place. We are dealing with one of the most vulnerable sections of society and the Chief Psychiatrist is being given carte blanche to determine what an appropriate place is. Surely it would have been more appropriate to have a list of these other places in the bill. An authorised hospital has been defined in the bill, but no limitation is provided of what another place could be. As we very well know from other public policy domains such as the accommodation of refugees, there are places housing refugees that some people may consider to be completely inappropriate. It is not so far-fetched that there will be a similar situation here, especially in rural and remote areas. My friend sitting in front of me is the member for Albany and I am sure there may be times when the local hospital in Albany will at some stage not have enough facilities to house people who need to be housed for mental illness. This bill will allow a psychiatrist, without parliamentary scrutiny, or scrutiny of any type actually, to declare a place another place. It is completely unacceptable.

Ms A.R. MITCHELL: I keep bringing this matter back to the fact that this provision is about a referral, not about staying —

Dr A.D. Buti: Yes, but they can still be there for 144 hours.

Ms A.R. MITCHELL: Can I please finish? At the same time, the Chief Psychiatrist is appointed by the minister and has to make an annual report to the minister, and any places used will be included in that report. The member mentioned remote areas, and one of the reasons each place is not specifically defined is that there may have to be some alternatives used at times based on locations. They would be places like emergency departments, general hospitals, mental health clinics and nursing posts, and they would be used to accommodate the situation, particularly in remote areas.

Mr D.A. TEMPLEMAN: I refer to clause 45(1)(a), which states —

the place where a referral is made under section 26(2) or (3)(a) is outside a metropolitan area; …

I seek clarification about the definition of "metropolitan area". On page 7 of the bill in the definitions section the metropolitan area is defined as an area of the state prescribed by the regulations as a metropolitan area. What regulations does that refer to? The reason I ask this question is simple: Mandurah is not in the metropolitan area, so I would understand that it is captured by this particular clause and therefore there are ramifications for a person residing in the City of Mandurah within the definitions of this bill. I want clarification about the regulations referred to on page 7 under the definition of "metropolitan area" and I also seek the parliamentary secretary's comment about the impact of this particular clause on a person who may reside within the City of Mandurah, which is not part of the metropolitan area.

Ms A.R. MITCHELL: I thank the member and I understand his concern about Mandurah. The regulations that will be developed within this bill and the purpose of this bill will comply with state regulations.

Mr D.A. TEMPLEMAN: I want the parliamentary secretary to tell me what those regulations are. Is she telling me that those regulations are yet to be drafted? I want to know in regard to this bill and this clause where a citizen of Mandurah, which is in the Peel region outside the metropolitan area, is captured. By definition a person living within the municipal boundary of the City of Mandurah is not a citizen of the metropolitan area. Therefore, does this bill, and this clause, consider them to be a citizen outside the metropolitan area? If so, this clause refers to them. If it is assumed that they are considered to be part of the metropolitan area, I want to know which regulations define them as so. The parliamentary secretary and her bureaucrats would be aware that the delivery of health services to the City of Mandurah is done by the South Metropolitan Health Service, which includes Peel Mental Health Services. However, this clause with this definition applies to a referral made outside the metropolitan area. Therefore, logically if a referral was made within the municipal boundary of Mandurah, it is my understanding that this clause is relevant to a citizen of Mandurah. If it is not, I want an explanation about what the definitions are based upon, because in my view they are contrary to the definition of what is metropolitan and what is not.

Ms A.R. MITCHELL: I think the member's question is a very good one. I wish to make a correction if I was inaccurate in my last answer. The member is right: Mandurah is considered a metropolitan area under the government health boundaries and therefore it will remain in that boundary for this legislation.

Mr D.A. TEMPLEMAN: Can I therefore ask a question about a person who may reside in the Shire of Murray, which is, again, a non-metropolitan municipality? The hospital overseen by WA Health is of course Murray

District Hospital, which has a specific function. If a person who resides in the River Glades Resort, which is across the boundary from the City of Mandurah, some 100 metres from the Serpentine River but in the Shire of Murray, happens to be subject to a referral, does this clause capture that person, or not?

Ms A.R. MITCHELL: I say to the member that the metropolitan health boundaries will continue to apply for anyone within the area he has referred to. If the person resides inside the metropolitan area, as per the health boundaries, then he or she will be treated that way. If the person resides outside the metropolitan health boundaries, he or she would fall under the area as a regional area. That will be set out clearly in the bill in the regulations.

Mr D.A. TEMPLEMAN: I am happy to accept that. I will be interested to see the regulations when finalised. However, the parliamentary secretary is saying that for definition purposes, the regulations will prescribe boundaries related to health jurisdictions. In other words, the South Metropolitan Health Service will be the defining boundary and not strictly the state planning boundaries, which, of course, are different. Is that correct?

Ms A.R. MITCHELL: Yes, that is how I understand it will be.

Clause put and passed.

Clauses 46 and 47 put and passed.

Clause 48: How assessment must be conducted —

Dr A.D. BUTI: There is a definition issue here. In clause 48 we have a list of occupations that are determined to be prescribed health professionals, which becomes important under subclause (4). We also have a definition of "mental health practitioner"; we have a definition for all those occupations. "Medical practitioner" is defined in clause 535 and prescribed health professionals are defined in clause 48(1). "Authorised mental health practitioner" is defined in clause 536 and "medical practitioner" is defined in clause 4, but nowhere—one may see this as being irrelevant or semantic but it is not—is "practitioner" defined. If we look at clause 48(3) and (4), we see it refers to a practitioner who will be doing the assessment, but the bill has not defined what a practitioner is.

We have gone to all this length to define all these other occupations, as I have stated, in various clauses throughout the bill, but then the bill says that the practitioner can do the assessment—he or she can even do an audiovisual assessment—but what is a practitioner? Where is the definition for "practitioner"? It may be in the bill, but I have not seen where it is.

Ms A.R. MITCHELL: It is my understanding that in this clause, the prescribed health professional is the practitioner.

Dr A.D. BUTI: That was not my question. We know what "prescribed health professional" means because it is listed in clause 48(1). It could either be a medical practitioner, a nurse, an occupational therapist, a psychologist or a social worker, and it then refers to issues about Aboriginal or Torres Strait Islander descent, which is interesting to note, but I will get to that in a minute. However, my question is not about what a prescribed health professional is, because the bill lists that. My question is: what is a practitioner? The bill does not define what a practitioner is. The bill defines what a medical practitioner is under clause 535, but it does not define a practitioner. In this clause, it is the practitioner who does the assessment.

Ms A.R. MITCHELL: It is my understanding that the word "practitioner" is, I will say, the shorthand version. Rather than writing it out the whole time, it is the medical practitioner or the authorised mental health practitioner. That is understood within this legislation because we are now talking about assessment.

Dr A.D. BUTI: Why would we go to the trouble of clearly defining all these other occupations? Why would we go to the trouble of defining who is a prescribed health professional, what a mental health practitioner is and what an authorised mental health practitioner is? The response to my question was that a practitioner is just a shorthand method of saying a medical practitioner. That is actually sloppy drafting in the legislation. I think the best thing to do would be for the parliamentary secretary to say that it is an oversight and that she did actually mean a mental health practitioner. Maybe she should move an amendment so that it is cleared up or, if not, at least notify the Minister for Mental Health in the other house that the clause is incredibly sloppy. To say it is just a shorthand version of what a medical practitioner is defeats the whole idea of defining the terms.

Ms A.R. MITCHELL: If I could take the member back to clause 26(1), it states —

> A medical practitioner or authorised mental health practitioner may refer a person ...

The provision is quite clear. They are the only people who can refer a patient on. I think it has been covered and it is covered throughout this bill. What has not been done is the prescribed health professionals—that is, what

constituted that definition. However, previously the bill has referred to the medical practitioner and the approved authorised mental health practitioner.

Dr A.D. BUTI: The reason I picked it out is that I spent the weekend going through this bill in greater detail. That is why I missed it in clause 26. In fact, the parliamentary secretary will not be happy to note that that oversight, or inconsistency, occurs in many parts of the bill. It is sloppy drafting. We should not define things and then use an abbreviation in legislation. It is all right to say that we have talked about it, but because we have talked about something does not mean it is part of the legislation. The parliamentary secretary is saying that a practitioner is the same thing as a medical practitioner. Can she point out to me—if she is using that logic in that answer or that standard position—where in the bill it states that a practitioner means a medical practitioner? By that analogy, we could also define what a nurse is but then in another part of the bill use a different word or a shorthand version of a nurse. That is not how legislation is drafted; it has to be precise. In saying that a "practitioner" means a medical practitioner, could it not mean something else? Psychologists, nurses and social workers could all be called practitioners. How are we to deduce that "practitioner" means only a medical practitioner if there is no definition of it in the bill?

Ms A.R. MITCHELL: I refer the member to clause 26(1), which refers to a "medical practitioner" or an "authorised medical practitioner" and to subclause (2), which refers only to "practitioner".

Dr A.D. Buti: That is wrong.

Ms A.R. MITCHELL: Although this is a fairly large bill, counsel has advised the use of the word "practitioner".

Dr A.D. BUTI: I did not know that the length of a bill determines whether or not we use shorthand—that is interesting. Yes, it was an oversight, and I should have picked it up in clause 26; I did not, but I am picking it up now. If I have to, I will pick it up in every clause. Clause 49 refers only to a "practitioner". Why does the parliamentary secretary not admit that that is an oversight?

Ms A.R. Mitchell: It is not an oversight.

Dr A.D. BUTI: If it is not an oversight, it is sloppy and illogical drafting. There is no definition of "practitioner" in the bill. I refer the parliamentary secretary to clause 48. Where does it define that a practitioner means a medical practitioner and that it does not mean a nurse, an occupational therapist, a psychologist or a social worker? Where in the clause or anywhere in the bill does it read that a practitioner does not mean one of those other prescribed health professionals? The public of Western Australia have to take it as so, because the bill states that it means medical practitioner—that is it—even though there is no definition in the bill.

Ms A.R. MITCHELL: We just passed clause 47, which is dedicated to the role of a medical practitioner and an authorised medical practitioner throughout the bill.

Dr A.D. BUTI: Just because we may have erroneously passed one clause does not mean that the clause 48 defect has been dealt with. I am asking the parliamentary secretary to tell me where in the bill I can find the definition of a "practitioner". As I stated, specifically with regard to clause 48, there are a number of prescribed health professional occupations and any one of them could be a practitioner. There is no definition in the bill that a practitioner means a medical practitioner. A practitioner could mean any one of those health professional occupations.

Ms A.R. MITCHELL: I believe it is covered throughout the bill and is limited by clause 47.

Dr A.D. BUTI: It is not. We will continue to go around in circles. It is a defect of the bill. When the bill reaches the other house, I hope that the Minister for Mental Health sensibly looks at incorporating the definition of "practitioner" as being a medical practitioner.

I refer to clause 48(1)(f), which states "if the person being assessed is of Aboriginal or Torres Strait Islander descent". Paragraphs (a) to (e) list prescribed health professionals while paragraph (f) refers to an Aboriginal or Torres Strait Islander mental health worker. I understand to a degree what this refers to. However, is an Aboriginal or Torres Strait Islander mental health worker any different from any mental health worker? They may need different qualifications, but if they do not, this subparagraph is superfluous.

Ms A.R. MITCHELL: To be an Aboriginal or Torres Strait Islander mental health worker, a person has to be an Aboriginal or a Torres Strait Islander. That is part of the application for the role and it should assist them with issues pertaining to Aboriginals and Torres Strait Islanders.

Dr A.D. BUTI: If I am an Italian mental health worker, am I an Italian mental health worker? I am not talking about a person's genetics or ethnic origins; rather, I am asking whether there is a different qualification for a

person who wants to be an Aboriginal or Torres Strait Islander mental health worker. If there is not, Aboriginal and Torres Strait Islander mental health workers should not be separated or distinguished because in doing so, the government is creating another special class.

Ms A.R. MITCHELL: Yes, they do receive different training, and they receive that training through the Aboriginal Mental Health Service so that they can be of most value to people of Aboriginal and Torres Strait Island descent.

Dr A.D. BUTI: They may receive additional training, but when they receive their diploma or qualification, does it state that they are an Aboriginal or Torres Strait Islander mental health worker or does it state that they are a mental health worker? Can the parliamentary secretary see the problem that will be created? I am sure the Minister for Mental Health had good intentions in trying to say that someone who is an Aboriginal or a Torres Strait Islander will hopefully be assessed by an Aboriginal or Torres Strait Islander mental health worker. However, they do not have to be. The government has prescribed an additional class based on race. As we all know, we have to be careful not to do that. One could read this as suggesting that an Aboriginal or Torres Strait Islander mental health worker is of a different class than other mental health workers. We do not say that someone is a Polish mental health worker or an Italian mental health worker—they are just mental health workers. Unless the bill reads that an Aboriginal or Torres Strait Islander is to be examined only by someone of Aboriginal or Torres Strait Island descent, that requirement is superfluous. It will create a picture of the government treating Aboriginal and Torres Strait Islander mental health workers as a separate class.

Ms A.R. MITCHELL: Yes, they do have a specific qualification—that is as an Aboriginal or Torres Strait Islander mental health worker. They do not do the examination. They are listed there as a support person during the examination to assist the person who is being assessed.

Dr A.D. BUTI: I understand that they do not do the examination, but the parliamentary secretary says that they have another qualification. What is that qualification? I do not refer to the training. I assume the training they do helps them understand the particular characteristics or demands that may be thrown up by an Aboriginal or Torres Strait Islander mental health patient, but surely a non-Aboriginal or Torres Strait Islander person could do that same training. I am sure that in remote communities many non-Aboriginal mental health workers have done the same training. If they have done the same training, how are they any different from the other mental health workers, apart from the fact that they are not Aboriginal or Torres Strait Islander? As the parliamentary secretary would know, we try to get away from the language of, "That's an Aboriginal footballer", or "That's an Aboriginal cricket player." That is all I am trying to get to. I know that is not what is meant, but that is what is being created.

Ms A.R. MITCHELL: The point the member makes can be brought into it, but it is not what this is about. It is generally accepted that there is an over-representation of Aboriginal or Torres Strait Islanders in the mental health system. The member who sits next to the member for Armadale has said many times that we have some real issues. Someone could be trained. There are probably people who are naturally empathetic and understanding of people of Aboriginal or Torres Strait Islander descent. We also have recognised that a greater focus is needed on helping people of Aboriginal or Torres Strait Islander descent, and to have people from their own culture available to support them in this role. We believe that is very important and has proven to be successful.

Dr A.D. BUTI: I totally agree with those comments, but of course this clause does not mandate that the prescribed health professional who may be with such patients must be an Aboriginal or Torres Strait Islander. Let us leave that. That is repeated in clause 79, but I think we have had a good enough exchange on that aspect.

Clause put and passed.

Clause 49: Information to which practitioner may have regard —

Dr A.D. BUTI: This is really a point of clarification. I think I know what the parliamentary secretary will say. Clause 49 states —

> The practitioner —

Let us leave that term now; otherwise, we will go around in circles —

> may have regard to any information about the person being assessed that is obtained by the practitioner —
>
> (a) from —

(i) the person, including information obtained by observing the person and asking the person questions; or

(ii) any other person;

and

(b) from the person's medical record.

I assume the parliamentary secretary will tell me that "any other person" could also include the current treating practitioner. Will it include that person?

Ms A.R. Mitchell: Yes.

Dr A.D. BUTI: Should we not have made that more explicit? I would have thought information from the current treating practitioner would be something that is incredibly important to obtain. The way the clause reads at the moment, there is no obligation to obtain information from the current treating practitioner.

Ms A.R. MITCHELL: It could be a treating psychiatrist, but it could be someone else—it could be a family member; it could be anybody. It should not be limited to the treating psychiatrist. The other thing that the member should note is that an examination of a patient cannot be made based only on what another person said. The first part is crucial to that aspect. It is a safeguard, once again, that the examination of the person is required, and that one cannot rely on information that another person may provide. This will also be detailed in the clinicians' guidelines.

Clause put and passed.

Clauses 50 and 51 put and passed.

Clause 52: Detention for examination on referral made under s. 26(2) —

Ms A.R. MITCHELL: I move —

Page 42, line 21 — To delete "person" and substitute —

person, the person's psychiatrist

This follows from an amendment made earlier during consideration in detail. It is one of those natural follow-ons. I do not think I need to speak any more about that.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 53: Detention for examination on referral made under s. 36(2) —

Ms A.R. MITCHELL: I move —

Page 43, line 17 — To delete "person" and substitute —

person, the person's psychiatrist

The amendment is moved on the same basis as the others.

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 54 to 57 put and passed.

Clause 58: Detention for examination —

Ms A.R. MITCHELL: I move —

Page 47, line 8 — To delete "the person" and substitute —

the person, the person's psychiatrist

Amendment put and passed.

Clause, as amended, put and passed.

Clause 59: Detention at place outside metropolitan area —

Ms A.R. MITCHELL: I move —

Page 48, line 18 — To delete "person" and substitute —

person, the person's psychiatrist

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 60 and 61 put and passed.

Clause 62: Detention to enable person to be taken to hospital —

Ms A.R. MITCHELL: I move —

Page 51, line 20 — To delete "the person" and substitute —

the person, the person's psychiatrist

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 63 to 69 put and passed.

Clause 70: Detention at authorised hospital —

Ms A.R. MITCHELL: I move —

Page 56, line 4 — To delete "person" and substitute —

person, the person's psychiatrist

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 71 to 78 put and passed.

Clause 79: How examination must be conducted —

Ms A.R. MITCHELL — by leave: I move —

Page 60, lines 27 and 28 — To delete the lines and substitute —

(a) the person being examined is at a place that is not an authorised hospital and is outside a metropolitan area; and

Page 61, line 5 — To delete "or practitioner"

Page 61, lines 10 and 11 — To delete "section 77(i) or (j) —" and substitute —

section 77(h), (i) or (j) —

Page 61, line 12 — To delete "or practitioner"

I apologise for the short notice on these amendments. The policy is that a person should not be able to be made an inpatient in an authorised hospital by means of just an audiovisual examination, which is clause 79(4). It also reflects the fact that only a psychiatrist can conduct the examinations referred to in clauses 79(5) or 79(6)(a). The other point is that this way, we can ensure that an examination by a supervising psychiatrist for the purpose of making an order revoking a community treatment order can be made via audiovisual communication. The amendments are based around audiovisual communication.

Amendments put and passed.

Clause, as amended, put and passed.

Clause 80: Information to which examiner may have regard —

Dr A.D. BUTI: Once again, this is a point of clarification or information being sought. I do this only to place the clarification in *Hansard* of "Information to which examiner may have regard". I think it is incredibly important that information is obtained by the patient's choice of current treating practitioner. I know that the parliamentary secretary is going to tell me that that can be under any other person, and that is fine and I accept that, but it would have been more advantageous and gone further towards protecting the interests of the patient, which is part of the "Objects" under clause 10, to expressly or explicitly mandate that information must be obtained from the patient's choice of current treating practitioner. I will not move an amendment, but I just wanted to make that point—that really, it should be mandated that information come from the patient's choice of current treating practitioner.

Ms A.R. MITCHELL: The member is right, it can be covered within that not to make it mandatory, but I can reassure the member that that will be noted within the clinician's guidelines for use as well.

Clause put and passed.

Clauses 81 to 92 put and passed.

Clause 93: Involuntary inpatient to be advised of expiry —

Dr A.D. BUTI: Clause 93 applies if an inpatient treatment order expires. It provides that the treating psychiatrist must advise an involuntary inpatient in writing of the expiry and its consequences. My question is: what is the time stipulation? There is nothing in that clause to say that it has to be done within a reasonable time or at the first foreseeable or practicable time. It just provides that the treating psychiatrist must advise an involuntary inpatient in writing of the expiry and its consequences. I had hoped that there would be a time stipulation attached to that clause.

Ms A.R. MITCHELL: Our advice was that "within a reasonable time" is implied within that clause.

Dr A.D. BUTI: Obviously, once the expiry takes place, any further detention would be unlawful, so it is of paramount importance that speed is of the essence.

Clause put and passed.

Clause 94 put and passed.

Clause 95: Person must be allowed to leave —

Dr A.D. BUTI: This clause makes it permissible, at the expiry, for the person to leave the hospital at which they have been detained. That is quite a significant event and should be a notifiable event. Clause 93 provides that the expiry is a notifiable event under part 9. Surely, it should also be notifiable when the patient leaves the premises. I say that because an expiry may come to an end and the patient may be notified, but they still have to leave the hospital, and the leaving of the hospital itself is an incredibly significant event. That should be notifiable because that way we can keep track of the time from the expiry taking place and that information being communicated to the patient, to the time the patient leaves the hospital. For good governance and to ensure that this procedure happens in a speedy manner, I think leaving detention should be a notifiable event.

Ms A.R. MITCHELL: Firstly, as soon as the person is no longer an involuntary patient, they may leave at a time that they choose; they are not under the management of it. Sometimes they do not want particular people to know what they are doing. However, at the same time, as soon as the notification of a change of status occurs, the family and carers are given as much notice as possible. Once that has occurred, the patient and whomever the patient chooses to associate with can function as they will.

Clause put and passed.

Clause 96: Delivery into custody under another law —

Dr A.D. BUTI: This is the issue about "other place". I just want it to be recorded that I think the way the bill has been drafted without properly prescribing these other places is inadequate and unsatisfactory. That also relates to clause 97 in division 5. I think the parliamentary secretary has made her comments about that.

Clause put and passed.

Clauses 97 to 104 put and passed.

Clause 105: Granting leave —

Dr A.D. BUTI: Clause 105, "Granting leave", provides that a psychiatrist may make an order granting an involuntary inpatient leave of absence from a hospital if satisfied that granting leave will be beneficial. We must remember that we are dealing with an involuntary patient, so one would assume that their mental illness is of such severity that they are an involuntary patient rather than a voluntary patient, but it may be considered to be beneficial that they be granted leave. Would it not be prudent in that situation for the information about granting leave to be relayed to the patient's choice of current treating practitioner or for the patient's choice of current treating practitioner to be consulted before the leave is granted? My reasoning for that is that one would hope that the patient's choice of current treating practitioner would know the patient as well as, and probably better than, anyone else who deals with the patient because they would have dealt with the patient for longer and would know their history. Would it not be prudent for the involuntary patient's choice of current treating practitioner to be consulted before the leave is granted?

Ms A.R. MITCHELL: The specific components of clause 105(1)(a) would apply if someone needed to attend the funeral of a person close to them or something like that or if they needed medical treatment. It is not really

about other treatment for their mental illness. The provisions are there for completely different reasons, rather than involving the person's treating psychiatrist or the person's psychiatrist.

Dr A.D. BUTI: That is the point. Anyone who reads that clause will not know that. It just states that it is likely to benefit the involuntary inpatient's recovery from mental illness or to benefit the inpatient's mental health in some other way. The parliamentary secretary mentioned a funeral. How could anyone know from reading that clause that that is what it refers to? Subparagraph (ii) states —

> enable the involuntary inpatient to obtain medical or surgical treatment or be likely to benefit the inpatient's physical health in some other way; …

I do not know that the parliamentary secretary's scenarios can be deducted from a plain reading of those subparagraphs. We are talking about legislation. It is likely that the current treating practitioner will have greater knowledge about granting leave than the psychiatrist, but, in any case, the scenarios that the parliamentary secretary articulated bear no relevance to a plain reading of those subparagraphs.

Ms A.R. MITCHELL: Once again, a document called a clinicians guide will be prepared, and examples and things like that will refer to the legislation to clarify for people how that could be interpreted.

Clause put and passed.

Clause 106: Extending or varying leave granted —

Dr A.D. BUTI: I have the same comments about consulting the patient's choice of current treating practitioner. There is no need for the parliamentary secretary to comment if she does not wish to.

Clause put and passed.

Clauses 107 to 117 put and passed.

Clause 118: Monthly examination of patient —

Dr A.D. BUTI: This clause deals with the monthly examination of the patient. Subclause (2) states —

> The involuntary community patient must be examined, on or within 14 days before the day on which a review period for a community treatment order ends, by —
>
> (a) the supervising psychiatrist; or
>
> (b) another medical practitioner or a mental health practitioner —

The terms "medical practitioner" and "mental health practitioner" are used here, but in the next clause only the term "practitioner" is used. The term "mental health practitioner" is defined in clause 535. Is there any minimum experience or level of qualification that the supervising psychiatrist, the medical practitioner or the mental health practitioner need to have for the examination?

Ms A.R. MITCHELL: The person will need to have worked successfully in the field for three years.

Dr A.D. Buti: Is there somewhere in the bill that provides for that?

Ms A.R. MITCHELL: The person also needs to be a psychologist, a nurse, an occupational therapist or a social worker who has had three years in the field working in mental health.

Dr A.D. Buti: Is there somewhere in the bill that tells us that?

Ms A.R. MITCHELL: It is in clause 535.

Dr A.D. Buti: Thank you.

Clause put and passed.

Clause 119: Supervising psychiatrist may request practitioner to examine involuntary community patient —

Dr A.D. BUTI: My comments on this clause apply also to clause 120. Clause 119(1) reads —

> For the purpose of section 118(2)(b)(ii), the supervising psychiatrist may request another medical practitioner or a mental health practitioner to examine the involuntary community patient.

Are there any restrictions on delegation? Here we are really talking about delegation when the supervising psychiatrist is delegating the examination to another practitioner. With delegation, of course, comes the question of how far that delegation should go and what are the minimum requirements for examination to be undertaken.

Ms A.R. MITCHELL: I refer the member to clause 118(3) where it requires that the involuntary community patient must be examined by a practitioner under the supervising psychiatrist within the two-month period. That

would be temporary and it cannot be delegated every second month. The examination must be by a psychiatrist. Clause 113 also refers to that.

Dr A.D. BUTI: Although there can be delegation of an examination, I assume there is not a delegation of responsibility in the sense that it is the supervising psychiatrist delegating the examination to another party but that the obligation they have to the patient remains regardless of whether the examination is done.

Ms A.R. MITCHELL: Yes, that is right.

Clause put and passed.

Clauses 120 to 141 put and passed.

Clause 142: Notification not in person's best interests —

Dr A.D. BUTI: Subclause (3) provides that the Chief Medical Health Advocate will receive a copy of the notification. Subclause (1) provides that a nominated person, carer or close family member is not entitled to be notified under clause 140(1) of the making of an order under clauses 28 and 29. Can nominated persons, carers and close family members receive notification of all other orders that are not part of clauses 140, 28 or 29?

Ms A.R. MITCHELL: It is best understood that the way things will be dealt with in this area will always be in the best interests of the patient, and that may vary from patient to patient and situation to situation.

Clause put and passed.

Clauses 143 and 144 put and passed.

Clause 145: Making, revocation or expiry of involuntary treatment order —

Dr A.D. BUTI: I move —

> Page 108, after line 30 — To insert —
>
> (aa) the Chief Psychiatrist;

In addition to the Chief Mental Health Advocate and the Mental Health Tribunal being the bodies or persons who are notified with regard to making, revocation or expiry of, an involuntary treatment order, the Chief Psychiatrist should also receive notification. It is part of the good governance of mentally ill people that the Chief Psychiatrist is kept in the loop about this very significant event.

Ms A.R. MITCHELL: The Chief Psychiatrist is quite pleased that the member thinks he should be informed of this, but he said that he does not support the amendment because his involvement at this stage would be of no benefit to the patient. He can always get that information but it does not necessarily have to come to that. At this stage it would be perceived as an unnecessary administrative burden without any benefit to the patient.

Amendment put and negatived.

Clause put and passed.

Clauses 146 and 147 put and passed.

Clause 148: Making transport order —

Dr A.D. BUTI: I move —

> Page 111, after line 29 — To insert —
>
> (ba) give a copy to the Chief Psychiatrist and the Chief Mental Health Advocate; and

We should understand that transport orders are quite significant events because they involve moving people from one place to another, and that amounts to detention. While patients are being transported, particularly if they are involuntary, and more often than not they will be, that amounts to detention.

The powers of detention or transportation being exercised are quite significant to curtailing the freedoms and rights of patients. As we know, clause 10 outlines the objects of the Mental Health Bill and the minister has categorically stated that under the bill the patient's rights and freedoms are very important and the bill should impose the least amount of invasion of or infringement on those rights and freedoms. Of course, a transport order is an infringement of a patient's rights and freedom of movement, for instance. This amendment seeks to mandate that a copy of the transport order be given to the Chief Psychiatrist and the Chief Mental Health Advocate. I expect the parliamentary secretary will say that she has discussed this with the Chief Psychiatrist and

that, as applies to clause 145, he or she does not want to be burdened with this additional administrative exercise. He or she may not want that, but so be it. We are looking at what is best to protect the rights of the patient while still allowing the objects and the various other aims of this bill to be accomplished.

This bill will not be hindered by a requirement that a copy of the transport order be given to the Chief Psychiatrist—far from it. The transport will take place and a piece of paper—a copy; it could be an electronic copy—will be sent to the Chief Psychiatrist. More importantly, the Chief Mental Health Advocate should be provided with a copy of the transport order because, as I stated, the transportation is exercised by a medical practitioner or an authorised medical practitioner, and many authorised medical health practitioners will have very limited psychiatric training. Of course, we would expect a psychiatrist to have reasonable psychiatric training, but a medical practitioner, and more importantly an authorised medical health practitioner, who could be an occupational therapist or social worker, may have very limited psychiatric training, and they may have the power to exercise transportation, which is a major infringement on the rights of the patient. Therefore, a copy of that transport order should be sent to not only the Chief Psychiatrist, but also the Chief Mental Health Advocate. I do not see how that requirement is an onerous burden on the smooth operation of this bill.

Ms A.R. MITCHELL: The rationale for my comments is very similar to what I said previously. The Chief Psychiatrist can access information about transport orders if required. It is my understanding that there could easily be more than a thousand a year, so there would be a significant administrative component to this. Neither the Chief Psychiatrist nor the Chief Mental Health Advocate would gain anything from knowing about a transport order. They will find out at a later date, but at that point in time it is a transport order and nothing further than that. They do not feel it is necessary.

Dr A.D. Buti: Have you asked the Chief Mental Health Advocate?

Ms A.R. MITCHELL: No, we have not because that position is not in place, but certainly the Chief Psychiatrist and the Chief Mental Health Advocate will have access to the medical records of referred persons who request advocacy and those people would get that if they became involuntary patients. We understand what the member is saying, but we believe we have covered his concerns.

Dr A.D. BUTI: I am glad the parliamentary secretary understands what I am saying, but I do not think she recognises how seriously we have considered this amendment. It is very well to say that the Chief Mental Health Advocate can obtain a copy of the transport later on, but it might be too late. We should be trying to ensure that infringements on people's freedoms and rights are minimised. If they are infringed upon, that infringement should be kept to a minimum and any improper infringement corrected as soon as possible. We do not agree that this is not an important amendment or issue.

Ms A.R. MITCHELL: I have received an update that the Chief Mental Health Advocate has not been appointed as such, but the current head of the Council of Official Visitors, who is most likely to become the Chief Mental Health Advocate, has not recommended a change to this provision and is happy with it as it is in the bill.

Dr A.D. BUTI: That person may not have recommended a change, but that does not mean they would not be happy with the provision proposed by this amendment. Once again, the Chief Mental Health Advocate's role is to advocate strongly for the patients whom they have jurisdiction over. This is an important piece of information. Transport orders should not be made willy-nilly and hopefully they will not be made willy-nilly. They are important and when they are made, the Chief Mental Health Advocate should be notified as soon as possible in a contemporaneous manner.

Ms A.R. MITCHELL: That advocacy is recognised and it will come into play as soon as a person is detained or becomes an involuntary patient, but not when there just is a transport order.

Dr A.D. BUTI: As we know, there have been some unfortunate scenarios of detained people in Western Australia. The actual transportation is incredibly important and probably more so in remote areas. That is why the Chief Mental Health Advocate should receive knowledge of it as soon as possible.

Ms A.R. MITCHELL: There are safeguards in place because they need to be. Patients can contact their families or the Chief Mental Health Advocate; it is not as though they cannot do that. We believe we have put safeguards in place to make sure that transport is a safe experience for those people.

Dr A.D. BUTI: As the parliamentary secretary says, there are "cans", but we want to move above "cans" to make the obligation mandated. That is why we have moved this amendment.

Division

Amendment put and a division taken, the Acting Speaker (Ms L.L. Baker) casting her vote with the ayes, with the following result —

Ayes (16)

Ms L.L. Baker	Mr W.J. Johnston	Mr M.P. Murray	Ms R. Saffioti
Dr A.D. Buti	Mr F.M. Logan	Mr P. Papalia	Mr C.J. Tallentire
Ms J. Farrer	Mr M. McGowan	Mr J.R. Quigley	Mr P.B. Watson
Ms J.M. Freeman	Ms S.F. McGurk	Mrs M.H. Roberts	Mr D.A. Templeman *(Teller)*

Noes (31)

Mr P. Abetz	Ms M.J. Davies	Mr C.D. Hatton	Dr M.D. Nahan
Mr F.A. Alban	Mr J.H.D. Day	Mr A.P. Jacob	Mr D.C. Nalder
Mr C.J. Barnett	Ms E. Evangel	Dr G.G. Jacobs	Mr J. Norberger
Mr I.C. Blayney	Mr J.M. Francis	Mr S.K. L'Estrange	Mr D.T. Redman
Mr I.M. Britza	Mrs G.J. Godfrey	Mr J.E. McGrath	Mr A.J. Simpson
Mr G.M. Castrilli	Mr B.J. Grylls	Mr P.T. Miles	Mr T.K. Waldron
Mr V.A. Catania	Dr K.D. Hames	Ms A.R. Mitchell	Mr A. Krsticevic *(Teller)*
Mr M.J. Cowper	Mrs L.M. Harvey	Mr N.W. Morton	

Pairs

Ms M.M. Quirk	Ms W.M. Duncan
Mr R.H. Cook	Mr T.R. Buswell
Mr D.J. Kelly	Mr R.S. Love
Mr B.S. Wyatt	Mr W.R. Marmion

Amendment thus negatived.

Clause put and passed.

Clauses 149 to 153 put and passed.

Clause 154: Revocation of transport order if no longer needed —

Dr A.D. BUTI: I move —

Page 115, after line 22 — To insert —

(ba) give a copy to the Chief Mental Health Advocate; and

My reason for moving this amendment is the same as the reason I gave for moving the previous amendment. Granted, this amendment is not as important as the previous amendment because this clause deals with, hopefully, the end of the detention or transportation of a patient. I believe that the Chief Mental Health Advocate needs to be informed of all parts of the mental health system and its interaction with patients.

Ms A.R. MITCHELL: We will not be supporting this amendment based on the same rationale that we used previously.

Amendment thus negatived.

Clause put and passed.

Clause 155: Return of person if transport order expires or is revoked —

Ms A.R. MITCHELL: I move —

Page 115, line 27 — To delete "under section 154(1)," and substitute —

because of section 153,

This amendment is as a result of a drafting error.

Amendment put and passed.

Clause, as amended, put and passed.

New clause 155A: —

Dr A.D. BUTI: I move —

Page 116, after line 9 — To insert —

155A. Person not to be detained for more than 96 hours

Notwithstanding anything in this Act to the contrary, the sum of:

(a) the periods a person is detained pursuant to all orders made under section 28; and

(b) the periods a person is detained pursuant to all transport orders made under this Act (including any extensions thereto),

must not exceed 96 hours.

With this amendment I seek to restrict the time that someone is detained as a result of transportation et cetera. Ninety-six hours amounts to four days, which is quite a length of time. The object of the act, as stated in clause 10, is to try to reduce the restrictions on a patient to ensure the restrictions are kept to a minimum. Surely, four days, or 96 hours, is a sufficient time for transportation orders. This clause deals with the transportation of the patient, and, in many respects, the rights of mentally ill patients are less than those of someone who may have committed a criminal offence. It is imperative that we do our best to reduce the time that mentally ill patients are detained, and that is the reason that I am moving this amendment to insert a new clause into the bill.

Ms A.R. MITCHELL: We believe that this amendment is more than covered by clause 28, which makes the maximum in the non-metropolitan area 144 hours. Yes, we all agree that this should be done as soon as possible, but in some cases, because of the size of the state and the way it is set out, that is not always possible. That is not necessarily the fault of those involved in the mental health area. I am not saying that we should start blaming other people, but sometimes it is not easy arranging transport. It can take a while and it could be that transport is arranged, but then that changes. We believe that the member for Armadale's amendment is not necessary and that we have those matters covered in other areas of the bill.

Dr A.D. BUTI: The parliamentary secretary is correct in saying that sometimes the best laid plans go astray. But a legislative regime must be in place and certain restrictions must be imposed. Perhaps the government could insert a provision in another clause that refers to necessary extensions et cetera, although under my amendment it would remain at 96 hours. I cannot see why in most cases, if not all cases, one would need to detain a person for more than 96 hours. The safety of the patient and the community is, of course, of paramount importance, but detaining a person for more than 96 hours may do harm to that person's mental health. We are trying to keep such harm to a minimum and by mandating it in legislation, there is greater motivation for those who are dealing with a mentally ill person to ensure that any detention is kept to a minimum.

Ms A.R. MITCHELL: We have no problem with a person in the metropolitan area being detained for 72 hours. We believe that to make this work for people in regional and remote Western Australia, the time that a person can be detained could be more than 96 hours. Most people will be assessed as quickly as possible, but we need to make sure that we look after every person who needs assistance and assessment, and we believe that 144 hours is appropriate in this case.

New clause put and negatived.

Clause 156: Apprehension by police officer of person suspected of having mental illness —

Dr A.D. BUTI: I move —

Page 117, after line 24 — To insert —

(ba) must, as soon as practicable after apprehending a person under subsection (1), notify the Chief Mental Health Advocate of such action; and

Clause 156 deals with police powers and people who have not committed a criminal offence. This is an important issue. We will be allowing the police to be involved in a situation in which someone has not committed an offence but is interacting with the police because of a mental illness. Let us be clear that we are dealing with people who, if not for their mental illness, would not be interacting with the police. If people interact with the police because of an alleged crime, the criminal justice system and all the rights that are conferred on a suspect in the criminal justice system come into play. Why should people have fewer rights or not have their rights guaranteed when their interaction with the police does not result from allegedly committing a crime, but because of mental illness? We recognise that the police unfortunately have to become involved. By way of background information, when the Mental Health Bill 1996 was being debated, I was working at the Aboriginal Legal Service of Western Australia. There were serious concerns among many Aboriginal people that the Mental Health Bill would be used unfairly against them and that they would be earmarked and discriminated against on the streets of Perth and in metropolitan and remote areas. Unfortunately, as members know,

Aboriginal people disproportionately interact with the criminal system. There is no doubt that the Indigenous population and their contact with WA Police is completely disproportional. By that, I refer to alleged crime or antisocial behaviour of a criminal nature, which is one thing, but many Aboriginal people are homeless, and being homeless creates uncertainty in any person's life and can lead to other problems of an abusive nature. I assure members that when I was at the Aboriginal Legal Service and the Mental Health Bill 1996 was being debated, there was genuine fear among many Aboriginal people that it would give police additional avenues to pick them up. I know that the Minister for Mental Health does not want that to happen; I understand that. But, unfortunately, if history is any judge, it may happen, and there is reasonable probability that it will happen.

Mr P.B. WATSON: I would like to hear more information from the member for Armadale.

Dr A.D. BUTI: If that was a fear among Indigenous people, it will be a fear also among people who have a mental illness whether or not they are Indigenous. I understand that it may be necessary for the police to interact with people who have a mental illness and apprehend them but there must be as many safeguards as possible. They do not have the same safeguards that are provided in the criminal justice system. All the opposition seeks is a reasonable and minimal amendment that, as soon as is practicable after apprehending a person under subsection (1), the Chief Mental Health Advocate be notified of such action. Surely if the Chief Mental Health Advocate is to do his job properly and represent the interests of the mentally ill, there is no reason why he should not be notified when a police officer has apprehended a person who has a mental illness.

Ms A.R. MITCHELL: The word used in the bill is "suspect"—it goes no further than that. Therefore, at this point of police involvement—I think I mentioned this in my second reading speech—and the role of the police if they suspect a person has a mental illness is that of welfare; indeed, that is part of their training and they recognise that such situations have to be treated differently. They may become involved with someone who they suspect of having a mental illness, but that person could be rather drunk or under the influence of drugs. The police do not examine such people for mental illness. The person may not be examined and may not have a mental illness, but to start giving them a mental illness pathway with information going to other agencies is actually a breach of privacy and not something we support. The rationale is that at that stage they would not have been examined to determine whether they have a mental illness; therefore, there is no reason for the Chief Mental Health Advocate to become involved. Also, it would be a significant administrative duty for police, who were very much involved in the drafting of the provisions of this bill that relate to them, and they have indicated that they do not support such an amendment.

Sitting suspended from 6.00 to 7.00 pm

Dr A.D. BUTI: The advisers do not have the stamina of the parliamentary secretary—they are working on a rotational basis down in the pit!

I am talking to the amendment in my name to clause 156, which I moved before the dinner break. I stated that it was important to have mandatory reporting of these matters to the Chief Mental Health Advocate, but the parliamentary secretary said that we are looking only at situations in which there is a reasonable suspicion that a person may have a mental illness. That may be the case and they may be found to not have a mental illness, but the point is that they have been apprehended by the police. I assume that the threshold regarding "reasonably suspects" is not low but is reasonably high; otherwise, the matters I mentioned before the break, particularly with regard to Indigenous people, would become even more relevant. When I was working for the Aboriginal Legal Service of Western Australia in the mid-1990s, many Indigenous people were concerned about how the previous act might affect them. If we are to set a low threshold for "reasonably suspect", that will be a real worry. Let us work on the basis that there is a reasonable suspicion about the characteristics or behaviour of the person and that they may have a mental illness. The parliamentary secretary stated that the police are trained in these matters. I would hazard a guess that they are trained in these matters at a very low level. There is a lot to get through at the police academy. I brought a matter before this house during the last Parliament about two friends of mine who were apprehended and tasered in Fremantle. They had been minding their own business, basically. The matter was thrown out of court and the magistrate strongly criticised the actions of the police. Although I have great regard for the police as a totality and there are some very good police people in my neighbourhood, I do not think that they would be considered to be experts in mental health or in recognising the signs of mental health. All we want with this amendment is to provide a safeguard to the extent that the Chief Mental Health Advocate is notified of a person's apprehension as soon as practicable. The amendment uses the words "as soon as practicable". Sometimes it may not be possible to do it immediately, but the Chief Mental Health Advocate should be informed as soon as practicable after a person is apprehended under clause 156(1) because there is a reasonable suspicion of mental illness. We consider that to be consistent with the objects of this bill and we can see no reason for it to not be agreed to.

Ms A.R. MITCHELL: I say again that at that point of suspicion, the person has not been placed on referral and has not been made an involuntary patient; therefore, there is actually nothing that the Chief Mental Health Advocate can do. The information is not relevant at that point in time because the person has not been examined. We are not experts in mental health but I think we all recognise that it is actually quite difficult to determine whether a person has a mental illness or is intoxicated with alcohol or drugs, so a good examination has to be done at an appropriate time. That will always be as soon as possible.

Dr A.D. BUTI: They may not have been referred, but they are being apprehended. There is no reason that the Chief Mental Health Advocate should not be notified of that. The parliamentary secretary said that there is nothing that the Chief Mental Health Advocate could do, but what they could do is to prepare for a situation when that apprehension leads to detention or a transport order. There does not seem to be any ideological barrier to the government agreeing to such an amendment, if one takes into account the objects of this legislation.

Dr G.G. JACOBS: Maybe I can help the member for Armadale. I suppose one of his major concerns is that somehow an injustice may be done to somebody because they are wrongfully arrested or whatever. What would be the greatest measure in this clause to prevent someone from being wrongfully arrested under this legislation?

Ms A.R. MITCHELL: I put on record that the person is not being arrested; the person is being apprehended because someone suspects that there is the potential for them to have a mental illness condition. That is all. The police officer can then transfer that person for referral and examination.

Dr G.G. JACOBS: In my experience, the police are excellent in this regard. They never apprehend somebody without following it up. They do that by arranging an assessment by a medical practitioner of the person who was apprehended. It is not about apprehending them, arresting them, throwing them in a cell and saying that that is it. I find that police today are very conscious of the need to follow up a person who has been apprehended and to not act precipitously or unilaterally. The guys and girls in the police force who service my town show an enormous amount of patience and professionalism in actually following up people who are apprehended—not arrested, as the parliamentary secretary pointed out—and getting that opinion.

In the cut and thrust on the street, if there is some disturbance, a police officer may apprehend a person if that officer suspects a mental illness, or because of the mental illness the person needs to be apprehended for their own safety and to prevent that person causing or continuing to cause serious damage to property. That is perfectly reasonable. I am sure the parliamentary secretary agrees that there are enough safeguards in the bill, but I have to say that with that scenario in operation, what the heck about notifying the Chief Mental Health Advocate. That is after the fact. It has happened, okay; one could notify the Chief Mental Health Advocate. Member for Armadale, the Chief Mental Health Advocate needs to know because there could be a serious injustice here or a serious injustice could be perpetrated by the police in apprehending someone who should not have been apprehended. The police in my area—I am sure it is pretty widespread—will not apprehend or arrest and detain somebody unless the police have actually complied with the law. They are very cognisant of that; they recognise that there are issues with arresting people or detaining people and the consequences that can sometimes have. The police are very conscious of that today.

Division

Amendment put and a division taken, the Acting Speaker (Mr P. Abetz) casting his vote with the noes, with the following result —

Ayes (13)

Dr A.D. Buti	Mr F.M. Logan	Mr P. Papalia	Mr D.A. Templeman *(Teller)*
Ms J. Farrer	Mr M. McGowan	Mr C.J. Tallentire	
Ms J.M. Freeman	Ms S.F. McGurk	Mr P.C. Tinley	
Mr W.J. Johnston	Mr M.P. Murray	Mr P.B. Watson	

Noes (28)

Mr P. Abetz	Mr M.J. Cowper	Mr C.D. Hatton	Dr M.D. Nahan
Mr F.A. Alban	Ms M.J. Davies	Mr A.P. Jacob	Mr D.C. Nalder
Mr C.J. Barnett	Mr J.H.D. Day	Dr G.G. Jacobs	Mr J. Norberger
Mr I.C. Blayney	Mr J.M. Francis	Mr S.K. L'Estrange	Mr D.T. Redman
Mr I.M. Britza	Mrs G.J. Godfrey	Mr P.T. Miles	Mr A.J. Simpson
Mr G.M. Castrilli	Mr B.J. Grylls	Ms A.R. Mitchell	Mr T.K. Waldron
Mr V.A. Catania	Mrs L.M. Harvey	Mr N.W. Morton	Mr A. Krsticevic *(Teller)*

Pairs

Mr R.H. Cook	Ms W.M. Duncan
Ms M.M. Quirk	Mr R.S. Love
Mr D.J. Kelly	Mr T.R. Buswell
Mr B.S. Wyatt	Mr W.R. Marmion
Mr J.R. Quigley	Mr R.F. Johnson
Mrs M.H. Roberts	Mr M.H. Taylor
Ms R. Saffioti	Mr J.E. McGrath

Amendment thus negatived.

Clause put and passed.

Clauses 157 to 161 put and passed.

Clause 162: Search of person while detained or admitted —

Dr A.D. BUTI: I feel like a broken record, but I am basically going to repeat what I stated in the debate on clause 156. The member for Eyre commented, "So what if the Chief Mental Health Advocate is told or not." Actually, it does matter. We have people who we at least think are mentally ill; otherwise, they would not be apprehended by the police. Under clause 162, we are looking at the search of a person while detained or admitted. Clause 162 states —

> (1) This section applies —
>
> (a) to any of these people —
>
> (i) a patient who is admitted by a mental health service;
>
> (ii) a person who is detained under this Act at a mental health service or other place to enable an examination to be conducted by a psychiatrist;
>
> (iii) any other person who presents at a mental health service for treatment;

Subclause (2) states —

> A police officer or authorised person who reasonably suspects that there is on or with the patient or other person any article listed in section 164(2) may —
>
> (a) search, in accordance with sections 163 and 172, the person and any article found on or with the patient or other person; and
>
> (b) seize, in accordance with sections 164 and 172, any article listed in section 164(2) that is found on or with the patient or other person.

They are pretty powerful provisions, I would have thought. We are dealing with the Liberal Party, the members of which keep talking about the virtues of liberty and freedom and keeping the evil government's hands away. We have an instrument of the state, which is the police. We have a situation with search and seizure powers. They are incredibly important powers. Under the United States Constitution, these powers have to be exercised in a manner in which there are certain constitutional protections; they are not just willy-nilly powers. However, we are saying that a mentally ill patient may be subjected to a police search of the person for any article that may be found on or with the patient, but there will not be any protections afforded to a person under the criminal justice system. That is quite absurd. If someone has allegedly committed a crime, he or she has certain protections under the criminal justice system, but if someone is a mentally ill person, he or she does not have those protections. All we are asking for is that there be notification to the Chief Mental Health Advocate. I move —

Page 121, after line 19 — To insert —

(3) A police officer or authorised person who searches a person under subsection (2)(a), or seizes any article under subsection (2)(b), must, as soon as practicable after such search or seizure, notify the Chief Mental Health Advocate of such action.

I challenge the parliamentary secretary or the member for Eyre to say, "So what! What difference would it make if you notify the Chief Mental Health Advocate?" Someone should be notified.

Several members interjected.

Dr A.D. BUTI: Maybe the Chief Psychiatrist would be! But when I tried that angle—the member for Eyre was not here before dinner—I was knocked back because the standard response from the parliamentary secretary was, "We have spoken to the Chief Psychiatrist and he does not want to be burdened with this additional administration. Let us leave the Chief Psychiatrist out of it; the Chief Mental Health Advocate is there to advocate for people who have a mental illness."

I still do not get the obstacle or opposition to the Chief Mental Health Advocate being notified. I do not think there is any real objection, but, as usual, governments never like to take amendments from the opposition. That is what it has come down to. Governments do not want to take amendments from the opposition, even the numerous amendments put by the parliamentary secretary in regard to wording that I used about treating psychiatrists or current psychiatrists. What does the government do? It will not agree to my amendments. It has to put "the person's psychiatrist", in short, just to be slightly different.

Ms A.R. MITCHELL: I want to assure the member for Armadale that we have examined all his amendments in great detail. I think he will find that we have certainly given it great consideration, as we will continue to do throughout consideration of the rest of this bill. However, I refer the member to clause 165, which outlines a very prescriptive procedure for recording search and seizure processes that might occur under clause 162. The procedure is quite detailed in clause 165. Under that clause, the Chief Mental Health Advocate has access to medical records, which would contain any details of the search at that stage. It would automatically be there, or if they make a request of the advocate, it would be there as well. If the person becomes an involuntary patient, the mental health advocate has the information anyway. Once again, I know the member for Armadale thinks we are just trying to prevent this occurring, but at this stage all we would be doing is duplicating and creating more administrative work rather than benefitting the patient.

Dr A.D. BUTI: Which clause did the parliamentary secretary refer to?

Ms A.R. Mitchell: It was clause 165.

Dr A.D. BUTI: Yes, it was clause 165, "Record of search and seizure". The parliamentary secretary said that that is available to the mental health advocate, but what would trigger in the mind of the mental health advocate to go searching if he or she does not know? We ask that upon the apprehension, and in this case, upon the search being conducted, the mental health advocate be notified immediately or as soon as is practicably possible; otherwise, the advocate would not undertake a search to find out something they do not know about. In that case, by the time they found out, it would probably be long past when the search happened. I can assure the parliamentary secretary that people who should not have been subjected to such searches are subjected to searches of the person, and that these are conducted in a demeaning way. That has happened in our history of policing in Western Australia—not that it happens on a daily basis, but it does happen.

We are talking about mentally ill people—the most vulnerable of our society. To say that the search is recorded under clause 165 does nothing to protect the rights of the mentally ill because that is post facto. Reporting to the Chief Mental Health Advocate is also post facto, but, hopefully, it would not be as long in duration post facto as would be the case as outlined in clause 165. Nothing in clause 165 will trigger the mental health advocate to know. They would have to go searching on a daily basis to find what recording had taken place. The opposition amendment offers an alternative rather than the Chief Mental Health Advocate having to find out for himself or herself. The parliamentary secretary talked about the onerous demands on the Chief Psychiatrist. It would be a very onerous demand if the Chief Mental Health Advocate has to search to find out who has been subjected to a police search, including a body search or seizure of property or article that has been on the person who is mentally ill; therefore, do not make that demand! But of course the parliamentary secretary will not agree to it. I think it is contrary to the object of this bill that she will not agree to something that is incredibly reasonable.

Ms A.R. MITCHELL: Any detained person can make contact with the advocate at any time; they have that right. Safeguards are in place. If I could also —

Dr A.D. Buti interjected.

Ms A.R. MITCHELL: It is clause 163 as well. It outlines that the searches are quite different from what a normal police search may entail. I think that we are being very sympathetic to people in this situation. I think that we have covered it.

Division

Amendment put and a division taken, the Acting Speaker (Mr P. Abetz) casting his vote with the noes, with the following result —

Ayes (15)

Ms L.L. Baker	Mr W.J. Johnston	Mr M.P. Murray	Mr P.C. Tinley
Dr A.D. Buti	Mr F.M. Logan	Mr P. Papalia	Mr P.B. Watson
Ms J. Farrer	Mr M. McGowan	Ms R. Saffioti	Mr D.A. Templeman *(Teller)*
Ms J.M. Freeman	Ms S.F. McGurk	Mr C.J. Tallentire	

Noes (29)

Mr P. Abetz	Mr J.H.D. Day	Dr G.G. Jacobs	Mr J. Norberger
Mr C.J. Barnett	Ms E. Evangel	Mr S.K. L'Estrange	Mr D.T. Redman
Mr I.C. Blayney	Mr J.M. Francis	Mr J.E. McGrath	Mr A.J. Simpson
Mr I.M. Britza	Mrs G.J. Godfrey	Mr P.T. Miles	Mr T.K. Waldron
Mr G.M. Castrilli	Mr B.J. Grylls	Ms A.R. Mitchell	Mr A. Krsticevic *(Teller)*
Mr V.A. Catania	Mrs L.M. Harvey	Mr N.W. Morton	
Mr M.J. Cowper	Mr C.D. Hatton	Dr M.D. Nahan	
Ms M.J. Davies	Mr A.P. Jacob	Mr D.C. Nalder	

Pairs

Mr R.H. Cook	Mr T.R. Buswell
Ms M.M. Quirk	Ms W.M. Duncan
Mr D.J. Kelly	Mr R.S. Love
Mr B.S. Wyatt	Mr W.R. Marmion
Mr J.R. Quigley	Mr R.F. Johnson
Mrs M.H. Roberts	Mr M.H. Taylor

Amendment thus negatived.

Clause put and passed.

Clauses 163 to 174 put and passed.

Clause 175: Informed consent necessary —

Dr A.D. BUTI: Clause 175, in part 13, "Provision of treatment generally", provides for circumstances in which informed consent is necessary. It states —

> (1) A voluntary patient cannot be provided with treatment without informed consent being given to the provision of the treatment.
>
> (2) Subsection (1) does not apply in relation to any of these treatments because this Act makes specific provision in respect of each of them —
>
> (a) electroconvulsive therapy;
>
> (b) emergency psychiatric treatment;
>
> (c) psychosurgery;
>
> (d) treatment that is prohibited by section 210(1).

What do we mean by "informed consent"? We mean that the patient has received knowledge of every factor that goes into the type of treatment they will receive and the possible benefits or negative side effects. It also means that the patient has received information about the person who has recommended and will perform the treatment. It is a shame that the Minister for Planning is not here, as he is a former dentist. When I made my contribution at the second reading stage, I talked about informed consent and he understood exactly what I meant because he was in the health profession. Last week during the consideration in detail stage, we had a discussion about the lack of obligation for financial disclosure on the part of the treating psychiatrist, and the patient cannot give informed consent for that under this bill. The legal definition of "informed consent" is that the person who is giving the consent has knowledge of all factors that would have a bearing on whether they would agree or not agree to the treatment. That is the legal definition. The patient must have knowledge of all the factors that go into the treatment and the reason that the treating psychiatrist has recommended that treatment. I find it quite amazing

that because we do not have a financial disclosure provision in this bill—the parliamentary secretary did not agree to it—the so-called informed consent under clause 175 is not true informed consent. Shortly, the parliamentary secretary will stand up and give me some rationale, but I can tell her that it is not informed consent in the legal sense.

Ms A.R. MITCHELL: My understanding is that, in medical terms, the standards for informed consent do not mean that the person has knowledge of all factors; it is what the reasonable patient expects from the reasonable practitioner. There appears to be a differentiation between the member for Armadale's legal understanding of informed consent and the medical standard, which is what this bill is based on.

Dr A.D. BUTI: They may not necessarily have knowledge of all factors, but they must have knowledge of the critical factors. I am not sure how that medical definition would exclude the patient from having knowledge of any financial linkage between the treatment being offered and the person conducting the treatment. That is not just any knowledge; that is quite important knowledge. It is like a real estate agent selling a home and not telling the prospective purchaser of that home that they have a financial interest in that home besides the fees—we are not talking about fees; we went through that last week. I am not a betting man, but I bet my house on the fact that if a real estate agent sold a house and did not disclose to the prospective buyer that they had a financial interest in the home over and above the fees that they would receive for selling the house, that would breach the code of conduct and the legal requirements for a real estate agent. If treatment is to be done on a mentally ill patient for their mental state, is financial disclosure not relevant to informed consent? I find that a strange and illogical way of thinking.

Ms A.R. MITCHELL: I refer the member to clause 19(2), which is probably the clearest explanation that we can give and which we have covered already.

Dr A.D. BUTI: The parliamentary secretary has referred me to clause 19(2), which states —

> (2) The extent of the information required under subsection (1) to be provided to a person is limited to information ...

That might be the case, but it does not get away from the fact that we do not have informed consent. That is the point. Of course, we can enact legislation to remove informed consent; we know that Parliament can do that, but that is not right. The parliamentary secretary is saying that we need informed consent in many financial arrangements but we do not need informed consent when treating a patient. I just do not understand that logic.

Ms A.R. MITCHELL: I go back even further than clause 19. From clause 16 on, division 2 is all about informed consent to treatment. As I said, I believe we have covered this.

Dr A.D. BUTI: We are going on a fishing expedition until the parliamentary secretary can refer me to a section of the bill that justifies "informed consent". Clause 16 states —

> (1) A person gives informed consent to the provision of treatment to a patient (whether he or she or another person is the patient) only if —
>
> (a) the requirements of this Division ...
>
> (b) the consent is given freely and voluntarily.

That is the point. The parliamentary secretary might say that that section counteracts my argument. Actually, it does not. Legally, consent is not given freely and voluntarily if one does not have all the facts before them. Consent can be given freely and voluntarily but it cannot be given with the whole matrix of information that is required. Maybe it is in the list of definitions. We have gone back to clause 16; maybe it is in another clause. It still does not remove the fact that the government is allowing the possibility of a treating practitioner giving treatment to a patient for which they will obtain a financial benefit over and above the fees that they normally obtain. We do not allow that to happen in nearly all forms of commerce in Western Australia and Australia generally. Informed consent is considered to be given when disclosure of financial profit is not communicated to the patient.

Can the parliamentary secretary tell me why she would not want a patient to know that the treating practitioner has a financial relationship with the treatment or the service where they are giving the treatment? Why would she not want the patient to have that knowledge?

Ms A.R. MITCHELL: The member tends to go into disclosure and relate that to treatment but this clause is about treatment. Clause 19(2) —

Dr A.D. Buti: We have another clause now.

Ms A.R. MITCHELL: No; it is still within division 2, "Informed consent to treatment". In the medical field, clause 19(2) is the standard in Australia for informed consent for treatment.

Dr A.D. BUTI: Is the parliamentary secretary very confident in saying that if the media found out that a group of doctors engaged in prescribing certain forms of medication owned the pharmaceutical company and they did not disclose that to the patient, there would not be an uproar and that would be considered to be standard practice in the medical profession? There is enough disquiet with respect to how doctors provide certain medication and the fact that pharmaceutical companies pay for them to go to conferences. Does the parliamentary secretary not think the health minister would be a bit alarmed that a group of doctors might be prescribing medication that is made by a company that they solely own? Would that be okay? If that is okay, why do politicians have to declare conflicts of interest? When local councillors go to their regular local council, why do they have to disclose any perceived interest but a psychiatrist does not have to disclose if they will obtain a financial benefit for the treatment that they are recommending?

Ms A.R. MITCHELL: I believe that we have covered this under "disclosure of financial interests". We said that the Medical Board of Australia has a very strong code of conduct for doctors in Australia. Should anyone ever be in that position that the member is suggesting, I am sure they would be reported to the board and there would be very severe consequences for that person. I believe we have changed that.

Dr A.D. BUTI: In other words, that is the case now that the parliamentary secretary has changed her argument. Is she saying that doctors have an obligation under their code to disclose financial interests?

Ms A.R. Mitchell: We have always said that.

Dr A.D. BUTI: I do not think she said that last week. We can go back to the *Hansard* and check. It is important under the code that they disclose interest, but the parliamentary secretary does not see it as important enough to have it in the bill. The financial disclosure obligation was included in the 2011 draft bill. For some reason, it has been taken out. The parliamentary secretary is saying that financial disclosure is important. The first time she has said it is in this exchange tonight. Until now, she said that it was not important because she did not think it is part of the medical definition. Now she is at least acknowledging that financial disclosure is an important issue, but it is not important enough to put in the Mental Health Bill that contains over 500 clauses. I find that a strange way of drafting legislation.

Ms A.R. MITCHELL: I will respond, but we have covered this previously. I will not go on but it was taken out of the previous draft by the AMA, which said it was not required to be in the Mental Health Bill as it was covered under its code of conduct.

Dr A.D. BUTI: Can we get this on the record? Is the parliamentary secretary saying that it was removed from the 2011 draft bill on the recommendation of the AMA?

Ms A.R. Mitchell: Yes.

Dr A.D. BUTI: I will seek confirmation of that at a later date.

Dr G.G. JACOBS: I just wanted to make a comment. Would it not be true, parliamentary secretary, that in this whole issue of informed consent, the patient is central to it? This is what we are talking about when we talk about informed consent. The member for Armadale described those issues of doctor misconduct and kickbacks to doctors. I did not take terrible umbrage to it but maybe I should have. They will be dealt with by the code of ethics, code of practice and standards of practice by colleges of psychiatry and the medical board. I suspect that the reason the parliamentary secretary was suggesting that perhaps there was some involvement by the AMA to remove financial disclosure from the draft bill relates to the fact that this is a patient-centred bill. It is about informed consent of the patient. That informed consent is patient-centred. I think we should leave it at that. It should be patient-centred. I believe other measures and other jurisdictions will deal with the issue that has been suggested.

Dr A.D. BUTI: I did not suggest that the AMA asked for it to be removed; the parliamentary secretary said that the AMA asked for it to be removed from the 2011 bill. The member said that this bill should be patient-centric. That is exactly right; I totally agree with him. To say that it will be dealt with later is too late. What is the use of some ex post facto determination of whether everything was disclosed? That should be disclosed upfront. As the member for Eyre rightly said, this bill should deal with the patient first and foremost. That is why the patient should have all relevant information before them if they are going to satisfy that they had informed consent. One cannot consent to something if they do not know about it. Disclosure of financial advantage is a significant issue that the patient should be aware of before they tick the appropriate box to say they agree to the treatment.

Clause put and passed.

Clauses 176 to 178 put and passed.

Clause 179: Patient's psychiatrist must ensure regard had to patient's wishes —

Dr A.D. BUTI: If the patient's psychiatrist is required to ensure that regard is had to the patient's wishes, I would have thought that the patient should also be given all information with regard to—I am not going to say financial information this time, member for Eyre—the side effects and risk factors associated with that treatment and/or any other treatment options that are available. The patient's wishes may be directed by what the patient knows of that treatment and any possible side effects, and the other treatment options that are available. Most doctors provide that advice in the course of normal professional conduct. Most doctors tell patients about the possible side effects, and the alternatives. I do not understand why there is a problem with putting that in the legislation. That would provide a legislative regime that will give it greater weight and provide a greater safeguard for the patient.

Ms A.R. MITCHELL: I believe that clause 180 covers the member's concerns.

Dr A.D. Buti: That is fantastic.

Clause put and passed.

Clauses 180 and 181 put and passed.

Clause 182: Further opinion may be requested —

Dr A.D. BUTI: Subclause (1) provides in part —

> This section applies in relation to any of these people —
>
> (a) the patient, whether or not the patient has the capacity to give informed consent to the treatment being provided …

I repeat my argument that regardless of whether the patient has the capacity to give informed consent, the patient cannot give informed consent if they have not been given information about any financial advantage or financial interests that the treating physician may have with regard to any treatment. However, I will move on from that.

Subclause (5) states —

> In obtaining the further opinion, the patient's psychiatrist or the Chief Psychiatrist must have regard to the guidelines published under section 543(1)(c) about the independence of psychiatrists from whom further opinions are obtained.

I assume that the purpose of this subclause is to ensure that any persons from whom further opinions are obtained are independent and not influenced by the patient's psychiatrist or the Chief Psychiatrist. I understand the need for that provision. However, as we know, that may be very difficult to achieve. But we can only do what we can do. At least the government has put it in the legislation, and that is commendable. But, to make the point again, how can a person be independent if they have a financial interest? I wonder also why financial disclosure was taken out of the 2011 bill. It must at some stage have been considered appropriate, because it was in the draft bill. The parliamentary secretary told me that it was taken out because the AMA advised that that should be the case. It would be interesting to follow that up. However, it seems inconsistent with this provision, which refers to the independence of the psychiatrist. The person from whom a further opinion is being obtained might be independent of the treating psychiatrist, but they are not independent if they have a financial interest in the treatment being advised. I believe this legislation has a major flaw, because it does not require financial disclosure.

Subclause (8) states —

> The patient's psychiatrist must, as soon as practicable after obtaining the further opinion —
>
> (a) file the opinion and give a copy to the patient; and
>
> (b) if the opinion was requested by a person other than the patient — give a copy to that other person.

I seek clarification of who "other person" may be. That may be dealt with somewhere else in the bill. Who can be the other person?

Ms A.R. MITCHELL: Other person may be a relative, a person who is classed as a nominated person, a carer or a guardian. There are a number of people who would fit under that definition.

Dr A.D. BUTI: That may be the case. But there is no definition in the bill of "other person". What is the limitation of who the other person may be? Normally it would be a relative. But there is no guiding principle or

list as to who the other person may be; or there may be, but the parliamentary secretary has not been able to refer me to it.

Ms A.R. MITCHELL: It is clause 182(1), paragraphs (a) to (e).

Dr A.D. Buti: Thank you.

Clause put and passed.

Clause 183: Request for additional opinion may be refused —

Dr A.D. BUTI: I wonder whether this clause should contain some restriction on the refusal, in that the refusal should relate to the same aspect of treatment; and, also, if there is a refusal, whether that should be a notifiable event.

Ms A.R. MITCHELL: Clause 183(3)(b)(iii) is probably the most applicable part of this provision as it refers to the Chief Psychiatrist, who has the ability to refuse requests; and the guidelines that he would have to make this workable.

Dr A.D. BUTI: I am not saying that the clause is unworkable; I am saying that the refusal should be more limited, and, if there is a refusal, it should be a notifiable event.

Ms A.R. MITCHELL: It is notifiable to the Chief Psychiatrist.

Dr A.D. Buti: Is it notifiable under part 9?

Ms A.R. MITCHELL: No.

Dr A.D. BUTI: Therefore, it is not a notifiable event under the bill, and I argue that it should be, as other events are. It is quite significant to refuse a further opinion. There may be reasons for it, but that should be notifiable.

Ms A.R. MITCHELL: Under clause 183(3)(b), the member can see that people are notified, depending on who has requested that. There is notification, but it is not part of the part 9 notification series. There are areas of notification in this clause.

Dr A.D. BUTI: I understand that, and I have one final comment. I understand there is some communication, but I still say it should be a notifiable event under part 9.

Clause put and passed.

Clauses 184 to 193 put and passed.

Clause 194: ECT on child under 14 years prohibited —

Dr A.D. BUTI: Now we move on to electroconvulsive therapy. I move —

> Page 145, line 15 — To delete “14” and substitute —
>
> 16

Of course, this is a controversial area. I thank the parliamentary secretary for organising the briefing last week, which was very useful. As I said at the briefing, the opposition is not opposed to ECT, but we think the age is an issue. However, a lot of people are opposed to electroconvulsive therapy and it is important that I read into *Hansard* some of the correspondence I have received, and that maybe the parliamentary secretary has received, from N. McLaren of Northern Psychiatric Services Pty Ltd in Queensland—in fact, this letter may have been sent to everyone. It reads —

> Dear Dr Buti
>
> **RE: Debating ECT in Mental Health Bills.**
>
> People who advocate wider use of electro-convulsive therapy (ECT), such as the proposal to not fully ban the use of ECT on children in WA, often point to the position statement issued by the Royal Australian and New Zealand College of Psychiatrists to justify their views. Despite the widespread misunderstanding, this is not a scientific statement; it is a consensus opinion derived by an overtly political process. It draws on some scientific facts but not all.
>
> The statement asks a series of questions such as whether it is safe (generally) and effective (in the short term) or who should do it but the one question it does not pose is this: Is ECT necessary? It must be understood that many psychiatrists do not use it at all, that its use varies dramatically from one hospital to another, or one part of the country to another. Some practitioners use it so commonly that it is almost

> routine; others, practicing in the same setting seeing a similar if not identical population of patients, never use it.
>
> In two hospitals to which I was appointed chief psychiatrist, including five years at the former Hollywood Repatriation Hospital in Perth, ECT was used prior to my taking up my appointment. It was not used for the time I was in charge, then it was started again some time after I left. This says that while ECT is a treatment option, it proves emphatically that ECT is *not* "(an) essential treatment option that should be available to all patients in whom its use is clinically indicated." For some practitioners, ECT is close to the first treatment option considered. For many others, treating the same types of cases, its use is never "clinically indicated." It is of interest that in both hospitals, during my term of office, the admission rates, bed occupancy rates and duration of stay all dropped, only to rise again after I left. The notion that ECT achieves some therapeutic goal not available by other means is simply not true.
>
> The RANZCP statement on ECT says that patients should give informed consent. Strictly, this should include patients being told that some psychiatrists use ECT a great deal, while others rarely or never use it, and it is a matter of chance to which psychiatrist the patient has been referred.

Not so long ago, the member for Nedlands, the Minister for Housing; Mines and Petroleum, presented in Parliament some petitions from his constituents that opposed ECT.

Mr D.A. TEMPLEMAN: This is very interesting and I would like to hear the member for Armadale continue.

Dr A.D. BUTI: There was also a letter from Professor John Read, clinical psychology, University of Liverpool, in *The West Australian* on 27 February 2014, titled "The ethics of electro-shock therapy". It reads —

> Reports spreading around the world that the State Government of Western Australia may permit the use of electro-shock treatment on children are alarming.
>
> Contrary to the claims of the small group of psychiatrists that have recently been promoting the increased use of electro-shock treatment in Australia, including for children and adolescents, there has never been a single study showing that electro-convulsive therapy has any lasting benefits compared to placebo.
>
> There is, however, overwhelming evidence that it causes brain damage in the form of cognitive dysfunction, especially memory loss.
>
> Government guidelines here in the UK state, moreover, that "the risks associated with ECT may be enhanced during pregnancy, in older people, and in children and young people".
>
> Passing the equivalent of about 140 volts of electricity through adult brain cells equipped to deal with tiny fractions of one volt seems intuitively bizarre. To inflict this on our young people, whose brains are still developing, is both unscientific and unethical.
>
> Busy as they are, politicians must somehow find the time to read the research. Australia's children deserve protection from these well meaning but ill-informed, and therefore dangerous ECT, enthusiasts.

I did some research and I have a paper that is, again, from John Read—I did not have to read the author! This paper by John Read and Richard Bentall titled "The effectiveness of electroconvulsive therapy: A literature review" was published in *Epidemiologia e Psichiatria Sociale*, volume 19, issue 4, December 2010. Members will be happy to know I will not read out this article. As the paper is by John Read, it is anti-electroconvulsive therapy as a whole, but the paper states —

> Given the strong evidence … of persistent and, for some, permanent brain dysfunction, primarily evidenced in the form of retrograde and anterograde amnesia, and the evidence of a slight but significant increased risk of death, the cost-benefit analysis for ECT is so poor that its use cannot be scientifically justified.

I am, of course, not a psychiatrist, and during the briefing that was organised we were told that there are practitioners who are very supportive of ECT. Here we are looking at the issue of ECT on children. What was interesting in that discussion is that there is presently no limitation or restriction on the age ECT can be given to a child. But, as acknowledged in that briefing, this is a political decision that has been made by the government because of political pressure by certain groups that there should be some limitation. As admitted at that briefing, the decision to have 14 years old as the mark was an arbitrary matter; it was not scientific, it was arbitrary. It was an arbitrary decision that ECT could not be engaged in on a person aged under 14 years. If it is arbitrary, surely we should always be cautious. We will not get the whole community or medical profession to agree on the benefits and disadvantages of ECT, but some groups of psychiatrists believe it is beneficial. The Labor Party is

not arguing for a blanket ban; even though it is very concerned about ECT on children, it is saying that it would be appropriate to increase the age from 14 years to 16 years. That is what our amendment seeks to do.

Mr D.A. TEMPLEMAN: I am very interested in hearing more from the member for Armadale.

Dr A.D. BUTI: During the briefing we were told that 14 years was an arbitrary age limit, so would it not be advisable to be even more cautious and prudent and increase that age to 16 years? During the briefing there was discussion about what would happen if there was an emergency situation and a 15-year-old should need to receive ECT. That may be the case, but legislation should not be drafted just because of a possible exceptional situation. We have to look at what is of greatest benefit to the greatest portion of the population or to safeguard against any damage that may occur. The science is not settled on ECT. This government has decided on 14 years; we say it is more prudent to have the age limit as 16 years old.

Mr D.A. TEMPLEMAN: I would like to speak on this very briefly. I was not able to attend the briefing provided. This is probably the most controversial aspect of the Mental Health Bill 2013 that has been before us, and I am concerned that many members probably have not even read the bill and are not aware of the implications of what is being proposed in this clause in regard to the age. I am concerned about there being an arbitrary factor in the determination of the age, and I am also concerned about the prevalence of the use of electroconvulsive therapy. I would be interested to know from the parliamentary secretary the prevalence of the use of this therapy in Western Australia. Is it widespread? Is it only used at certain times? My understanding of the therapy is the application of electric current through areas of a person's head, which seeks to, as highlighted in the meaning in clause 192, produce a generalised seizure. That is a serious therapy, and as per the clause we are debating, the government is seeking to put a minimum age limit on when that form of therapy might be used. I am a little disappointed that there are not more people involved in the debate on this clause on both sides of the house, because this is a significant and serious concern given that we as legislators are, effectively, putting in place a law that will see the sanctioning of this type of therapy on children aged 14 years and above. I think that is significant. Although the member for Armadale has highlighted some research, I am sure members received the same correspondence from those who the member for Armadale quoted. I am no psychiatrist and I would never profess to be somebody who is well and truly cognisant of this particular issue or therapy, but I have to make a decision. Before making that decision I want to be convinced by the parliamentary secretary and her government that this is the right way to go. I would like the parliamentary secretary to explain to us how the 14 years has been arrived at and why the government does not consider the opposition's proposed amendment to 16 years as appropriate. We know that 16 years old is probably known as that magical age in terms of adulthood; although 16-year-olds may not have the full application of the law as they would at 18 years old, at 16 years a person has certain responsibilities and aspects of the law that can be applied to them. I really believe this is a serious matter. We have fewer than one dozen people in this place about to consider an amendment. I might just need a bit more time.

Mr P.B. WATSON: I am very interested in what the member for Mandurah is saying. I would like him to continue on with his commentary; I am very interested in it.

Mr D.A. TEMPLEMAN: I think it is serious. If this amendment is not only not debated properly, but also if the bells are rung and a division is called and people file into this place, I can guarantee that 90 per cent of them will have no idea what they are voting on—no idea at all. If we go and ask them, they are outside doing other things. I am not critical of them, but we are in the situation that we are being asked to consider this as part of a comprehensive bill. As the member for Armadale highlighted, the opposition does not oppose the thrust of the Mental Health Bill 2013 because we recognise the need for modern, effective and efficient mental health legislation that addresses a range of issues that affect people with mental health conditions and mental health challenges. But here we are at this point, at 8.20 pm on 18 March, about to consider whether it is appropriate that a 14-year-old child should have wires attached to their head and a current—I think the member said it can be up to 140 volts—passed into their brain as a means of therapy. It saddens me a bit that very few people in this place tonight are even aware that we are debating this and are prepared to ask questions about whether this is appropriate. I am asking that of both sides of Parliament. I am not trying to attack the parliamentary secretary or the government, but this is the situation that we face tonight. Yes, the bill can be debated and passed. We might have a division on the amendment, but how many of us have genuinely thought about the implications of this particular aspect of the bill?

I apologise for not being able to make the briefing. I should have made an effort to get there and I apologise for that. However, I need to know from the parliamentary secretary exactly why the age of 14 years was considered appropriate. I hope that it was not arbitrary. I would like to know the prevalence of this therapy in Western Australia today; in other words, how many people on average would be required to undertake this form of therapy? That is something I need to know before I not only, obviously, vote on our amendment, but also decide

whether we will oppose the age limit the government has proposed. I would very much appreciate the parliamentary secretary's answers to those queries.

Ms A.R. MITCHELL: I thank both the member for Armadale and the member for Mandurah for their comments. I will go through a range of them as quickly as I can. If I miss something, please jump in with it. I thank the member for Armadale for saying that the briefing was worthwhile. I think it was worthwhile and I am sorry that the member for Mandurah missed it, because I think it allayed a number of fears. Some films, such as *One Flew over the Cuckoo's Nest*, have a lot to answer for and a lot of other beliefs are held by a certain sector that has put messages out that are unfounded. Likewise, without being critical of Dr Read or his research partner—sorry, I do not have his name—they are not psychiatrists; they are psychologists and do not work in the area of electroconvulsive therapy. It is probably quite difficult for someone who is not working in the area of ECT to legitimately make commentary about its value or lack of value and how it works. That is not to discredit those two gentlemen; however, they do not work in the field of ECT.

The Mental Health Bill 2013 has been in the making for quite a long time. The current act does not have any age limits for ECT for anybody. We are introducing an age limit because we believe that —

Mr P.B. Watson: Are people younger than 14 being treated?

Ms A.R. MITCHELL: They could be, under the current act. I have not got to that part yet. The member asked about numbers, but I am just saying that in the current act, there is no age limit. Therefore, ECT could occur with just the approval of the Chief Psychiatrist and another psychiatrist. We believed that there should be some safeguards in the bill and one of those is that there must be approval for a child's treatment from the Mental Health Tribunal as well. If it concerns a child, a child psychiatrist will be on the Mental Health Tribunal.

Another point is that ECT has in fact been around for quite a long time. It is not necessarily a new form of treatment. It is a treatment that has improved over time and, certainly, in recent years. It is done under general anaesthetic; it is not a procedure whereby a person simply lies down and has someone put electrodes on them. It is done under general anaesthetic with an anaesthetist and the psychiatrist. We had those people at the briefing to explain how it is done. The voltage does vary and it is suited to the age and the condition of the person.

Another thing that is really important to remember is that ECT is life saving. It is probably one of those treatments that is used at the life-saving time. In an older person, they might use it as a—I am trying to think of the word —

Mr P.B. Watson: Can you explain why it is life saving?

Ms A.R. MITCHELL: Often because it is one of the last forms of treatment that people would use. It is a treatment for severe depression. I am trying to find the list of what it is used for. It is used to treat severe depression, manic depression, mania, bipolar diseases and those sorts of things when most people have tried other forms of treatment prior to receiving ECT. Others, once they have had ECT, will want to use it more often. People do die from severe depression and there are lots of other issues that go with it. Therefore, it is used to stop that severe depression affecting the rest of their lives. It is a treatment that has been used for a number of years and it has got better and better. What we have tried to do in the legislation is to put in safeguards to ensure that it is not used inappropriately.

I can give the member some numbers —

Mr P.B. Watson: Can you give us the success rate, parliamentary secretary?

Ms A.R. MITCHELL: I will just give the numbers first because the member for Mandurah asked for them. The total number of people in Western Australia treated with ECT in 2012 was 434, but there was a total of 5 543 treatments.

Mr D.A. TEMPLEMAN: Mr Acting Speaker, I am happy for the minister to continue.

The ACTING SPEAKER (Mr N.W. Morton): Thank you, parliamentary secretary.

Ms A.R. MITCHELL: Thank you for that, member.

Mr D.A. Templeman: Parliamentary secretary—should have been the minister, of course! We were banking on —

The ACTING SPEAKER: Thank you, member! You wanted extra time; the parliamentary secretary has got it, so let us get back to the point.

Ms A.R. MITCHELL: Member, I have just been advised that I said that there would be a child and adolescent psychiatrist on the Mental Health Tribunal. That will not always be the case, but the Mental Health Tribunal will try to have one on the tribunal if it is making a decision about a child.

I will go back to the numbers.

Mr D.A. Templeman: You said 434 for 2012.

Ms A.R. MITCHELL: That is the number of people. The number of treatments that those 434 people had was 5 543.

Mr D.A. Templeman: Do you have any detail on the age of those 434 people? I don't need an exact figure, but how many would be classified as children—in other words, aged 18 and under?

Ms A.R. MITCHELL: Please, just be patient. Sixty-eight people received involuntary ECT in 2012. Those numbers are similar over the period 2010 to 2012. No ECT was given for under-18-year-olds in Western Australia in 2011 and 2012. ECT for under-18s is considered rare, and for under-16s it is probably classed as extremely rare. Therefore, it is not something that we just use in Western Australia. In other states, there is no age limit. I think that the psychologist who was talking about ECT is from Queensland where there is no age limit. Therefore, it is interesting that he has written to us, given that we are putting in an age limit whereas in Queensland there is no age limit. That is a little interesting. It does not mean a lot, but it was just strange to us that he would to write to us given that Queensland has no age limit.

It certainly is not a high number for children. In the development of this age limit, we went by the community consultation that has occurred extensively on this bill and recognised that, yes, there should be an age limit, so 14 years is not bad. The other thing that was influential in that decision is that child and adolescent psychiatrists worldwide, not just in Western Australia, are advising that they are seeing severe depression in younger and younger people. That was the trigger to go lower, because should treatment be available for people going forward—not necessarily in this day and age—then the legislation should allow that to occur.

In the consultation, the commission received clinical input from the Office of the Chief Psychiatrist, child and adolescent psychologists and other clinical advisers. This bill has gone through so much consultation to come up with an acceptable level, and we are never going to please everybody. I do not have children, but if I did, I would be upset if there was only one form of treatment left that could save my child's life and the legislation set an age limit that meant I would have to take my child interstate for a series of treatments rather than having the treatment at home in the family environment.

Mr P.B. Watson: What if you had a 14-year-old child who didn't want it done?

Ms A.R. MITCHELL: They would not have it done. It has to go to the Mental Health Tribunal; the parent does not choose.

Mr P.B. Watson: What if the parent didn't want it?

Ms A.R. MITCHELL: It still has to go to the Mental Health Tribunal.

Mr P.B. Watson: It goes to the tribunal; but if the parent doesn't want it, you're saying that they have to go to the eastern states?

Ms A.R. MITCHELL: Sorry, I have lost my train of thought. Where was I going? As the member for Mandurah has mentioned, this is a critical and important part. I ask the member for Mandurah to give me more time.

Mr D.A. TEMPLEMAN: I am happy to assist the parliamentary secretary.

Ms A.R. MITCHELL: Because it is a recognised form of treatment and because people worldwide are being diagnosed at a younger age with not only depression but severe depression, we need to look at that.

The member for Mandurah said earlier that there are not a lot of members in the chamber. I just want to say that I am pleased that the members who are present are genuinely interested in the bill and take it very seriously. I would prefer quality to quantity. The people who are genuinely interested in the bill are in the chamber, and I appreciate their being here.

Mr D.A. TEMPLEMAN: The parliamentary secretary said that no child under the age of 18 years has received electroconvulsive treatment in 2011–12. I do not want to go back years and years, however, I am interested in knowing whether any children who may have been in the care of the state—that is, in the care of the chief executive officer of the Department for Child Protection and Family Support—have been considered for this treatment. I would be interested in any figures for previous years.

Ms A.R. Mitchell: We do not have any figures on that.

Mr D.A. TEMPLEMAN: There have been none. I am also interested in the trend of those 434—that is, over the last 10 years, is 434 an average number every year? Is the trend for this treatment dramatically declining or increasing? I am interested to know that because this is, as the parliamentary secretary said, a form of therapy that occurs—I am loath to say—as a last resort. It is a therapy that seems to be considered after many other treatments have been considered. What trend would we see in the last period of time? We have a figure of 434 for 2012, and that was for 5 000-plus treatments in total. I am interested in the trend issue. I am also interested in—obviously, this will depend on the person's circumstances and severity—an average number of treatments that seem to be —

Dr G.G. Jacobs interjected.

Mr D.A. TEMPLEMAN: Do not get me wrong, I am not trying to say that it is not an important treatment, but the member for Eyre is correct, what would be the average number of courses that a person might go through in the treatment? I think the member for Albany made a very good point when he interjected about the success rate. If this is a treatment—for want of a better term—of last resort, what is the success rate of somebody who goes through a course or courses of electroconvulsive therapy? I would like the parliamentary secretary to flesh out the trend issue. What is that 434 in comparison to? Is it up, down, average, to what we would expect with a growing population? Is it higher because we have more people? The parliamentary secretary said that this is a treatment for severe depression, as one example. We all know that one in four people in Australia might experience some form of depression, which is a very high rate. Are we going to see the increased use of electroconvulsive therapy? I want to know the trends and I want to know a bit more about the average type of course of this treatment a person might expect to experience. As the member for Albany correctly asked, what is the success rate of this treatment?

Ms A.R. MITCHELL: My understanding is that over the past 10 years it has plateaued. We do not have the facts or the figures in front of us, but it decreased prior to that. It has plateaued a bit lately, which if there is an increasing population, it has probably decreased. It is important to remember that ECT is not a cure; it is a treatment. For people with mental illnesses, like other conditions, things get better—they do not need things because they are fine; they come back and need some more treatment. It often depends on the person. It is hard to categorically say: this is what will happen; this is the effect of it. Most people who go in for a treatment program will go perhaps three times a week. Some may want to continue it as a maintenance program, rather than taking antidepressants. The member for Albany asked how effective it is. Once again, I do not have any data, but there are people who would say that it is more effective than antidepressants.

Mr P.B. Watson: Are there after-effects, parliamentary secretary, from the treatment?

Ms A.R. MITCHELL: I will come back to talk about the after-effects. I keep losing my train of thought.

Some people may go in once a month just for that. I have been told—I think members at the briefing would have been told also—that I would be surprised that there are people working in Perth or elsewhere who might go in for a treatment once a month, and that is their form of treatment. They may miss half a day to a full day's work and then carry on. Different people react differently to it, and if it works for them, they choose to do it and they want to be able to have that treatment.

Once again, the after-effects can be different for different people. The member for Albany was at the briefing, so I do not want to go over this all again.

Mr P.B. Watson: No, I was not.

Ms A.R. MITCHELL: Firstly, it is done under anaesthetic, so there are the effects of coming out of an anaesthetic. It is not a heavy dose of anaesthetic. Dr Patchett, who is sitting next to me, has been involved in it and I am confirming with him that it is not a heavy anaesthetic; a person is only under anaesthetic for five minutes while the process kicks in. There might be some memory disruption, but it is normally very short term. It is based on what happens after someone has an epileptic fit—that is where they learnt about it. When someone comes out of an epileptic fit, they are often a bit tired but they then pick up that it has been a trigger to improve their mental capacity.

Mr P.B. WATSON: The parliamentary secretary is saying that there could be memory loss. A 14-year-old child could be getting this sort of treatment, as opposed to, say, a 45-year-old, 25-year-old or 35-year-old. Would that not be a problem? It is a concern to me if there is memory loss with smaller brains. As we all know, young men's brains develop a bit further down the track—not in me; I was lucky!

Ms A.R. Mitchell: It is short-term memory loss.

Mr P. PAPALIA: I have some questions arising from the answer the parliamentary secretary gave earlier to the member for Mandurah. In my view, it is not acceptable for the government to come into this place and say that it does not have the statistics on the number of children in state care who might be subjected to this treatment or who have been diagnosed with an illness that might result in them being treated in this manner in the future. The government wants us to approve legislation that would allow children as young as 14 to receive what is not an uncontroversial treatment. I respect and acknowledge the evidence that we received in the briefings with regard to this being a treatment that does prove worthwhile for some people. What I find baffling is that the government is incapable of justifying why a 14-year-old should be subjected to it, other than the fact that around the world clinicians are increasingly diagnosing people with illnesses that might be said to be treated by electroconvulsive therapy. That does not strike me as a justification. If there is no evidence in Western Australia to suggest that it is required for 14-year-olds, I do not think we should do it. Just saying that we may in the future want to use the treatment for illnesses for children who are 14 years of age does not really justify, in my view, including them. I understand that there previously was no age limit and I understand that this is an improvement. Extensive submissions were received from a range of bodies and individuals. The opposition is suggesting that the minimum age should be 16. I would like to hear a justification for why it should not be 16 as opposed to 14. Also, it is essential that the parliamentary secretary provides information on how many children in state care have been diagnosed with illnesses that might be treated with ECT if this legislation is passed. My interest also goes beyond state care. I have found it impossible to extract information from the government on how many children in detention are currently being treated for mental illnesses and how many of those children might be subjected to this type of treatment in the event that this legislation passes. It is not good enough for ministers to respond to the questions I have asked for four years in this place by saying that the administrative processes at Banksia Hill Detention Centre cannot deal with answering my questions on how many detainees are mentally ill, how many are being treated with drugs and how many are being treated for illnesses that might result in them being subjected to ECT in the future if this legislation passes. If the government wants us to support its legislation and wants to convince the people of Western Australia that it is appropriate to allow 14-year-olds to be submitted to ECT, then I want to know how many children in detention and state care, who will not necessarily have their parents standing up for their rights and who will not necessarily be represented by an independent person as opposed to the tribunal, could be treated in this way. If the parliamentary secretary does not know, I would appreciate her taking it on notice with a view to getting that information to us.

Ms A.R. MITCHELL: I refer again to the information I gave the member for Dawesville; that is, in Western Australia, no ECT was given to any children under 18 in 2011–12.

Mr P. Papalia: That was not my question. My question was: how many children under the age of 14 were diagnosed with an illness that might in the future be treated with ECT if this legislation is passed?

Ms A.R. MITCHELL: I do not think that is in the legislation that we are dealing with at the moment.

Mr P. PAPALIA: The government is enabling the treatment to be used on 14-year-olds. I am assuming that children in state care will have fewer safeguards in place than children who are in the care of their parents or loved ones. I am interested in how many children in state care have been diagnosed with an illness that might be treated with ECT if this legislation were to pass. I am also very interested in how many children in Banksia Hill Detention Centre are currently being treated for an illness that may, in the event this legislation is passed, be treated with ECT.

Ms A.R. MITCHELL: This does not apply. Detention centres are not authorised hospitals; therefore, they are not able to use ECT there anyway. It has not happened yet, but the approval of the Mental Health Tribunal would be needed for any child to undergo this treatment. It would not just be a matter of someone at a detention centre giving the go-ahead for something to occur; it does not happen like that. I am sorry that the member was not here a bit earlier when we were going through how those things occur.

Mr P. Papalia: Don't be sorry. When you sit down, I will get up and explain myself.

Ms A.R. MITCHELL: It is evidence-based treatment. It has been used around the world for a long time. Under the current act, there is no limit at all; anybody could have this treatment as that legislation does not have the safeguards that we are putting in place. The 14-year-old age limit has come about from community consultation—they believe there is a place for it. That was combined with clinical expertise and research from other jurisdictions in Australia and also the worldwide recognition that there are many, many young people suffering severe depression who may need this form of treatment. We believe that as we are preparing legislation that will last for a few years—we will have a review in five years, but it could last a bit longer than that—we certainly hope that we do not have that situation in Western Australia. Obviously, we will do as much as we can to make sure that it does not happen, but we need to be prepared for that. Some children have gone over east for different reasons and I do not think we should be doing that to people in Western Australia.

Mr P. PAPALIA: How many juveniles in detention at Banksia Hill are currently being treated for depression?

Ms A.R. MITCHELL: I do not think that is relevant to this legislation.

Mr P. PAPALIA: It is absolutely relevant to this legislation. The government is seeking to pass legislation that will enable children of 14 years of age and over to be treated with ECT for depression. Where they reside is irrelevant. If they are sitting in Banksia Hill and a clinician determines that they are in need of ECT and they do not have a parent representing them, they will go in front of this tribunal, which will determine that they be treated.

Ms A.R. Mitchell: No.

Mr P. PAPALIA: I am sorry that I do not have the absolute trust in the authorities that the parliamentary secretary has! I am sorry that I do not want to surrender every bit of my cynicism about the treatment of children in state care or detention in the same fashion that she does, because she is so reliant upon those people doing exactly what she thinks they are going to do. If a child is in detention at Banksia Hill and a clinician deems that they need this treatment, they will be getting it. Therefore, if the government wants us to support this legislation and wants the people of Western Australia to not be cynical about it, not be sceptical or even worried about it, then the parliamentary secretary must be able to at least tell me how many of those children are currently being treated for depression.

Ms A.R. MITCHELL: The Department of Corrective Services manages the health of juveniles in detention, not the Department of Health. Therefore, we do not have that information; we do not have numbers.

Mr P. Papalia: Will the parliamentary secretary get the information?

Ms A.R. MITCHELL: We do not have the information.

Mr P. Papalia: Will the parliamentary secretary undertake to get the information?

Ms A.R. MITCHELL: The member has the process for doing that through the Department of Corrective Services.

Mr P. Papalia: No, I do not, because I have been asking for four years and the parliamentary secretary's government cannot answer.

Ms A.R. MITCHELL: I am not going to ask for that information.

Mr P. Papalia: They did not have the threat of electroconvulsive therapy until now.

Ms A.R. MITCHELL: It is not a threat; it has been there all the time. We are putting in safeguards and I believe that these safeguards will be fine. The question is not relevant.

Mr P. PAPALIA: Parliamentary secretary, the reason I have been incapable of getting an answer to the question of how many juveniles at Banksia Hill, or in the days when we had Rangeview, were being treated for depression is because the government is incapable of answering the question. It does not matter which minister I ask, they are incapable of answering the question. I would have thought that the parliamentary secretary, representing the minister in this place, might have a little bit of interest in just how many children in detention at Banksia Hill may potentially be subjected to this treatment in the event that the legislation passes. I would have thought that would be a reasonable thing for the parliamentary secretary personally to ask so that she knows and, beyond that, so the government knows.

I will tell the house what happened in 2008. In late 2008 after we lost office, I went to a briefing from the Auditor General on the most prolific juvenile offenders in the state. He handed down a report in September or October after the election. In that report there was a small line about the number of child offenders in detention who were being treated for mental illness. At the time I asked him how many juveniles in detention were being treated and he said, "Oh, they all would be." It was an anecdotal response; it was not informed by statistics or data. I then commenced a process over a number of years of asking the government the same questions just to determine how many were being treated and what that treatment was. I was not asking for specific names; I just wanted numbers and the type of treatment.

I know that currently they can be treated with ECT—anyone can be, but no-one has been. Clearly, there has been no impetus to do so until now. I am assuming that there are clinicians in the state who would believe that this is a valuable tool to add to their armoury of treatment. I would suspect that there is going to be more likelihood of it being used on children aged 14 years in the future; otherwise what is the point of putting the clause in there? In the event that it is used, in the event that a child in detention at Banksia Hill is deemed to be depressed and may potentially benefit from the employment of this treatment, I would like to know how many are currently being treated for depression. I do not think it is that big of an ask or that far out of the realms of reasonableness for me

to ask the parliamentary secretary, in the context of this bill, to find out for me because I cannot get the answer by asking in the Parliament. I would have thought that as the parliamentary secretary for the Minister for Mental Health, the member would have an interest and that it would be something that she would like to know as well. I do not think it is that hard a question to ask the Minister for Corrective Services to go to Banksia Hill and ask his people to tell us exactly how many juveniles are currently being treated for depression.

Ms A.R. MITCHELL: What the member is asking me is not relevant to this bill but I will make some inquiries.

Mr P. Papalia: Is this not the Mental Health Bill 2013?

Ms A.R. MITCHELL: What the member is asking is not relevant to the clauses in this bill.

Mr P. Papalia: Would the parliamentary secretary like me to pick a different clause?

Ms A.R. MITCHELL: May I finish speaking? What the member is asking is not relevant to the clause in this bill in the way that we are discussing treatment with ECT; but I will inquire and see what I can do for the member.

Mr P. Papalia: Thank you.

Dr A.D. BUTI: Just one other thing before we go to my amendment. As we know, at the moment there is no age limit for ECT and this bill seeks to put the age limit at 14 years of age. It was either in the explanatory memorandum or at the briefing that it was said that this treatment has not been inflicted on a child in Western Australia because it is considered to be a drastic treatment. Perversely, by putting in an age limit of 14, the psychological mindset is such that psychiatrists will see that it is now expressly permissible under the law to give ECT treatment from the age of 14. My concern is that by putting in this barrier, which is arbitrary—we cannot deny that it is arbitrary—we will see an increase in children being subjected to ECT from the age of 14 or 15. That is a major concern. I respectfully listened to the arguments the parliamentary secretary made about the benefits but the science is not settled on this. I read the letter from N. McLaren, who did practice in Western Australia. Perversely, by putting an age limit of 14, the government may actually be encouraging or giving more confidence to psychiatrists to now treat 14 year olds with ECT.

In regard to the member for Warnbro, it is actually very reasonable to assume that children in detention are probably very likely subjects for ECT. It may be that that will not be proven to be correct but I think it is a reasonable assumption or prediction to make. In any case, having an age limit of 14 could be seen to be giving legitimacy to treating children with ECT. We on this side of the house have concerns with that and that is why an age limit of 16 years of age is more reasonable. That is why we have put this amendment.

Ms A.R. MITCHELL: I would probably prefer to use the word "life-saving" rather than "drastic" for ECT as a form of treatment. It is better to label it that rather than drastic; I do not think the word that the member used does the ECT form of treatment justice. Fourteen years of age—arbitrary? The member thinks people may want to use it more but it has been a zero age group up until now. Therefore, it has been available to practitioners and they have not chosen to use it. I do not agree that the member's arbitrary figure of 14 —

Dr A.D. Buti: The government's arbitrary figure of 14!

Ms A.R. MITCHELL: Our arbitrary figure of 14 will make a big difference to whether they decide to suddenly use ECT or not—which would still be the case if the arbitrary figure was 16. We believe that we have done a great deal of consultation with the community, with clinicians, with people who are involved and we have come up with a balance that we believe is a good age for the future and one that is in the bill now and will hopefully be in the act. We believe we have picked up a fairly good choice of age at that stage and we are quite comfortable with that.

Dr A.D. BUTI: The parliamentary secretary says "life-saving" treatment, which may be the case, but it is still a drastic treatment. As the letter from N. McLaren informs us, some psychiatrists are much more prone or eager to engage in ECT than others. It is not settled because if it was settled there would be children in Western Australia—there is no legal barrier now—who would have been treated. They have not been treated. If they have not been treated, it is because there is concern in the psychiatric profession with treating children with ECT. As the parliamentary secretary rightly said, under the 1996 mental health act there is no age restriction to ECT. Why has ECT not been given to a child? Because psychiatrists are rightfully concerned about it and the government is concerned about it. That is why the government put the age limit at 14, which is also arbitrary.

Ms A.R. Mitchell: They are additional safeguards.

Dr A.D. BUTI: At the briefing it was basically said that the age limit is 14. The reason that an age was put in at the end was due to political pressure. If the government is going to put an age limit in, then it should be even more conservative than 14. If we go by the history of the psychiatry profession in Western Australia, it has had

major concern about treating children with ECT. There is no legal barrier to treating children but the profession has still not engaged in it.

That shows us that the government is concerned about it. By now putting in that arbitrary age of 14 years, it is still permissible, as it is under the current act, but a psychological factor now comes into play. We are concerned that we will see an increase in electroconvulsive therapy on 14 and 15-year-olds. It is probably not appropriate to give it to any children, but we are trying to be reasonable and meet halfway; that is why we ask for the minimum age to be 16 years. The issues the member for Warnbro raises about children in detention are very valid. That is where the greatest fear should and will be.

Mr P. PAPALIA: I endorse what was stated by the member for Armadale about our concerns. I think that 14 is arbitrary, as is 16 by the way; it is a bit of a concession to the parliamentary secretary's indication that she would like children to be treated in this way. I apologise for the way I spoke to the parliamentary secretary before. It was more from frustration at years of trying to get this information. I really appreciate the parliamentary secretary indicating her willingness to find out that information. I would appreciate it if she could find the number of juveniles in detention who are being treated for depression and, in the course of that investigation, determine the nature of the treatment, which may give us an indication of the extent of this depression, the severity and the likelihood that they would be diagnosed as requiring this type of treatment in the future. I appreciate the parliamentary secretary indicating her willingness to try, and I wish her luck. She should not buy the argument that it is too much work, because there are only about 163 of them. As much as it might be difficult, I think it is an important issue. We need to reassure the public that those who are probably the most vulnerable in the state to being inappropriately treated—I am not suggesting unprofessionalism on behalf of anyone—and that fewer of those children and others will receive treatment that is potentially inappropriate.

Dr G.G. JACOBS: Parliamentary secretary, I have listened with interest to the debate on the issue of electroconvulsive therapy. We have heard a lot on people's view on ECT as a concept, but for me this debate is really about the 14–16-year-old threshold. I must say that I have a bit of sympathy for what the member for Armadale is trying to do here, but I am still not really resolved in my mind. The statistics do not help. If we could break down the number of children treated with ECT into those aged 14 years and under and those aged between 14 and 16 years, we might be able to gauge things better. For instance, in my mind, when focusing on the 14–16-year-old threshold, it is critical to ask: what benefit would the legislation have for the child population with refractory depression? Everything else has been tried, including medication, behavioural therapy and counselling, but the child still has depression and wants to take a long jump off a short pier. Let us be frank; they are suicidal. That is the life-saving part that I am interested in. In making a decision between 14 and 16, I want to know about the life-saving part. However, we cannot do that because we do not have any statistics in Western Australia that help us make a decision about that. I want to go home at night knowing that I have helped pass legislation that is useful and could potentially save a life. I cannot make that decision based on the statistics provided.

The minister was talking about the world experience; children are suffering depression at a younger and younger age. In helping us to make a decision about the minimum age being 14 or 16, what is the world experience? What are the world figures with ECT and children? How many children have had ECT? What was the result of the ECT? What was the important contribution in that 14 to 16 age group? I appreciate that it is not an exact science. Of course every time we draw a threshold line there are always people on either side of it. People have said to me that there may be a potential in the 14 to 16 age group. If we increase the minimum age to 16, the opposition may then say 16 is too young as well and it should be 18. Or the opposition will want to increase the minimum age for psychosurgery from 16 years to 18 years.

Mr P.B. Watson: We feel that 16 is a good balance.

Dr G.G. JACOBS: There might be a good balance in the minimum age for psychosurgery being 16 and the minimum age for ECT also being 16. It is not a perfect world and it is not a perfect science, but there may be some credibility in that.

Mr D.A. TEMPLEMAN: I am happy for the member for Eyre to continue.

Dr G.G. JACOBS: I suppose we are soon to adjourn this debate, but perhaps the parliamentary secretary could provide some detail on the world experience of children who have been provided with ECT so that we can tease out the demographics and the contribution in the debate on children aged between 14 and 16. It is not a perfect science, but it may help in answering some of the questions about the 14–16-year-old threshold.

Mr D.A. TEMPLEMAN: I do not know how we can accommodate this procedurally, but the member for Eyre is suggesting that if there is a way of providing some more global figures, as he determines it, it may help us grapple with this issue of whether the minimum age for ECT should be 14 or 16 years of age. I would not like us

to go to a vote on this clause when some questions have been raised. Leader of the House, I am not across the procedures; I do not know whether we can sanction off this clause or consider adjourning at this stage. Again, I do not know whether the advisers would be able to provide us with additional information in line with what the member for Eyre highlighted before we can come back to this clause tomorrow, but I sense that there is enough doubt in the chamber about what is before us to warrant some sort of action being taken to get that additional information. The government's proposal is to set the age limit at 14, bearing in mind, as we all know, that there is currently no age limit in Western Australian legislation. This bill effectively does that; it puts in a 14-year age group. The opposition, for various reasons, is suggesting the age of 16. We have just heard from the member for Eyre, a very learned fellow who is much more experienced in matters of this nature than I. He quite eloquently said that we need something else to convince us about the 14 and 16-year issue.

Dr A.D. Buti: The age of 16 that we put up, we have done with some unease. It is not to say that we have done it with great enthusiasm.

Mr D.A. TEMPLEMAN: I am looking at the Leader of the House. I am not sure whether he will suggest that we adjourn at this point and whether there is enough time for the parliamentary secretary, in the intervening hours before we reconvene tomorrow at 12 noon, when this bill might be brought on as the first item of business, to seek some more information from her advisers and/or experts that helps to answer this question from a global context that the member for Eyre has posed. To be honest, I just do not feel comfortable going to a vote on this tonight. I am certainly very uncomfortable about the figure of 14, and I do not think the parliamentary secretary has convinced us why that figure has been arrived at. The point that the member for Eyre made is that if we are not happy with 14, why are we proposing 16, what is that based upon and what is the global aspect? That is a valid point to make. I am seeking the parliamentary secretary's consideration of an adjournment of this piece of legislation at this point. Will there be time in the intervening period before this bill is brought back before the house to further debate this clause?

Ms A.R. MITCHELL: I certainly respect the thoughts and positions of the members who have spoken. As I said from the beginning, the age group that we have determined has been arrived at through extensive community consultation—people who are involved with medication; families, carers, support people, clinicians, psychiatrists, the Royal College of Psychiatrists and a number of learned people. Through their experience in the medical profession, they have done a lot of work in this area. They have done that work for us. It is not like we suddenly have to start doing our own research on the worldwide use of ECT and whether or not there are benefits. We have qualified people in our community whom we have consulted widely and often over a period of years to come up with the age that we have because of the reasons they have given us. I believe that we have done that work. We have gained from that experience, and that is why we have the age group that is before us tonight.

Dr A.D. BUTI: That may be the case but we are dealing with science, which is based on evidence. If that work has been done, it would have been advisable for the empirical evidence of that work and research to be provided to members of this house so we would be better informed. The member for Eyre is right: why the age of 16? We are uneasy about any child being subjected to ECT, as the profession has been, which is proven by the fact that even though there is no illegality or prohibition against children being treated with ECT, they have not. That tells us something on its own. The member for Eyre, who is much more learned in medical matters than we are on this side of the house, has asked about the advantages of 14 versus 16. If that work has been done, why has that work not been presented? Where is the empirical evidence that supports the fact that ECT should be performed on children; and, if so, why the age of 14? There is no empirical evidence to say that 14 is the age it should be because, as the advisers told us in the briefing, it was an arbitrary political position because people came to the government and expressed concern about ECT being allowed on children. The government did not arrive at a medical decision but a political decision that it be 14. Where is the medical evidence that goes with that political decision? It has not been given to us tonight. The parliamentary secretary has not been able to refer us to studies to that effect.

When this bill was first read into the house by the Minister for Health and when this bill was contemplated last year and in the previous Parliament, the parliamentary secretary knew that the opposition had concerns about the age limit. The Minister for Mental Health has failed to provide the opposition or the parliamentary secretary's own side with the empirical evidence that says that ECT should be performed on children. That evidence has not been brought forward. We are making the decision tonight. The parliamentary secretary's side is making a decision to support the age of 14 because the Minister for Health has made that decision. It is not based on medical evidence. Our side is voting for the amendment moved in my name, not based on medical evidence either.

Mr J.H.D. Day: It's a matter of judgement, isn't it? Sometimes you have to do that in these issues.

Dr A.D. BUTI: The Leader of the House is right that it is a matter of judgement but in a matter so important, we would think that the government would be providing the evidence to support its bill. It has not provided the medical evidence to support its bill. Even at the briefing, the psychiatrist from the Perth clinic, who talked about ECT, trying to allay any concerns we may have had, was not able to provide evidence of the benefit to children. He said that it may be a life-saving treatment. Why has there not been at least one occasion in Perth throughout history in which there has been a life-saving necessity for that treatment to take place? There may have been but the psychiatrist was unable to provide that.

Mr J.H.D. Day: It would be so rare that it would be used at that age.

Dr A.D. BUTI: If it is so rare, why bring in an age limit? All that will do is encourage its use.

Mr J.H.D. Day: There are a lot of hurdles to jump over.

Mr P.B. WATSON: I am very impressed with the member for Armadale, and I would like to hear more.

Dr A.D. BUTI: The Leader of the House says there are a lot of hurdles. There are not that many hurdles. It has to go to the Mental Health Tribunal and be approved. It is not a major hurdle. The treating psychiatrist has to show a reason or cause for that treatment to be imposed. That is not a major hurdle. The Minister for Planning is a dentist, so he is a scientist. The parliamentary secretary and I share a common first degree in human movement, so we were scientists at one stage of our education. Throughout the scientific world, we are told to base decisions on empirical evidence. The government has failed to provide us with empirical evidence today. As we very well know, when we engage in experiments, although it will be very difficult in this situation, we have a control group and an experimental group. There is none of that here. As I stated when I quoted the article from John Read, he may not be a psychiatrist but he was looking at the literature. The parliamentary secretary, the Leader of the House and the member for Eyre all know, as I know, that literature reviews are very common in the scientific world. Many academics make their living out of literature reviews. So there can be no opposition to the value of literature reviews. Professor Read's literature review showed that the benefits were incredibly marginal. So why impose an age of 14? As the minister's own advisers have told us, the age of 14 is arbitrary. All that will do is set an express permissible age limit, which will only encourage ECT to be performed; and, also, even worse, the member for Warnbro's fears may be realised.

Mr W.J. JOHNSTON: The parliamentary secretary said that the decision to include the clause in this form was the result of consultation with experts in Western Australia. Could the parliamentary secretary let us know which experts disagreed with the recommendation to have an age limit of 14? I cannot imagine that the views of the experts were unanimous. I imagine there was a range of views. Could the parliamentary secretary give us advice about which of the experts who were consulted did not agree with the age of 14?

Dr A.D. BUTI: As I have stated, this is not an amendment that I put forward with great joy, because we do not want ECT to be performed at all on children. However, this amendment is incredibly important. As the member for Eyre has said, he wants to go home tonight knowing that he has voted on something that will be advantageous. The member for Eyre is a medical practitioner. He knows the importance of empirical evidence. The member for Eyre will more than likely vote against our amendment out of party loyalty. The member for Eyre is one of the most loyal members on the government side. He was dudded by the Premier, but he has remained loyal and very disciplined in this house, and he always puts his genuine views on whatever he speaks about. We have had major disagreements on this bill. The member for Eyre will not be able to go home tonight confident that he has voted for something that will be beneficial, and nor will members on our side. If our amendment gets up, at least we will go home knowing that there will be less of a chance that children will receive ECT at an age when they should not receive ECT.

Mr W.J. JOHNSTON: I thought that the parliamentary secretary would get up and answer the question that I asked. It is obvious from the question that I asked that there is no unanimous position in the medical profession on this issue. It is an arbitrary decision. It would be good if the government would be honest with the people of Western Australia about the eminent people who have disagreed with this recommendation. It is a bit dark and inappropriate for the government to say that it has these experts who agree with it. Of course the government also has experts who do not agree with it. We all know that there are people who have told the government that this should not happen, yet the government is not prepared to be honest in this chamber about that issue. It just says, "Trust us." That is not what the role of the Parliament is. It is not a particularly unreasonable amendment from the member for Armadale to change the age from 14 to 16. I was interested to hear the Minister for Planning's interjection to the member when he said that we are just creating a different arbitrary level; instead of the arbitrary level of 14, we are creating an arbitrary level of 16. That is true. However, if the government wants to persist with its arbitrary level, surely it should not be afraid to explain itself. I feel sorry for the parliamentary secretary, not just because she was left out of cabinet in the reshuffle on Friday —

Ms A.R. Mitchell: You are appealing to my soft side, and I do not have a soft side.

Mr W.J. JOHNSTON: I am not appealing to the parliamentary secretary's soft side. I am just making the point that I was surprised that both she and the member for Wanneroo were both ignored by the Premier in choosing his cabinet.

The ACTING SPEAKER (Ms L.L. Baker): Member, please keep to the clause.

Mr W.J. JOHNSTON: Yes, Madam Acting Speaker; I am doing my best.

The government needs to tell the people of this state the truth on this issue. Before we choose this particular arbitrary level, the government needs to explain what the proper level of debate was. As I have said, the Leader of the House is right: we are choosing one arbitrary level over another. We have got the support of the people with whom we have consulted. The government has not told us the basis of its decision, other than that is its decision. That is the second reason I feel sorry for the parliamentary secretary—she probably was not involved in those discussions. This is a complex bill, and I imagine the Minister for Mental Health did not involve the parliamentary secretary in these detailed discussions, so she probably is not aware of the information that we are seeking. That is probably a good reason to follow the suggestion of the member for Mandurah and not vote on this matter tonight. I understand that standing orders allow us to adjourn this particular clause, without adjourning the bill in its entirety, so that we can have a proper discussion about what is a very important issue. I am surprised the Liberal Party is persisting in going down this path, because it talks about the primacy of the family, and of course this bill is undermining the primacy of the family. That is very disappointing.

Dr G.G. JACOBS: The parliamentary secretary talked about the world experience. I wonder whether there are any statistics in the wider area, not just in Western Australia, that demonstrate the number of children between the ages of 14 and 16 who have had ECT, the conditions those children had, and the results that were achieved. I understand that there are life-threatening conditions for which ECT could be life saving. The question is whether ECT should be given at the age of 14 or the age of 16. A 15-year-old child may have refractory depression and needs ECT to save their life. I wonder what the world experience is, because, as I have said, we cannot determine that from our experience in Western Australia. We cannot say there were three or four children in Western Australia last year who had refractory depression and were suicidal and needed treatment, and the only treatment that was effective was ECT, and that is a good argument for why the Parliament should consider allowing ECT for that group. That is what the chamber is struggling with. We cannot determine those issues, because we do not have any figures in Western Australia. What are the world figures? How many people in other jurisdictions, other countries, have the ability to give ECT to a 15-year-old, and what are the conditions under which that is given, what prompted that therapy and what is the result of that therapy? They are the issues on which we are stuck at the moment.

Mr P.B. WATSON: I have been in this place for 13 or 14 years now and this is one of the most difficult decisions I have had to make as a member. I may go home tonight after this chamber has voted to allow 14-year-olds to receive ECT treatment. The parliamentary secretary could have come into the chamber and given members the relevant statistics from around the world. However, the government is basing this clause on what has occurred in Western Australia, where ECT has not been given to children in at least the last four or five years. I find it very hard to stomach that this chamber will vote on whether a 14-year-old will receive this treatment. I have seen some good bills and bad bills—good legislation and bad legislation. This clause has not been thought through properly. As the member for Eyre said: why not put this aside so that the parliamentary secretary can get the statistics? Members on the other side and members on this side will vote how they like, but if I have to vote on whether a 14-year-old can receive ECT treatment without being given the proper research, I will go home tonight and be really upset for not only myself but also on behalf of my constituents. Some people say that ECT treatment is okay for children, and some people say it is not. Is this clause so important that it has to go through tonight? I feel I cannot make a proper decision to vote on it until I get all the information, and I do not think we are getting it.

Mr D.A. TEMPLEMAN: My response is along the same vein as the member for Albany. I accept the parliamentary secretary's answer to the previous question that this bill has had a huge amount of consultation and discussion. However, the parliamentary secretary has not told me how the people that she consulted arrived at 14 years of age, given there are no statistics to rely on in Western Australia on treatment for someone who is legally defined as a child. I know that the parliamentary secretary did not mean to imply that the opposition was throwing a spanner in the works after the bill had gone through so much consultation. The point is that the parliamentary secretary has not convinced the opposition at all why 14 is the age and what that is based upon. Is it based on a global statistical perspective or an international trend? For example, I now want to know which countries have restrictions on the age at which children can be given ECT treatment and what they are. I want to know whether other countries in the world have 16 as the age in which a clause like this can be triggered. I

would like to know which countries in the world have 14 as the age in which this treatment may be considered for children. I want to know now which countries in the world have a position of using the legal age, which most countries to my knowledge determine adulthood, of 18 years of age. Unfortunately, this clause opens up more questions than the parliamentary secretary has been able to provide answers to. The more this debate has gone on, the more I am convinced that we are not going to get it right by voting tonight—even on our amendment to 16 years, which the member for Armadale said we have arrived at without any major enthusiasm. I know that the bill has had wide consultation and the vast majority of the sector wants to see a whole range of reforms in this bill passed. The parliamentary secretary should not get me wrong: the opposition does not want to hold up this bill at all. However, at the end of the day, members in this place make the decisions and we are the ones who get criticised, many a time, for the decisions we make. Indeed, in a whole range of factors, when people are not happy with the law or acts of Parliament such as this, they look to members of Parliament as the decision-makers. Therefore, what the opposition is doing tonight is very much what its job is in this place—that is, to scrutinise legislation and policy of the government of the day.

Mr P.B. WATSON: I am enjoying the contribution of the member for Mandurah and I would like to hear more of what he is saying.

Mr D.A. TEMPLEMAN: It is our role to scrutinise legislation, and no convincing argument has been put tonight as to why 14 years is the magic number or, indeed, why 16, as the opposition is proposing, is the magic number, except that we do it with no great enthusiasm but with a great deal of concern about the age of 14. The parliamentary secretary has not come in here, either during the second reading speech or in her answers to this clause, and said she has a list of countries and she can highlight where they sit in this matter; for example, in Denmark, the age is X; in the United Kingdom, this is the case and these are the figures behind it; and in the United States, this is what occurs in the general context of how this is seen. Of course, there will be debate among the experts for and against this therapy, but we do not have something that says that this clause has come from the sorts of things that were created through whatever the parliamentary secretary mentioned earlier and the government has come to this decision through professional evidence-based treatment that is backed up in these countries in the world and has arrived at this age and these are some statistics that sit amongst that. What honestly worries me and may even be the elephant in the room is that by defining an age group, an opportunity is being created. Please, I am not attacking the profession, but an opportunity is being created for the really, really tough cases that may face us now and into the future if we have this increasing prevalence of depression amongst young people and the compounding impact that depression may have on their lives. They may get to a stage when they need to be saved, but what I do not want is that because we put in legislation a minimum age of 14 years, it somehow becomes a fallback position.

Dr A.D. Buti: Legitimacy.

Mr D.A. TEMPLEMAN: To give it legitimacy. I do not want to be part of that, quite frankly, because it worries me.

Mr J.H.D. Day: Therefore, should there be no age limit in the bill?

Mr D.A. TEMPLEMAN: I would prefer, Leader of the House, to err on the side of caution and go with the higher level. I would prefer, quite frankly, to go higher because of this worry. We are proposing 16 years of age, but I have a major problem with 14 years old. Fourteen years of age is still a kid; 14 is a child, and there are a whole range of things going on in that child's life. I think the member for Warnbro made a very important point: one of the most vulnerable kids members will ever see in their lives is a child in the care of the state. I am a former Minister for Child Protection, and I have to tell members that some of the cases I have seen as minister for that portfolio made me not sleep at night.

Mr P.B. WATSON: I am really enjoying the member for Mandurah's conversation. Can we continue?

Mr D.A. TEMPLEMAN: I consider that to be one of the most difficult portfolios anyone can have in government, and the minister is ultimately the guardian, through the chief executive officer of the Department for Child Protection and Family Support. When I first became minister, I can remember being driven back and forth to Mandurah sometimes late at night, and with a driver we have a chance to do a lot of reading on the way. After about two or three months in the job the one thing I did not do was read files on the way home on kids in care and kids who were vulnerable or kids who were being abused and the circumstances. I did not do it. I could not do it in the end. In the end, I would never read files like that going home because when I got home, I would be thinking about that kid's safety. I used to read some horrific files about some horrific stuff that happens to kids. We all know the stories. The last thing I wanted to do is go to bed having just read a story about the horrific abuse or horrific circumstances that kids in Western Australia are suffering. That happens every day and every night; we know there are kids tonight who are not safe, despite the fact that they may be under the care of the CEO. That is where my concern comes from.

Let us look at children in care, for example. By law, those children are under care until their adult life—18 years of age. That is the legal age, yet through the government's proposal in this clause—the government is indicating it is not going to support the amendment to at least lift the age to 16 years—we are sanctioning 14 years as the age at which we will allow a child to be a recipient of this form of therapy after certain processes have been completed, if deemed necessary. I plead with the members opposite who have been here—I plead with them—not to file into this place, if we go to a division on this clause tonight, and just sit on this side and oppose us. Think consciously about the argument we have been putting; even the Liberal Party's member for Eyre has indicated his uneasiness. We do not have enough information at the moment to make that decision. I appeal to the Leader of the House. I wish the health minister was here because on a couple of occasions when we have made what I think have been good points, he has sensibly said, "Look, I think we should defer this", or, "We should adjourn this so that we can come back after thinking about this."

Mr J.H.D. Day: If I thought there had not been a higher level of professional advice—clinical advice—from experienced psychiatrists and clinicians involved in this issue, I would agree with you. But I have confidence that that input has been provided over a long time with a lot of consultation.

Mr P.B. Watson: Have you read the reports?

Mr J.H.D. Day: No; I have confidence in the professionals who have been involved.

Mr P.B. Watson: It's a big call, minister—a big call—14-year-olds.

Mr D.A. TEMPLEMAN: I appeal to some of the newer members, perhaps, in this place who in their inaugural speeches talked about a whole range of important matters, including the fact that they were so-called independent thinkers and capable of looking at an issue on its merit without toeing the government line. I appeal to them. The member for Ocean Reef said that in his inaugural speech, but he is going to follow what he has been told by his leader because he does not have the guts to think about what the debate has been tonight. That is what he should be doing. But he will not do it, and the Leader of the House will not simply allow us to defer this to think about it. I think it is ridiculous, and I appeal to members opposite to think about what they will do if we divide.

Dr A.D. BUTI: The Leader of the House interjected during the considered and passionate contribution of the member for Mandurah, and said he would postpone the debate if he was not confident that the government had consulted and taken advice. There is a difference in the scientific world between consulting and taking advice, and basing a decision on empirical evidence; in the end, when consulting and taking advice, that advice is taken from people with a subjective viewpoint. It is quite clear that the psychiatry world is divided on electroconvulsive therapy, as is articulated by N. McLaren in the letter we would have all received, I assume—I do not know whether it is a he or a she. N. McLaren said that in their time in Western Australia they came across people who used ECT as a matter of course and others who did not use it at all. Just taking advice not based on evidence is concerning. It would be like taking advice from a lawyer who has not looked at the statute books or common law precedents; it is a subjective view. I may have a view of certain legal principles that are more of a subjective view than the black letter of the law. As demonstrated by the literature review I quoted tonight, no consensus exists about the benefits or otherwise of ECT for anyone, let alone children. In hindsight, I think members on my side should have gone with our original decision and put an amendment that ECT should not be allowed on any children. I say that because the science is uncertain and because, as the member for Eyre said, where is the empirical evidence that it is beneficial for children? I say that because the state has not used it on children, even though it is legally able to. I say that because as the member for Warnbro has articulated, the kids who are most vulnerable are those wards of the state who are in detention. The state has a terrible record as a parent. It does not matter who is in government, the state is not a good parent. I had never thought about this until the member for Warnbro raised the matter, but I am concerned about those kids in detention. Once we include "14 years of age", it gives legitimacy; it focuses the psychiatrists' mind to the fact that Parliament has enacted legislation that states that it is legally okay to give ECT to a child of 14 or 15 years.

My son is 14 years old. I could not contemplate that my 14-year-old son could be subject to ECT. He is basically out of primary school. When we talk about allowing 14 years to be the age at which ECT can be used on kids, we are talking about kids who are entering high school. High school can bring on a lot of emotions and lead to situations when mental illness manifests itself. This clause will mean that children as young as 14 can be subject to ECT. We do not allow 14 year olds to vote, go to war, engage in consensual sex or get married, but we would allow them to be subjected to a medical procedure for which there is no consensus about the benefits for adults, let alone children. Of course, there are arguments that it is beneficial, but there are also many arguments to say it is not beneficial. Should we not be erring on the side of caution, particularly when ECT has not been used on children in Western Australia in contemporary times?

Mr D.A. TEMPLEMAN: I would like to hear further from the member for Armadale.

Dr A.D. BUTI: It has not been used on children in contemporary times in Western Australia because there is no consensus that it should be used on children. Is it not being used because psychiatrists are afraid of using it on children because they are not sure of the side effects? I am sure that must be one of the reasons. There is concern in the psychiatry world about the possible negative effects of using ECT on children.

As the member for Mandurah stated, I also plead with members of the government. Members on the government side, in the Liberal Party, have a free vote, which is one thing members on this side generally do not have, although we do on certain matters. Members of the Liberal Party have a free vote.

Mr W.J. Johnston: Ha!

Dr A.D. BUTI: Allegedly they have a free vote. That is what they say. I have been watching members on the other side, especially with my glasses on, and I detect some unease about voting for this. The member for Balcatta might smile, but was he not a principal of a high school?

Mr C.D. Hatton: No, I was not.

Dr A.D. BUTI: Primary school.

Mr C.D. Hatton: Primary.

Dr A.D. BUTI: Primary schools contain 12 to 13-year-old children who could within 12 months be subject to ECT. I would find it surprising if the member for Balcatta were comfortable with that. I am sure there are members on the government benches who are uneasy about that. The member for Eyre, who has a scientific medical background, is uneasy about it, because he knows. I am sure there are members on the other side who are uneasy about it, but out of loyalty they will vote for the 14-year-old limit. Why vote for 14 years? Why can we not as a Parliament show that we really care about this and either adjourn the matter to another day to allow the government to provide the empirical evidence or do as the member for Cannington requested, which the parliamentary secretary would not agree to, and provide us with the range of people who have provided advice, including those who did not agree with ECT? Of course, at our briefing we had a psychiatrist who was very enthusiastic about ECT. I am sure that we would not have a briefing from a psychiatrist who was not enthusiastic about ECT. We are considering an incredibly important piece of legislation.

I am heartened by the contribution of members of my side and the member for Eyre and their genuine concern about passing a clause that will give legitimacy to ECT for a 14-year-old. There is no legal prohibition against it now, but by including this permissibility of 14 years and above, the government is focusing the mind of the psychiatrists who know that they have the imprimatur of legislation that it is okay to give ECT to a 14-year-old. I cannot contemplate the thought that a 14-year-old would need to undertake ECT. I find it appalling. I am even uncomfortable with the age limit of 16 years, but at least it is not 14 years. At least 16 years of age is two years from majority and not four years from majority.

Ms A.R. MITCHELL: I respect the comments of members, but, unfortunately, they do not achieve what we set out to achieve. Members were on a very good footing for a while, having a good, honest debate. As I have said a number of times today, I would hope that members believe that the government has done its homework and research. It certainly has. I am not going to bring all of that research and homework to the chamber, but the people who were involved, including the consumers, carers and families, have done their research, particularly the experts and the psychiatrists, who have unanimously stated that 14 would be a good age group to be included in this bill.

Dr A.D. Buti: Unanimously now?

Ms S.F. McGurk: No dissent?

Ms A.R. MITCHELL: I said the ones who have been actively involved, working together, doing the research have agreed that 14 was the age group to include in this clause, and they had their reasons for that.

Mr P.B. Watson: They won't put their names to it, but we are the ones who have to pass this legislation.

The ACTING SPEAKER (Ms L.L. Baker): The parliamentary secretary has the floor.

Ms A.R. MITCHELL: That has been said a number of times and the reasons for that have been given. We could keep going forever on this because 16 years of age is the same. We have put something in there; it was an age that was agreed to by the community and by the people.

Dr A.D. Buti: It was not agreed to by the community.

Ms A.R. MITCHELL: They have had their opportunity to comment on the opposition's amendment and they have not agreed with that. The government will stick with what it stands for.

Mr D.A. TEMPLEMAN: If the parliamentary secretary thought she was going to clarify something, she has done the opposite. The opposition will debate this until the government gags this debate and tells the opposition that it will put this motion to the vote. That is how strongly the opposition feels about this. Until the parliamentary secretary presents to this place clear evidence that underpins the reasons she has arrived at 14 years of age, I believe that she and we are being negligent if we allow this clause to pass. I have to tell the parliamentary secretary again that she has not presented tonight any evidence in her answers to questions on this clause that will allay our fears as to, firstly, how she arrived at 14 as the minimum age for ECT therapy as provided in this clause or, secondly, what that is based upon. The parliamentary secretary's comment just now creates even greater fears about how that possibly may have been arrived at. That is the point the opposition is trying to make. That is why the opposition has proposed and is appealing to the parliamentary secretary and members of her side to further consider this serious matter, the implications of which are so serious. The opposition is not prepared to simply allow this clause to go to a vote without its questions being answered.

The point is that the parliamentary secretary has not answered them. I want to make sure that what we pass tonight is leading-edge legislation and world's best practice. All that the parliamentary secretary has been able to tell us is that after consultation and discussion, the government arrived at 14 years as the minimum age for ECT therapy. This is no reflection on the sector and all those people whom the government may have consulted, but I am not convinced. I am not confident at all that voting down the opposition's amendment to insert 16 as the minimum age for ECT is the right thing to do. The parliamentary secretary will then put up the clause unamended, which seeks to impose the minimum age as 14 years.

I am a bit reluctant to use this, but there are a number of Christian people in this place, many of whom have highlighted that fact as an important aspect in their approach to being members of Parliament. I do not criticise them for that—absolutely not. However, I appeal to members opposite from that perspective; in our attempt to try to get this message through, the government may move to gag the debate so that it is voted on tonight and government members may vote against this amendment proposed by the opposition. I look around at some members opposite. I have no qualms with the member for Bateman, but I ask him to genuinely consider—he has listened to the debate and he has been here and I appreciate that, and I thank the member for that—whether in all good conscious this is really the right thing to do. I do not know whether he went to the briefings or whether he read them; I will not ask him that as that would be unfair. However, I ask him to consider where this argument is coming from. There are times in this Parliament when through motions and discussions and debate we can come to an agreement. I think the agreement should be that we do not have enough information. This is a vexing question. The parliamentary secretary needs to convince us that the minimum age of 14 years for ECT therapy is the magic figure.

Dr A.D. BUTI: I am very interested in the member for Mandurah's contribution and I would like to hear more.

Mr D.A. TEMPLEMAN: I do not believe that we have been given the evidence that 14 years is the appropriate minimum age for ECT therapy. I would love the government to adjourn this debate tonight. It is 10 o'clock; let us adjourn this now without going to a vote. Let us adjourn it and give the parliamentary secretary time to talk to the Chief Psychiatrist and other people tomorrow and tell them that the opposition and some other members, including the member for Eyre, have raised a number of matters; they are not convinced about how we have arrived at 14 years of age. They are not convinced that 14 is the magic number, so we need to convince them. The minister can do this; the minister is listening to this. Minister, I am appealing to you! I mean this seriously. My understanding is that the minister said, "No, the party room has already decided—too bad." That is not good enough. Please, give us some time. Adjourn the house; use the time tomorrow morning and bring this debate on late tomorrow afternoon, if necessary, or Thursday. We have other bills that we can go on to tomorrow; the custodial legislation is in consideration in detail and the Sunset Reserve Transformation Bill is due to come on. That is all I am asking, members for Perth, Wanneroo, Churchlands, Bunbury and Belmont—who is a decent person. Let us adjourn this tonight. Let us use the time to address these concerns. The parliamentary secretary can come back and convince us. I will tell the parliamentary secretary what: if she convinces me, I will vote for it, for goodness sake. If the parliamentary secretary can come in tomorrow or whenever and say, "This is what; this is why; this is the evidence; and this is what is happening in Scandinavia, in the UK, in the United States and in the western world", I will have no argument with her. This is not a reflection on Western Australia. I want Western Australia to be leading edge. I want us to have the best legislation.

Ms A.R. Mitchell: We have.

Mr D.A. TEMPLEMAN: But the parliamentary secretary has not convinced us of that, particularly on this clause. I am appealing to the parliamentary secretary.

The member for Swan Hills is a decent person. All we are asking for is some time to convince us. In my two minutes left, I am looking at the parliamentary secretary and the Leader of the House to ask: surely that is

something that is reasonable. We are not trying to filibuster; I can honestly say that. All we want is time to be convinced. At the moment the answers we have received have actually, in my view, made us even less convinced that we are going down the right track here. It is not insurmountable for the parliamentary secretary to simply say, "Okay; we'll go away and consult." If she comes back tomorrow and says, "We've consulted with X, Y and Z and they've come back with this; they have looked at some of the things happening in the western world and other countries, even the other states of Australia, and this is why we believe 14 has to be the figure", we will be convinced.

Mr J.H.D. Day: Consultation has occurred. We can go around and around in circles about this all night, all week—that is the point. It has occurred. You might have a different point of view, I respect that, but there has been extensive consultation.

Mr D.A. TEMPLEMAN: I do not have a bone to pick with the Leader of the House either, but the fact is this is something that has been debated now for two hours.

Mr J.H.D. Day: The Minister for Mental Health—you are saying she is up there, are you?

Mr D.A. TEMPLEMAN: No; I was appealing to the camera.

Mr J.H.D. Day: She needs to be able to make the case in the public arena, I agree, and also when the debate is in the Legislative Council. The debate on this bill has a long way to go and she needs to be able to justify the argument, but in the end it comes down to a matter of judgement.

Mr D.A. TEMPLEMAN: So the Leader of the House is asking us, in good faith, to make a decision that we do not feel good about and that we do not feel confident about.

Mr P.B. WATSON: I would like to hear more from the member for Mandurah.

Mr D.A. TEMPLEMAN: The Leader of the House is asking us to do all those things and that somehow we can fix it in the other place if we are wrong. I do not think that is a good way of basing legislation and debate. I do not think that is a good way of doing things at all. Yes, the other place is a house of review, but goodness me, is it not one of our objectives to get it right here? This is where the government is formed—in this house. In my view this is where debate is the most robust and in many respects the opportunity for people to genuinely raise issues and matters of concern. Every now and then we have to take a Bex and have a good lie-down. Now is the chance to do it. Now is the chance to simply say, "Some legitimate concerns have been raised." I am asking for probably 24 hours. If the experts have the answers, and the parliamentary secretary claims that it has all been gone over and raked over and put forward, give us 24 hours so that the parliamentary secretary can come back and show us exactly why they are right. My right as a member of this place, elected by the people of my constituency, is to question legislation that comes before us on their behalf. I am not absolutely convinced that I am placed to make a decision based on the evidence, or lack of, before me on behalf of a 14-year-old kid who lives in Mandurah or that child's family. That is what I bring to this debate. I am not convinced. This discussion should not be party political. Give us 24 hours.

Mrs G.J. Godfrey: You should have gone to the briefing.

Mr D.A. TEMPLEMAN: The member for Belmont —

Mr J.H.D. Day: You're being very alarmist.

Mr D.A. TEMPLEMAN: No, we are not. What a stupid thing to say, that we are being alarmist.

Mr J.H.D. Day: Some of the debate has been alarmist.

Mr P. Papalia: You don't think it's something to be concerned about?

Mr D.A. TEMPLEMAN: I would love the Leader of the House to give an example of when we have been alarmist.

Mr J.H.D. Day: Of course we're concerned about it; it's a very serious issue. But no-one's suggesting there's going to be anything like widespread use of this particular technique. It's just a question of whether it should be allowed in very rare circumstances. That's what it's really all about. It is for the benefit of the patient.

Mr D.A. TEMPLEMAN: But the government is proposing the age of 14 as the age this type of therapy can be applied. We are quite simply saying what we believe, despite the assurances of the parliamentary secretary that the so-called experts and the community and all those consulted have arrived at the age of 14. The parliamentary secretary told us in her last little interlude that that age had been arrived at unanimously. That is the first time we heard about that tonight in all of our discussions. Again, her last answer demonstrated the very reason we should adjourn tonight. I will sit down in a moment. I ask the Leader of the House to give me an assurance that he will

stand up now and move to adjourn the house and bring the bill back on tomorrow. I would be happy to sit late tomorrow.

Mr J.H.D. Day: I'll do a deal. We'll vote on the amendment but not the final clause tonight.

Mr D.A. TEMPLEMAN: They are fighting words. The government wants to vote on the amendment to defeat it without getting the information. That is really not appropriate. Before we come back to debate this clause, I hope the minister provides empirical evidence backed up by the global perspective as to why this is the best that we can put forward for Western Australia.

Ms S.F. McGURK: I am interested in hearing the member for Mandurah.

Mr D.A. TEMPLEMAN: We would like to know the reasons why the age of 14 has been arrived at and how it relates to world's best practice and why our legislation will be most appropriate that 14 is the determined age. If the parliamentary secretary comes back to us with that information and the evidence is there in black and white, clear and researched, I think we will find it very difficult to further argue against it, but I do not believe that she has given that information. I ask the Leader of the House to reconsider and adjourn this debate. If we adjourn debate on this bill tonight, I appeal to the minister, who is listening to the debate, to give us a very clear example and explanation tomorrow or when this bill comes on for debate again why the 14 years age limit has been arrived at, what empirical evidence it is based on and where that sits in the global perspective in other like countries—in other western democracies. That is not a great deal to ask of the Minister for Mental Health. If we are then convinced that it has to be 14, and that 16 or even 18 is not appropriate, we will support it. But if the minister could indicate to the Leader of the House that that is appropriate, then I ask her and plead with her to do so. I have not been able to catch the minister's eye, but I ask the minister to please indicate to the Leader of the House that we need 24 hours; that is all we need. I am sure that the minister can get that information to us in that time, or we could bring this bill back on, on Thursday morning or afternoon, after grievances, with the information that we are asking for having been provided to us. If the minister could just indicate that to the Leader of the House, I plead with her to do so. The minister is in the Speaker's gallery and we are simply asking that she give us 24 hours to answer those questions. I am not prepared to vote in support of this legislation on behalf of the 14-year-olds who live in my community and their families, and I do not think it should go to a vote until we have those answers.

Mr P. Abetz interjected.

Mr D.A. TEMPLEMAN: What does the member mean? He should not say something stupid. He is a man who talks about principles. The member for Southern River talks about principles; well, here is an opportunity to stand on the principles of independence and free thinking. He is a Christian man and this is about powers that we are giving this state over 14-year-olds—children—children in care, children who are troubled, children who are suffering from depression and other mental health conditions, and it will be on his conscience. I am appealing to him; I am not having a go at the member for Southern River. I am saying to him as a member of the Liberal Party, who has espoused a number of very important values that he brings to this place, that we are simply asking to adjourn this debate so that we can get the information.

The minister is now moving from the Speaker's gallery and she is leaving. I am disappointed, minister; that is a disappointment. Surely she could have indicated to the Leader of the House that we would adjourn. I appeal one last time: adjourn the house tonight, go and get the answers to those questions, present them to us as soon as possible, and we will debate this clause and vote on it. But if the government does not, then be it on its head, because I think that is very poor decision-making. If the parliamentary secretary wants to become a minister, here is her chance to show her guts.

Dr A.D. BUTI: That was an incredibly moving contribution by the member for Mandurah, who spoke from the heart. I am very disappointed in the response by the Leader of the House, who I actually have great respect and admiration for. He offered us the deal to vote on our amendment but not on the substantive clause. To me, that just smells of a political decision. He will not give us any leeway; he does not want to be seen to be giving us a slight win. So we are to vote on our amendment, even though we do not have the evidence that electroconvulsive therapy is good for kids. We will then go away, we will find out the evidence, come back, present it to the government, and then we will vote on the substantive clause. That is incredibly disappointing on the part of the Leader of the House. He is actually one of the few ministers on the other side who I think can hold his head up high since the formation of the Barnett government, but for him to use this tactic is disappointing. He cannot deny that everyone on this side of the house who has spoken to this clause has done so with compassion and genuine concern.

The parliamentary secretary said that she got us a deal where we will vote on our amendment but we will not vote on the substantive clause. All the parliamentary secretary is concerned about is ensuring that she has a

political win. That is all the parliamentary secretary has been able to do tonight. She has not been able to show us the empirical evidence that supports her clause that ECT should be utilised on a 14-year-old. As has been stated in the briefing and as has been stated tonight, 14 is an arbitrary age. We admit that our age of 16 is arbitrary also. We should have stuck to the position that we once held, namely that no child should receive ECT. But we wanted to act in good faith and show that we were not trying to engage in political pointscoring, so we have agreed to the age of 16, because at least that is closer to the age of majority than is 14. Fourteen-year-olds cannot buy cigarettes, yet the government is saying they are old enough to engage in ECT. The parliamentary secretary said there is a unanimous view that ECT is possibly beneficial to 14-year-olds. That is absurd. Of course that is not the unanimous view; if it is, the government has cherry-picked the advisers from whom it has sought advice. If there is any empirical evidence, it certainly would not be unanimous. The only person who has provided any empirical evidence tonight is my good self. I do not have the document now, because Hansard wanted the article that I referred to. I am the only one who has referred to a scientific article about a literature review that stated that, if anything, there is only minimal benefit from ECT treatment, and that was on adults. The parliamentary secretary has brought this bill to the house and is asking us to vote on it, but she had not provided any empirical evidence to support her view. The response from the parliamentary secretary is that we will vote on our amendment, but we will not vote on the government's amendment, because the government can go away and ensure that it gets the empirical evidence. The Leader of the House might be more confident than he should be. I think he will be battling to find the empirical evidence that will provide sufficient support to convince this house that for ECT on 14-year-olds—even on 16-year-olds—the benefits outweigh the possible negatives.

The fact remains that under the current Mental Health Act, ECT is permissible on children of any age in Western Australia. However, it has not been utilised. That can tell us only that the psychiatry world is concerned about using ECT on children. I have been incredibly impressed with the member for Eyre's contribution. But the member for Southern River has just lobbed into a very passionate and considered response by the member for Mandurah and made a glib statement. The member for Southern River, as a Christian man, does stand on principle and on the sanctity of the family. He should not think that ECT treatment for a 14-year-old would not have serious consequences for a family situation.

Adjournment of Debate

MR J.H.D. DAY (Kalamunda — Leader of the House) [10.23 pm]: Mr Speaker, having had a discussion with the member for Mandurah, I move —

That the debate be adjourned.

Question put and passed.

House adjourned at 10.23 pm