

**MENTAL HEALTH BILL 2013**  
**MENTAL HEALTH LEGISLATION AMENDMENT BILL 2013**

*Second Reading — Cognate Debate*

Resumed from 25 February.

**MS S.F. McGURK (Fremantle)** [10.22 am]: I welcome the opportunity to speak this morning about the rewrite of the Mental Health Act in debating the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. There would not be many Western Australians who have not been affected by mental illness in some way at some time. Whether they have experienced it themselves through depression or some sort of mental illness or whether it was through family, friends, neighbours or a work colleague, most people at some stage are likely to come up against this issue. In turn, people also begin to experience how this state treats and cares for people with mental illness. The effective treatment of mental illness can occur, but very often care is centred around management of the condition.

I will read from the July 2012 review by Professor Bryant Stokes which was particularly into the admission —

**The ACTING SPEAKER (Ms J.M. Freeman)**: Order, members! There is a low murmur at the front and back of the chamber. It was going on throughout the CCC committee report. Members might want to move on and give the attention to the member for Fremantle.

**Ms S.F. McGURK**: They should pay attention, Madam Acting Speaker!

I am referring to Professor Stokes' review entitled "Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia". In the executive summary, Professor Stokes makes the point —

... it is important to acknowledge that the all-pervasive and multifaceted nature of psychiatric illness and required support and care is not the responsibility of any one person, service or agency ... Mental health treatment is one component of a broader framework to support people with mental illness. Other components, such as social support, housing and employment, each play a crucial part.

I endorse that sentiment. Any effective care in this state of people with mental illness cannot be in isolation to employment, income support and housing needs. For instance, there is real concern that the federal Liberal government's flagged review of disability support payments could actually result in people with mental illness being pushed off payments and put under more stress; in turn, exacerbating any mental health condition they experience. Of course employment is desirable but not always possible, particularly because of the labour market at any one time or because of the psychological stability of the person involved. With unemployment levels rising, a broadening of income inequality between high and low income earners, and stretched housing availability both in the public and private sectors, we can fully expect at some stage that that will be felt disproportionately by many who suffer mental illness. Without an individual having adequate housing and income, care and management of mental illness is akin to pouring water into a bucket with a hole in it. Availability and coordination of services across the board is crucial.

I join with other members on this side of the house who have taken the opportunity in this debate to make the point that the legislation and accompanying regulations around how the state manages people with mental illness is one thing, but it will mean very little if there are inadequate resources to carry out the work required. One example of poor resource allocation affecting quality of care is the case of two of my constituents, Jodi and Mark Ball. They came to see me last year after they learnt of a decision to cut Jodi's access to an occupational therapist case manager through the Living Skills program. The OTs were being moved from this outpatient service to inpatient wards at Alma Street. I refer to a letter I wrote to the minister on this point describing Jodi's condition. I said that she was very distressed to hear that the program would be ending in its current form.

**The ACTING SPEAKER**: Sorry, member for Fremantle; there is that low noise emanating from it seems from the member it was emanating from previously. Perhaps we need to give the member for Fremantle the opportunity for the parliamentary secretary to hear her speech.

**Ms S.F. McGURK**: I was speaking about Jodi Ball and how she was distressed to hear that a program that she had benefited from was ending in its current form. She spoke to me passionately about how important the program had been to her recovery. Although there has been a significant turnover in treating psychologists for Jodi, her occupational therapist has provided consistent, stable treatment and care. The supportive social nature of the Living Skills program enabled Jodi to make great strides in managing her illness. She feared that without the program her condition and that of other patients would worsen. I understand there is considerable pressure on inpatient wards. However, this program particularly equips patients with the skills needed to live in the

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community while receiving treatment. This decision therefore strikes me as incredibly short-sighted. It is likely to exacerbate the very issues it was taken meant to address. Without adequate outpatient support, admissions to mental health wards will increase. Jodi was joined by her husband, Mark, who echoed those concerns. He said that the consistent work that had been provided by the OTs through the Living Skills program had meant his role as primary carer for Jodi had been made possible. I am happy to say that I contacted the Balls this week to see how things were going. In fact that program has not yet been cut nor, therefore, her availability to OT. I welcome that. However, she is not sure whether it will continue into the future, and that uncertainty is not useful for a patient in Jodie's condition. This is just one story about the removal of resources and the effect it can have on an individual's management and condition. I am sure there are many more.

One area I want to speak about on the effective treatment and care of mental health patients is the coordination of services and the involvement of patients' families and carers in that treatment. Members might remember the tragic death in 2012 of highly respected academics Gavin Mooney and Del Watson, former residents in the electorate of Fremantle. Professor Mooney and Ms Watson had moved to Tasmania, and in the course of trying to manage their son and stepson's schizophrenia were murdered in their home. Their son was charged with those murders. Members might also have read the reports in *The West Australian* in which the accused's siblings described their frustration at a number of points. Firstly, there was absent or, at best, poor communication between Fremantle Hospital Alma Street Centre clinic—the WA treating facility—and the Tasmanian health authorities after the patient had moved with his parents to Tasmania. This led to the difficulty that the young man was not taking his medication, and delays in addressing that problem resulted in the most tragic of outcomes. They also expressed the frustration that family members were not included to the extent that would have been of great benefit to this man's treatment plan. In this case the patient's brother, who he says was perhaps the person closest to the patient, was sidelined by treating professionals, and the treatment was deficient as a result. They also made the point in *The West Australian* articles that some very good suggestions from the family for the method of taking antipsychotic medication were ignored, and that these suggestions may have overcome some of the many difficulties in stabilising this particular patient.

I understand that there are privacy considerations in the treatment of a patient when it involves, in this case, the family, and that regard must be given to the right of patients to determine their own course of treatment. I appreciate that the tension in balancing these considerations is central in effective lawmaking in the area of mental health care. However, the journey of those close to the patient—often family or close friends—can be one of incredible confusion and frustration. If they could be included in regular communication with treating professionals, it is likely that treatment plans could be improved and the day-to-day behaviour by the patient might be better managed by those around the patient. The Stokes review that I referred to earlier states that a common theme among carers is that they are not involved in the planning of risk, care and, importantly, the discharge of patients.

I give credit to Carmelo Amalfi of the *Fremantle Herald*, who has done some very thorough reporting on this issue. He drew out these points in his reporting of a number of suicides that occurred soon after discharge from Alma Street clinic in Fremantle. The quote from the Stokes review is repeated in some of Carmelo Amalfi's reports, and states —

Carer involvement is essential, especially in life-threatening situations, and is to be fostered at every opportunity. The sanctity of patient confidentiality should not be used as a reason for not communicating with carers in these situations.

The review also identified a lack of training and education for carers on the patient's condition as well as the signs of relapse and triggers that may cause a relapse. However, in many people's experiences of the WA health system, communication with carers is piecemeal, crisis driven and uncoordinated—as I said, often with tragic results.

Another example of the frustration of family members in the care and coordination of mental health patients comes from the case of an Alma Street patient, Ruby Nicholls-Diver. Ruby had been diagnosed with borderline personality disorder, and in 2011 had attempted to take her own life while she was in Alma Street but was discharged the following day, even though her father, Geoff, was interstate for work. Hours later, the 18-year-old took her own life. Geoff Diver's passionate and consistent advocacy was borne out of frustration of the circumstances of his daughter's death. As result of this case, as well as another four cases involving patients who have taken their own life after being discharged from Alma Street, the internal review by the Chief Psychiatrist, Rowan Davidson, was commissioned. That report, as members might know, called for wide-ranging changes to the hospital's treatment of mental health patients.

The number of suicides of patients soon after being discharged from Alma Street will be the matter of a full public inquiry by the State Coroner. The coroner will examine the circumstances of the deaths of five Alma Street patients: Ruby Nicholls-Diver, to whom I referred; Carly Elliott; Michael Thomas; Anthony Edwards; and

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Stephen Robson. However, other deaths of patients occurred around that time in 2011 that will not be included in that inquiry, much to their family's chagrin. I refer to the deaths of Clayton Robinson, Neil Marcial and Kim Smee. In the case of Neil Marcial, the family had very similar frustrations about the communication with the family about the condition of the patient and the circumstances of the patient's discharge. I will quote from an article on Neil Marcial in the *Fremantle Herald* of January 2013 —

Booked in for a referral, he was advised to contact Fremantle hospital's triage if any issues arose in the meantime.

Mr Marcial did contact triage trying to get help, but when Alma Street tried to call him back, his phone rang out. So they sent him a letter.

Neil Marcial's sister is quoted as saying, "Why did they not call the family?" If the clinic had called the family, she said that Neil would still be alive. The circumstances of that death will not be included in the public inquiry that I referred to earlier. I refer to another death of a mother of four children, Erin Berg, who took her life in 2008 in Mexico and who was in Alma Street's care when she flew out of Perth. In that case, Ms Berg had been allowed by the Mental Health Review Board to be discharged from hospital against the wishes of her treating doctor and her family, and despite staff discovering a suicide plan. Each one of these cases is tragic, but I raise them again because I wonder whether we can expect to learn from the premature deaths of these patients who were in the care of the state's mental health system. There is also an inquiry into 10 suicides that have occurred at Graylands Hospital since 2007 soon after the patients were discharged. The question is: can the government say that it has undertaken a thorough rewrite of the Mental Health Act when this bill is being debated before either of those open inquiries has been completed; that is, the open inquiries into the five Alma Street Centre deaths and the 10 deaths at Graylands Hospital?

This week the Minister for Health spoke about some changes to some emergency facilities that will be allocated specifically to mental health patients. Although those changes are welcome, the decision by this government to close Fremantle Hospital emergency department when Fiona Stanley Hospital comes online, whenever that will be, is not welcome. But the decision to close Fremantle emergency department is of concern. Although the Alma Street clinic is alongside Fremantle emergency, the clinic has triage available, as I understand it, only from 8.00 am to 8.00 pm.

[Member's time extended.]

**Ms S.F. McGURK:** There is a concern that Fremantle emergency department deals with a number of mental health patients after-hours and that when that department is closed, I believe mental health patients in the area will be worse off.

**Dr K.D. Hames:** Of course, it wasn't our decision; it was your decision.

**Ms S.F. McGURK:** I was going to say that the government will no doubt come back and talk about the Reid review, but I remind the house that Labor promised to keep an emergency facility in Fremantle.

**Dr K.D. Hames:** No, it didn't.

**Ms S.F. McGURK:** As part of its last election promise, it was very clear to the people in the Fremantle electorate. That was one of many stark differences between the Labor and Liberal commitments to Fremantle in the lead-up to the last state election.

**Dr K.D. Hames** interjected.

**The ACTING SPEAKER (Ms J.M. Freeman):** Minister, the member is not taking interjections from you.

**Ms S.F. McGURK:** No, I am not taking the Minister for Health's interjections; thank you.

**Dr K.D. Hames:** If we say we are not taking interjections —

**The ACTING SPEAKER:** Minister!

**Dr K.D. Hames** interjected.

**Ms S.F. McGURK:** There are a number of points in relation to this bill that —

**The ACTING SPEAKER:** Excuse me, member for Fremantle. Minister, if you have a problem with my ruling, you have a right to move a dissension motion. But if you want to question my ruling from the chair, I will call you. Thank you, minister.

**Dr K.D. Hames:** Thank you; I will wait until you are back in your seat.

**The ACTING SPEAKER:** So close.

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**Ms S.F. McGURK:** We were fortunate enough to be given a briefing by the Mental Health Law Centre about a number of concerns it has with these bills. Although it says that it is a significant step forward from the current act, it still has a range of concerns. I take this opportunity to put them on record.

The first is that a medical practitioner without a psychiatric qualification can work as a psychiatrist for any function under the act, including the Chief Psychiatrist and a Mental Health Tribunal member. That is a real concern, and the Mental Health Law Centre made the point to us that it had challenged the number of people without adequate qualifications working in the system. Those challenges had fallen on deaf ears until the matter was taken, I think, to the State Administrative Tribunal. Those concerns were upheld, and there was a need to tighten up the number of people working as treating practitioners as a result of those decisions.

The Mental Health Law Centre has also questioned the need for the expansion of the scope of criteria for involuntary detention and involuntary treatment. It questioned the loss of a patient's right to elect to have a legal practitioner represent them at tribunal reviews. It is concerned at the complete lack of independent oversight of the referral process; that was fairly central to its concerns. It asks what the point is of having a legislative process if no-one enforces it.

The Mental Health Law Centre pointed to the lack of an express requirement for anyone, including a referrer—a maker of an involuntary treatment order or treating psychiatrist—to consult the patient's choice of mental health practitioner outside the service. In fact, that point was raised in the 2008 case of the mother who ended up suiciding in Mexico. I think it was her treating psychologist who gave evidence that her advice was not sought or sufficiently considered by the review practice when there was no objection to her leaving the country.

The Mental Health Law Centre also pointed to the unfettered powers of the Chief Psychiatrist to delegate his or her powers; there are concerns about the unfettered nature in both the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. It is concerned about the new powers of non-psychiatrists to detain and treat, without consent, patients in general hospitals. It stated that there are very few sanctions for breaches of the bills by mental health services staff. Although I clearly say that the vast majority of mental health services staff are committed, very patient driven and work hard in what I am sure are very challenging circumstances, the point of the bills is that there needs to be sanctions. If there are restrictions in the bills about their activity, there need to be sanctions for breaches of components of those bills. However, there are an increased number of criminal sanctions against patients in the bills.

It was pointed out in that briefing that the fines and penalties for wilful neglect of a patient contained in the bills—the fines and penalties are up to \$15 000 and two years' imprisonment—are actually much less than those for the mistreatment of an animal, which is up to \$50 000 and five years' imprisonment. Similarly, the criminal threshold for mistreating an involuntary patient is actually lower and less well described than for harming animals. I look forward to hearing what the government says about that comparison of the penalties for the mistreatment of an involuntary patient or a patient under these bills.

Finally, there is no clear feedback system for complaints to generate an improved standard of care. Perhaps the new Mental Health Commissioner will take the opportunity to address that. However, obviously within the bills we need to look at what the opportunities are for, firstly, clinical care and administrative management of the system to be separated as best practice dictates; and, secondly, how we can continually improve what is clearly a very challenging environment to work within.

I look forward to the further examination of those issues during consideration in detail and future explanation by the government. That concludes my comments on the bills, and I look forward to examining some of those questions in detail.

**MS J. FARRER (Kimberley)** [10.48 am]: I also rise to speak on the second reading of the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013, and to outline my serious apprehensions about the bills before us. Mental health in the Kimberley is a major concern of mine. As I have stated many times before, the Kimberley, shockingly, has one of the highest rates of suicide in the world. Suicide and self-inflicted injuries are the second highest cause of avoidable mortality for males, as reported in 2007. Suicide and mental health issues are among the biggest issues in my electorate, and they affect young mothers, fathers and children. I recently went back to Halls Creek for the Christmas holidays, and in the lead-up to the Christmas period and in January there were five suicides in the Kimberley. Of the five, two were from my home town, Halls Creek, and the youngest was a 12-year-old boy who took his life on 11 January.

I have grave concerns about these bills and how they will affect remote communities in the Kimberley. I would like to congratulate the member for Eyre who gave a speech referring to himself in the first person in a situation regarding mental health and how it affects a mental health patient. It was a wonderful way to express that situation. A number of contributing factors influence someone's mental health. In the Kimberley, I often see

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people in isolated and very remote communities who are a long way from some of the services that we normally take for granted at hospitals with general practitioners, nurses and the like. In the communities that I visit I am always being told to be careful when I am talking to particular people, because often little things will set them off. It could be the colour of the clothes that people wear, vehicle sounds or many other loud noises that come alive in a small community when people congregate around the community store to buy food or the offices that provide essential services, such as Centrelink, the Department of Aboriginal Affairs, the banks and so on. There is a lot of noise, even in a small community. People have said to me that some people with a mental illness are affected by this noise, and they have told me what they would like to see happen.

**The ACTING SPEAKER (Ms J.M. Freeman):** Members, the member for Kimberley has a soft voice and Hansard needs to be able to hear her, and I ask that background noise be kept to a minimum.

**Ms J. FARRER:** Some of the people in those communities have told me what they would like to see in their communities. Some communities may have three or four people who are affected by mental illness, and each one has been affected very differently. As I said, some sounds will trigger a person's illness, and sometimes it is something that we do. It is often very hard for these people to see health professionals, because they live in an isolated community, and health professionals usually visit an established hospital such as Halls Creek Hospital. A mental health patient can be referred to a health professional at this hospital, but if they are not listed as a referred person and they live in an isolated area, there is no support for them.

Some people have asked me why their community cannot have quiet houses that are isolated from most residences in the community in an area that is set aside, where it is quiet and they are not faced with all the noises or with interaction with community members. That was one way in which they felt they could deal with some people who have a mental illness. This is the way that some families have been able to deal with their family members. However, because of the way houses are built and the overcrowding in some houses, some of those remote communities need some houses built in a quiet location. They believe this would solve some of the issues resulting from overcrowding, such as young people playing stereos or TVs loudly. These are some of the sounds and noises that trigger people who have a mental illness.

If someone with a mental illness needs to see a health professional, they are usually taken to a hospital many kilometres away, and often they wake up disoriented when they arrive at the hospital. This confusion is sometimes attributed to chemical restraints that are used on people. Sometimes when a person with a mental illness goes off and the family is not able to control them, the family rings their nearest hospital—if they have a phone—for example, Halls Creek Hospital. The family may be in a community that is 200 kilometres away and does not have an Aboriginal health worker living there or access to a nurse; the only people who live and work in the community are the teachers at the school and maybe the storekeeper. They are about the only people, apart from the Indigenous people, who live in the community. Members must remember that for a lot of the Indigenous people who have these problems—I do not know much about non-Indigenous people with a mental illness—it is sometimes very hard for them because they do not have access to a phone, so they have to go to the school to ring the hospital which is 100, 200 or 300 kilometres away. Someone in the community will ring and say that they have someone who is going off and they may ask for a nurse or the doctor to come out. The GP will then get in touch with the police and the police will come out, because that is the only way they can deal with that person. They take the person to a hospital and use whatever is necessary to sedate them, and sometimes, when people wake up, they are very angry.

I would like the minister to consider setting up some quiet houses for these people. It is important that facilities are located near the person's community and country. This will help keep people on their own country, because up there we are confined to our geographic boundaries and different language groups. This is very strong amongst Aboriginal people up there. If there were quiet houses in their own country, the families could deal with people with a mental illness. We talk about confidentiality as part of health issues, but for Indigenous people the families would like to know how or where they can support their family member. In a lot of these issues, a person with a mental illness will see a practising GP, but sometimes the psychiatrist we have in the Kimberley is the only person who can deal with the issue so he gets to see a lot of clients from right around the Kimberley. He is stretched too far and overworked.

I would like to tell members a story about Jodie, a young girl from Halls Creek. Jodie is an adult who suffers with mental illness and, as a result, she often has extreme mood swings. Her mum died giving birth to her and her dad raised her, but he had a problem of his own and he passed on. Jodie was placed with a number of families in that community, and because some of those families are in need of respite care themselves from looking after people with mental illness, Jodie was sent to Halls Creek, which has no facilities to hold people like Jodie, so they put Jodie in the frail-age home. However, because of Jodie's condition and the problems that affected her sometimes she would have very bad mood swings. I was approached by her carer because her carer

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did not know what to do with her, as there were no facilities to look after somebody with that sort of condition in a frail-age home. Jodie had a mood swing and became violent and attacked some of the elderly people living in the facility and Jodie was told that she had two hours to get out of the frail-age home that she was in; however, there was no place for Jodie to go. Her carer rang me and asked if there was any way I could support Jodie. I suggested they get in touch with the regional manager or director for disability services who is based in Kununurra. Jodie's carer did that and the end result was that Jodie and her carer were placed in a hotel. Jodie was given a room and her carer was given another room, and they stayed in that hotel for a few days before they could find an appropriate place to put Jodie. The end result was that Jodie was sent to Warmun, which is in another direction going towards Kununurra. Jodie was taken out of Jaru country, her own environment and the people she was familiar with, and sent in another direction. She had already been put in the frail-age home in Warmun, which is 165 kilometres to the north of Halls Creek. I have not followed Jodie's situation since then.

Mental health services are stretched in the Kimberley. We have been faced with this problem for a long time and something has to be done. We have only one psychiatrist in the Kimberley who can assess patients, and if someone is lucky, they get to see this psychiatrist once a fortnight; that is, if their name is on the list. It is concerning that the definition of a "psychiatrist" has been redefined in the bill to include a medical practitioner without a psychiatric qualification for any function under the act. This even extends to the Chief Psychiatrist and members of the Mental Health Tribunal. Furthermore, the minimum standard for a psychiatric practitioner will be a doctor or somebody from overseas with related qualifications and experience. This means that these practitioners are able to assess patients without being fellows of the Royal Australian and New Zealand College of Psychiatrists. Some locum general practitioners in our hospitals have no understanding of how to deal with people with this sort of illness or how to deal with those from an Indigenous culture who have English as their fourth or seventh language. We find that very hard. We are lucky in the Kimberley to have the Kimberley Interpreting Service, which was set up by Indigenous people. Its staff help break down the language barriers between GPs and their patients and family members. I fear that instead of increasing the frequency of seeing a psychiatrist, this bill will decrease the quality of care and assessment that patients will receive due to the little training and understanding of some practitioners.

Some voluntary and involuntary patients, particularly those who are detained, need legal advice and representation. Some of these people do not know how to defend themselves when they do not receive the service that they should be getting. There have been quite a few cases of misrepresentation. Under the Mental Health Act, it is not always suggested that patients need a lawyer, unless they lack the capacity to decide what is in their best interests. Arguably, the act implies an express right to legal advice for, and representation of, patients at the Mental Health Review Board. The bill before us concerns me because that implied right to legal representation will no longer exist. Rather, the bill provides permission to be represented by a lawyer. In the Kimberley, as in many electorates, people with mental health issues are predominately from lower socioeconomic regions and cannot afford legal representation. Legal Aid and the Aboriginal Legal Service of Western Australia are already stretched, understaffed and under-resourced. The Aboriginal Legal Service is not funded well enough to take on a lot of cases, so Legal Aid must take them on. People from non-English speaking backgrounds already feel that they are not well represented, which is why they use interpreters from the interpreting service. The interpreters help to bridge the gap between the many languages in the Kimberley. However, it too is underfunded and under-resourced. I cannot stress enough the great value these services provide.

All too often I see Kimberley constituents charged and sent to Perth without any knowledge of what is going on. That was the case with Graham—I am not talking about the member for Eyre! Graham was charged with assault and spent six months in a Perth prison. His case is concerning because his mental illness was not considered or acknowledged during his sentencing.

Another concern is the lack of regulations on the use of chemical restraints. Although the bill has some restrictions on physical restraints, there are none in place for chemical restraints. One of the oversights of the bill is that it does not account for the distances travelled in the Kimberley. Chemical restraints need to be regulated to ensure that those who have to travel long distances across the Kimberley or, alternatively, fly to Perth, do not suffer. If chemical restraints were better regulated, the likelihood of harm due to chemical restraints would be less likely. Chemical restraints were used on a patient who was flown from the Kimberley to Perth and admitted to Graylands Hospital. All we know is that she died at Graylands. Families do not hear about what happens. We talk about families healing, because that sort of thing leads to the mental breakdown of other family members, but the healing process can begin only when families are told what has happened to their family member. Many parents in the Kimberley do not fully understand their rights as it is and they feel as though they are in the dark when it comes to their child's health.

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[Member's time extended.]

**Ms J. FARRER:** Another concern is that under this bill there are two situations out of three in which children can have electroconvulsive therapy without family consultation. Voluntary or involuntary patients as young as 14 years can consent to ECT without reference to their parent or a responsible person with the approval of the Mental Health Tribunal. That will be hard for a lot of people in the Kimberley because, as I said before, many of them come from non-English speaking backgrounds. I just cannot understand how 14-year-olds can voluntarily agree to ECT without the consent of their parents or a family member. It is a dark area for many Indigenous people who come from that background. Unless interpreters are with patients and their families, they will not understand what a person will be subjected to when they voluntarily submit to ECT. Questions need to be asked about whether children should have access to this controversial treatment.

I urge the government to reconsider the elements of this bill that disproportionately affect people in the Kimberley. People in the Kimberley find it hard to understand the medical jargon used by GPs when they describe medication or outline what needs to be done. It is very important for family members to know how to treat people and what sort of medication they should be on. Sometimes people drink alcohol when they take medication, and the combination of the two can have a cocktail effect on them.

**MRS M.H. ROBERTS (Midland)** [11.07 am]: At the outset, I support the intent of the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013 and much of what has been presented to Parliament. Nevertheless, I have some reservations about some aspects of the bill—namely, electroconvulsive therapy and psychosurgery on minors. I will refer to the clauses of the bill that are of concern to me. Clause 192 outlines the definition of “ECT”, and reads —

**Electroconvulsive therapy (ECT): meaning**

Electroconvulsive therapy is treatment involving the application of electric current to specific areas of a person's head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent.

I note that the penalty for an ECT offence, which is a breach of sections 194 to 199, is a fine of \$15 000 or two years' imprisonment. Clearly, ECT is considered a significant procedure if a breach of the rules governing it warrants two years' imprisonment.

Clause 205 defines psychosurgery, and states —

Psychosurgery is treatment involving —

- (a) the use of a surgical technique or procedure or intracerebral electrodes to create in a person's brain a lesion intended (whether alone or in combination with one or more other lesions created at the same or other times) to alter permanently —
  - (i) the person's thoughts or emotions; or
  - (ii) the person's behaviour other than behaviour secondary to a paroxysmal cerebral dysrhythmia;

or

- (b) the use of intracerebral electrodes to stimulate a person's brain without creating a lesion with the intention that the stimulation (whether alone or in combination with other such stimulation at the same or other times) will influence or alter temporarily —
  - (i) the person's thoughts or emotions; or
  - (ii) the person's behaviour other than behaviour secondary to a paroxysmal cerebral dysrhythmia.

Clause 206 outlines the offence, and states —

A person must not perform psychosurgery on another person except in accordance with sections 207 and 208.

Penalty: imprisonment for 5 years.

Let us not be in any doubt that we are dealing with a very serious procedure. I will talk in more detail about both electroconvulsive therapy and psychosurgery. As I have explained, ECT is the application of an electric shock in a controlled environment in order to achieve a clinical improvement in a patient's condition. It cannot be performed on adults without their informed consent. The bill goes to some trouble to set out what informed consent might look like and the circumstances in which informed consent might not be possible. Psychosurgery,

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according to the definition, is physical intervention in the brain using needles to either stimulate or cauterise part of the neural cortex. Both these procedures are personally invasive, although they may, in certain circumstances, have beneficial clinical outcomes. What concerns me is the application of these procedures to children. The legislation requires that informed consent be given before these procedures can be undertaken on anyone. The Commissioner for Children and Young People, in response to an earlier draft of the legislation, wrote a submission to the Medical Health Commission, which I quote —

Although the Draft Mental Health Bill 2011 contains a separate Part dealing with children; there is no guidance in regard to how ‘capacity to consent’ is to be determined in regard to children and young people with a mental illness and who is to determine whether a child or young person with a mental illness has sufficient maturity and understanding to make reasonable decisions about matters relating to himself or herself. For children and young people in the mental health system there are two aspects to the question of capacity: age-related capacity issues and mental health-related capacity issues. In other words, a child or young person’s capacity to consent will be dependent on their general maturity and development as well as on the impact of their particular mental illness at the relevant time.

The legislation provides quite an oddity here. The application of ECT is banned on children under the age of 14 years; it is completely banned under that age. Fourteen-year-olds cannot be deemed competent to give informed consent on other matters, most notably sexual intercourse. Fourteen years seems an extraordinary age to be deemed capable of giving informed consent, when a 14-year-old cannot give consent to other matters such as sexual intercourse. There is no consistency in the application of the law here. Division 1 is not consistent with division 3, which deals with psychosurgery, as the age of informed consent for psychosurgery is deemed to be 16 years of age. Why is there an inconsistency? Why is the age of consent 14 years for ECT, yet it is 16 years for psychosurgery? Why is a person competent at 15 years to decide to have ECT, but not competent to decide to have psychosurgery? This is a very clear inconsistency. Indeed, why is there an inherent assumption that a minor of any age is genuinely capable of informed consent? This is inconsistent with threshold ages in other legislation. For example, the Young Offenders Act 1994 stipulates that 17 years is the age of independence; the Western Australia Criminal Code stipulates that 16 years is the age of consent for sexual interactions; and a driver’s licence cannot be awarded to someone under the age of 17 years. There may well be minors who are intellectually and emotionally mature enough to make such decisions, and some of them might find themselves in the unfortunate position comprehended by the legislation, but the law is not made for exceptions; laws are made for the rule.

On occasions when young people may find themselves in this situation, how can we be assured that consent from someone of that age is a properly informed consent? A good safeguard to ensure that consent is not contaminated by pressure from authorities is to return the right of consent to those to whom it belongs—parents and guardians. The member for Kimberley commented that people in Aboriginal communities cannot understand how this consent can be taken away from parents. I say to the member for Kimberley that I do not think this is just restricted to Aboriginal communities; I do not understand it either. I do not understand how a child of mine would be able to consent in those circumstances, and I expect that most people in the community would find it difficult to imagine that someone of only 15 years of age could consent to ECT of their own volition, especially when we consider that, in order to contemplate ECT as a solution, the person clearly has to have mental health issues. My personal view is that it would be better if we were to follow the recommendation of the Commissioner for Children and Young People and ban the application of these therapies altogether for people under the age of 18 years. There are many practitioners—psychiatrists—that do not engage in these procedures at all. I would urge a very cautious approach here; and caution would say that these therapies should not be used on people under the age of 18 years.

In either of these ways, the appalling gradation suggested between division 1 and division 3 can be wiped out either by the expediency of giving responsible adults the right to informed consent or, as the Commissioner for Children and Young People has recommended, not to use ECT or psychosurgery on minors at all. At first glance, these provisions seem both unreasonable and contradictory and when examined further the situation does not improve. I think most members of the community, if I am any judge, would be most concerned to discover that children can be deemed competent to give informed consent to such invasive procedures that can have a permanent impact. Given the sensitivity of this matter—that it is sanctioning the application of invasive therapies to children, and the lack of any rationale for the practices outlined and why they need to be made available to children of that age—I believe that most people in the community if properly informed about this would be most apprehensive. I do not think any proper rationale has been given for why there is one age for electroconvulsive therapy and another age for psychosurgery. They are both very invasive procedures. I do not comprehend why parents’ consent is not required. I do not think there has been a strong argument for the absolute necessity for these procedures to be performed on people under the age of 18. I have very grave reservations about the provisions in this legislation. At the very least, the community is owed a proper explanation for the significant

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inconsistencies in the two respective ages that I have outlined and the inconsistencies between the ages of consent for these procedures and various other ages of consent and ages of so-called maturity as defined in other legislation.

I have read out the definitions of these procedures. The definitions sound pretty scary to me; they sound awful. I cannot imagine a circumstance in which I would consent to that kind of surgery, particularly for children under the age of 18. I do not think the case has been made. It is most concerning that these procedures can be authorised by authorities to be performed on children without their parents' consent. I look for some explanation from the Minister for Health about how he has contemplated these matters, why different ages are listed in the bill and, indeed, why the comments of the Commissioner for Children and Young People in her submission to an earlier draft of the bill were not taken into account in this regard. I would be interested to know also what input the general community has had and what level of awareness there is of this in the general community. In a circumstance such as this, clearly the medical fraternity is properly informed and it makes recommendations to government, but most people in the community probably would have little knowledge of these matters. They would not generally experience these issues. I expect that 95 per cent of people or more would never have to worry about these procedures, but clearly people are dealing with these issues. I can only imagine the horror that some parents might ultimately feel when they find out that it is not their responsibility if such invasive procedures are to be performed on their children.

Before I conclude, I will refer to the definition of "psychosurgery". The bill explains it. It states that it is a surgical technique and refers to intracerebral electrodes, which effectively go into someone's brain. It is used to create one or more lesions at the same or other times to alter permanently, firstly, the person's thoughts or emotions or, secondly, the person's behaviour other than behaviour secondary to a paroxysmal cerebral dysrhythmia. I am not sure exactly what that is, but I think most people in the community would take very seriously a procedure which involves someone's brain and which would permanently affect their thoughts or emotions or their behaviour. It is a very serious matter if these kinds of procedures are to be done on people under the age of 18. I find it extraordinary that a 15-year-old will be able to give so-called informed consent for ECT to be performed on them. Unless I am sadly mistaken, I think most people in the community would also find this extraordinary. I do not see the justification. I do not see the rationale. The wisest words on this topic that I have been able to find have been submitted by the Commissioner for Children and Young People. I concur with her views. I think these procedures should be available only to people over 18 years of age. However, at the very least, let us have some consistency between the age of consent for the two procedures and require the age of consent to be at least 16 years for both procedures.

**MR W.J. JOHNSTON (Cannington)** [11.25 am]: I rise to make a few remarks on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. There is no question that mental health issues are the most serious problems raised in my office. I always say that the three most common issues raised by constituents in the seat of Cannington are homelessness, mental health issues and immigration matters. Often homelessness matters come in concert with mental health problems. We as a society have been grappling for a long time with how to handle mental health issues. If we look at the way mental health was dealt with 100 years ago, we can see that basically the existence of mental health problems was denied and people were locked away in institutions to keep them out of society. That was clearly bad for a number of reasons. Firstly, out of sight was out of mind. There was no proper way of dealing with the accountabilities that are required. Those terrible institutions of the nineteenth century are frightening if people visit any of those institutions today. They are now historic monuments, but they are frightening. It really was a case of out of sight, out of mind. People were treated appallingly and there was never any chance of recovery. That meant that mental health problems were denied whenever possible and nobody would own up to the questions that arose in the area of mental health. That continued well into the twentieth century, and it was really in the 1970s and 1980s when things started to change on that front.

I do not want to personalise these things, but I will make a point about my father, who had what was called at the time war neurosis but is now called post-traumatic stress disorder arising from his service during World War II. Hundreds of thousands, and probably millions, of Australian servicemen were in the same position as my father. I do not make his case special; it is just an example of what happened. My father died when I was two years old. My mother used to tell me that when his mental health problems became acute, he would be sent to the repatriation hospital in Sydney. My family lived in country New South Wales and later in Canberra. I think Concord Repatriation General Hospital was the old veterans' hospital in Sydney. He would go on the train to Concord and be gone for a month or six weeks and then he would return. My mum, who was a nurse, had no knowledge of anything that happened to him while he was at hospital, did not know what treatment he received or what procedures, if any, were performed on him, and did not know the drugs that he was prescribed. He would return to her care with a bunch of drugs and some prescriptions to continue his treatment and a referral to

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a local veterans' affairs doctor. She had to cope with that initially on the farm with as many as six children and later in Canberra with as many as eight children. That is the way mental health problems were dealt with. There was no admission of what was involved.

My father died when I was two years old. His death was recognised as being directly caused by his war service, but the actual cause of his death was an overdose of barbiturates and alcohol. The coroner's inquiry did not make a finding of suicide or anything like that but I have no knowledge of the exact circumstances of his death, only the report of the coroner. My mum did not give me a copy of the report of the coroner until I was 18 years old, so I never knew all the details of my father's passing until I was an adult.

I am sure many other people in society have similar stories to the one that I am telling. I am not saying that I am unique; I am saying the very opposite—that I think I am like many other people in the community who have had to deal with these sorts of matters from an early age. We can see the stresses that my father was under, much like so many other people. The way the treatment was arranged was wrong. It did not work. We know it did not work because, like so many other people, it failed my father at the age of 41. That same approach to mental health care has been failing people right across the country for a long time, which is why in the 1970s, 1980s and 1990s we did start to change and deinstitutionalise mental health. We wanted to put people back into the community. That is a good thing. We do not lock away people who have appendicitis so why should we lock away people who have mental health problems? They should be dealt with as much as possible in the community. Sometimes, for the benefit of the person, there needs to be an institutional response but, generally speaking, we want to see it done in the community. That means resources need to be available. One of the criticisms that I am sure everybody in this chamber hears frequently is that the resources are not available when people have mental health problems. The resources are not there when we need them, when dealing with these issues in the community.

I would like to give an example of a constituent in my electorate. I will not name them, although people familiar with the case will probably guess the name of the family anyway. This guy is in his 40s. He has lived a full and complete life. He has travelled the world. He has been a contributor but, unfortunately, in the past 10 years his mental health state has caused some problems. The symptom of his mental health problem is that he is a hoarder. He hoards car bodies in his yard as well as all sorts of things in his house. I have been to his house a number of times. It is a terrible place to visit because there is almost nowhere to stand in the place. Basically, the entire house is occupied by stuff. Some of it is junk and some of it is quite valuable. Apart from his leather lounge in the front room where he lies down and a little path through to the front door, there is basically no spare space in his house. Quite frankly, it is dangerous.

One of my difficulties as a member of Parliament is that when I am talking to the Bentley mental health people, they cannot talk to me about my constituent's case because of privacy issues. They can talk to me about general issues. I am told by the mental health team at Bentley Hospital that it is common for the houses of people who are hoarders to burn down because they often have flammable materials in their house. If something goes wrong, the place just goes up and one cannot get in. Apparently, it is not uncommon for people with these sorts of troubles to die in a house fire.

My constituent's neighbours have to put up with car bodies literally falling out of the yard. Fortunately for him, he has one neighbour. By the way, he owns his house; it is not a rental property. On the other side of his house is an easement for the Water Corporation. He lives at the end of a cul-de-sac. He has a neighbour behind him and a neighbour next to him. He fronts some parkland on the other side. It is suburban but relatively isolated. It is not as if he has neighbours on every side. He is fortunate in that way. One way or another, his neighbours have to put up with this terrible circumstance. They have complained to the council. The council has served him with all the appropriate notices to clear the car bodies out of his yard, which he has failed to do. The council took him to court a couple of years ago. He got some minor fines. More recently, they took him to court and he was fined \$70 000 for breaching the orders to remove the car bodies. There are a number of issues there. He does not have \$70 000 cash because the only asset he has is his house. If the house was sold, where would he live? He would go from at least having a roof over his head to being homeless. What is more, the car bodies would still be there.

The symptoms of this man's challenges are still impacting on his neighbours. His parents are in their 70s. His mother has cancer. The stress caused by trying to assist her son is leading to problems with her cancer treatment and she is also starting to suffer from stress-induced illnesses. His father, who is well into his 70s as well, also has to put up with all these challenges. Sometimes their son threatens to suicide. Sometimes he will not come out of his house. There are severe impacts. He has a sister who is married with children. Naturally, there are all these difficult family impacts between this man and his sister and his relationship with his parents and in-laws and

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nieces and nephews. It is troubling every time I have to deal with the family, as I help them try to navigate their way through all the different procedures. It is just heartbreaking.

**Dr K.D. Hames:** Do the neighbours come to see you as well for help?

**Mr W.J. JOHNSTON:** I have talked to the neighbours, but they did not raise it with me. Obviously, they made complaints.

**Dr K.D. Hames:** Often that happens, doesn't it? That makes it even more difficult.

**Mr W.J. JOHNSTON:** That is right. I will talk about what happens at Homeswest properties. That is often the case. We have to represent everybody. We want a good outcome. Clearly, having 15 car bodies in the front yard is not a good outcome. No matter what we feel about it, that is still not a good outcome.

As to the \$70 000 owing, I went to the council and said, "How about you do not enforce the orders?" They said that the council officials could not do it because of a policy. I went and saw the commissioner because the City of Canning does not have elected councillors. He was not prepared to vary the policy of the council, so the orders were passed to the Sheriff's Office for enforcement. Fortunately, rather than enforcing the sale of the house, the Sheriff's Office has put a caveat or whatever it is on the property, so when the property is disposed of, the value of the fines will be recovered at that point. He still has a home but the underlying problems are still there. On occasion he has been to the mental health unit at Bentley Hospital. I do not know this from talking to Bentley Hospital because obviously the staff cannot talk directly to me about his problems. The family tell me that the problem is that when he goes to the Bentley mental health unit, they say that he has a personality disorder, not a mental health illness. I am no doctor or psychologist.

**Dr K.D. Hames:** There is a fine line.

**Mr W.J. JOHNSTON:** Indeed. I am not a psychiatrist. I do not know the difference between a mental health illness and a personality disorder. My understanding is that they are effectively saying he chooses to act in the way that he does.

**Dr K.D. Hames:** Even if he had a mental health disorder, say schizophrenia, you cannot override his wishes in terms of treatment unless he reaches a stage at which he is diagnosed with a severe mental illness and gets formed. Whichever it is, there is nothing you can do if he refuses treatment.

**Mr W.J. JOHNSTON:** Absolutely, minister. I am just outlining all the problems that can arise. That is why we need to make sure there are enough resources invested in mental health. I think that clearly demonstrates the need for resourcing in this area. We can pass laws but we need to ensure resourcing is available so that the resources can follow the illnesses. If that is into the community, then the resources need to go into the community. I am not for one second criticising anybody at the Bentley mental health unit—I have no reason to do so; I am not making any adverse comment about it. I am trying to outline the problems for the family and for the community when people find themselves in that situation. It is 15 months since the family first came to see me. Sometimes I go and see the gentleman and he is as lucid as the Minister for Health.

**Dr K.D. Hames:** And sometimes he is more like yourself!

**Mr W.J. JOHNSTON:** Anyway; other times he is completely despondent and it is hard to help him do things.

I will go on to the question of homelessness. Many people who come to my office experience mental illness and homelessness, and I am sure it is the same in many other representatives' suburban electorates. When there are problems in a group of Homeswest units and we look at the unsocial behaviour, often the underlying problem is mental health issues for one resident in that group of units. There might be as few as five units or as many as 21 all together, in the case of the electorate of Cannington.

[Member's time extended.]

**Mr W.J. JOHNSTON:** To get into a Homeswest property, a person has to be on a very low income. There has to be something to lead a person there—a pensioner or, if a person is of working age, there has to be some underlying problem that has prevented them from getting a job for seven years. A person has to be on the waiting list for seven years to be eligible for a home. That means a person cannot have had a job for seven years. This is one reason there has been a significant reduction in the waiting list at Homeswest: in the past, a person had to be eligible for a Homeswest property not only when they applied, but also when granted the property, but now the Department of Housing checks every year that the people on the waiting list continue to be eligible for a Homeswest property. That means if at any time while waiting for a Homeswest property a person gets a job, even if it is only part-time or temporary, they cease to be eligible for a Homeswest property and fall off the waiting list. If a person loses their job or if it is only temporary, even though their circumstances have not

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improved, they are no longer on the waiting list and they have to reapply. That is just a comment about the way it works.

So, we end up with a group of units, whether it is five or nine—I imagine that most members in the chamber at the minute would have the same type of properties in their electorates—in which only one person has a mental health problem. If there is some crisis in that person's treatment, all those people in the Homeswest units end up having a problem. We know the sorts of things that happen, from very low level baiting of neighbours up to some major crisis. Of course, non-Homeswest neighbours often end up suffering from the issues involved. It is even worse for people who are not in a Homeswest unit and also have a mental health problem. Again, I imagine in many other electorates like Cannington, people come in who have mental health challenges that lead to them being unable, unwilling or compromised in dealing with bureaucracy. When they visit an agency, they do not understand why they have to fill in a form with Homeswest, a form with Centrelink and a form with somebody else; they think it should all be done together. They are probably right, but it is not. I always say to people, "If you're looking for justice, you have to wait until the afterlife; we're just dealing with the world that we have." All we can do is help people through the staggers of trying to get what they need out of bureaucracy. That is our job as members of Parliament. Sometimes a person's problems lead them to "blow up" with the Homeswest officer at the desk. The employee at Homeswest is entitled to work in a safe environment. I am not forgiving anything like that, but I am saying that if I can understand why the person has the problem, maybe we can find another way to help them through that process.

I dealt with a guy who had no documents to prove his identity. I notice the Deputy Speaker is nodding; I imagine it would be a real issue in Kalgoorlie. This particular gentleman was from Queensland. It took us at least eight or nine weeks, if not longer, to get a birth certificate for him. One of the amusing things was that the Department of Justice and Attorney-General in Queensland said that if he got a statutory declaration to explain what had happened, it would send his birth certificate. He brought the stat dec in to me, I signed it and sent it off. The Attorney-General's department wrote back to him and said that because I had signed the stat dec as a member of Parliament and not as a justice of the peace, it was not valid. But of course in Western Australia it is valid and because the stat dec had been signed in WA, it meant it was a valid declaration. I wrote to the Attorney-General in Queensland pointing this out and he wrote back to apologise. Of course, that was another delay. A person with underlying problems does not want to have to deal with those sorts of things. These are the sorts of problems that each of us have every day in the sort of working-class areas that I and so many others here represent. There is absolutely no question of a connection between homelessness and mental health problems. In my office, I see these two issues presenting together a lot.

I will move on to another issue: the question of the primacy of families. I am actually surprised about the Liberal government's decision to allow children to elect different categories of surgery without their families being involved. Given all the rhetoric of the Liberal Party about the primacy of families, I am astounded that it would come in here, undermining that clear primacy. I do not understand the reasoning behind the Liberal Party not wanting to put families first. That is what I thought would happen, given everything it said when in opposition. It is extraordinary that we would allow children to consent to permanent surgery without their families being involved. If the parliamentary secretary wants to outline the reasoning behind excluding the family's involvement in this matter, I will give careful interest to her commentary. I listened very keenly to the member for Midland's contribution to the debate and I agreed with what she said. Surely it would not be that hard to include a provision that there had to be some procedure like a court order or whatever, which I imagine could quite easily be dealt with. It is not as though a child with a mental health problem would go to psychosurgery instantaneously. There would be a process and I imagine the process would take quite some time. I imagine that it would take perhaps a year or so between the start of the process and the surgery. Nobody's brain would be permanently changed or given electro-shock treatment on a whim. It would have to be for a serious condition. I ask the parliamentary secretary: why would we not include such a provision in the legislation? I can imagine specific circumstances and unusual cases in which family consent would not be possible—a homeless person or a person estranged from their family; there might be many specific exceptions. However, given that they will be specific exceptions rather than the rule, why not build in a provision for family consent or a court order? Then at least society and the community would know that things were not being done on a whim and that they were being done for a proper reason. If I were a mental health practitioner—I am not—that is a provision I would welcome so that there would be no question of impropriety. To get things done, there would be family consent or an independent process. In that way, if there were an independent process, there could never be any allegation of improper conduct because it would be done through an impartial separate procedure. It seems to me that if I were a mental health practitioner, I would want that rather than what appears on the surface of the bill. I am happy to later hear from the minister. If I am not present in the chamber when he responds, I will certainly keenly read his words.

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I want to finish on the final comment about the involvement of police in mental health matters. Sadly, police end up being on the front line in most mental health matters in my electorate. I am sure it is the same in other working areas of Perth. They are the ones who get the call when something goes wrong. I really admire the fact that the police do that work. As you know, Madam Deputy Speaker, my wife is an old Kalgoorlie girl, and I imagine that is also the story in the electorate of Kalgoorlie. We have to admire the police for the way they handle most of these cases. As I say, it is usually the police on the front line rather than health professionals. It is therefore appropriate that the bill deals with the powers of police.

I was not in the chamber to hear my learned colleague the member for Armadale's contribution to the debate, but I have had the advantage of having conversations with him and I note the comments he has made. I have read through some briefing notes he provided to me about the importance of protecting police from accusations of doing the wrong thing. Making sure that police are properly protected is very important. We do not want the police worrying that they will be held to the wrong standards. Equally, having proper standards is part of protecting police. It will be a big help to police to have proper standards and procedures in place that allow them to know what to do when they are confronted on the front line. Police powers are very important. It is very important that we clarify them. As I said, they are on the front line most of the time, not health professionals. We therefore need to make sure that they have proper guidance from the community about what is expected of them and what their rights and responsibilities are, because in that way there will be fewer opportunities for people to complain about any outcome. It is very important that we protect our police in that way.

My final comment is that the history of complex legislation is that we usually do not get it right. There is usually some part of it that needs to be looked at again. I do not think that it is humanly possible to write a bill of this complexity and get it 100 per cent right the first time. It is therefore very important for the government to accept commentary from all sources in the community about how this bill will work as an act. It is important that the bill be open to review and amendment based on experience. That is because we cannot get legislation like this right the first time. It is not a criticism; it is just a statement of fact. I will be interested to see how the government responds to this legislation over the longer time.

**MR B.S. WYATT (Victoria Park)** [11.54 am]: I rise to also make some comments on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. They are being dealt with cognately but of course the Mental Health Bill 2013 is the principal bill. The member for Armadale, as the opposition's lead speaker, outlined in quite significant detail the opposition's position on this bill; that is, the opposition will be supporting this legislation. We will move a number of amendments, which have been outlined by the member for Armadale already, and hope that the government comes to the debate in good faith. We are not intending to make any particular issue beyond simply stating our belief in the way the legislation can be improved in the interests of people who suffer a mental illness.

Mental health is one of those areas on which I feel hopelessly and inadequately prepared to speak, simply because I am not an expert in the mental health field. However, in the eight years I have been a member of Parliament, mental health issues have dominated the time in my electorate office. The member for Cannington outlined some similar issues that he has experienced. During my time as a member of Parliament, I have of course on a daily basis had to deal with people who have significant mental health issues. Having experience of the facilities at the Bentley mental health service, which now adjoins the member for Cannington's electorate, and of support organisations such as the Richmond Fellowship of Western Australia, I have become significantly more aware and concerned by mental health issues suffered by my constituents. Often I find that the mental health issue presents itself in other ways, as the member for Cannington outlined—for example, complaints about the behaviour of people in properties, and not just in Homeswest properties. I am reminded of a similar issue to the one the member for Cannington outlined about the hoarder in a property in his electorate. There was a similar issue in my electorate about a house that was privately owned by the constituent—it was not a Homeswest property. She had a significant hoarding issue that ultimately presented itself to me by way of complaints from neighbours.

Some issues have been raised by the member for Armadale about that and I hope to get to them during my presentation this morning. Similarly with comorbidity issues, such as people suffering from a mental illness who may also be alcoholics, they may be abusing alcohol or drugs and that exacerbates those mental health problems, which then present themselves quite dramatically in our electorates. Often the consequences of those issues are left for the police to deal with. It is perhaps one of the more significant issues in my electorate and I dare say that most members of Parliament spend a lot of their time dealing with issues that are the result of mental health problems.

The main aim of the 2013 bill is outlined in clause 10. Clause 10(1)(a) reads —

to ensure people who have a mental illness are provided the best possible treatment and care —

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- (i) with the least possible restriction of their freedom; and
- (ii) with the least possible interference with their rights; and
- (iii) with respect for their dignity;

I think the debate around mental health over the last decade has very much focused on the rights of consumers of mental health services—that is, the people who suffer from a mental illness. The member for Armadale certainly outlined that fact.

The member for Midland dealt with some issues, but I also want to put on the record my views on some of the clauses on policing—not all of them—contained in the legislation. I want to thank a couple of organisations. One of course is the Health Consumers' Council WA. I assume all members received an email from our former parliamentary colleague Martin Whitely, who has been very active in this space for a long period. Another organisation I want to thank is the Mental Health Law Centre (WA).

The first point I want to address is in respect of the involuntary patient issue. I guess that first came to my awareness through the activities of the former member for Bassendean, Martin Whitely in the case of Maryanne Connor. That case is very relevant to clause 25 of the Mental Health Bill 2013, which deals with the criteria to be utilised in allowing someone to be admitted as an involuntary patient. As recorded in *Hansard*, the then member for Bassendean, Martin Whitely, stated —

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

I recall the then member for Bassendean speaking passionately on that point. Clause 25 of the Mental Health Bill 2013 does, on first appearance, seek to narrow the basis upon which a patient can be made an involuntary patient. The 1996 legislation gives five criteria, being safety, property, finances, relationship, and reputation. As the member for Armadale outlined in some detail that I will not repeat in its entirety, the criteria have been, at first instance, reduced to two, being “safety” and “unspecified serious harm”. It is that term “unspecified serious harm” that we do not need to be lawyers to rapidly recognise, on first consideration, is very, very broad. Page 14 of the explanatory memorandum in respect of serious harm reads —

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

The reason we focus in this space, and generally in the health space, so much on the rights of the consumer—that is, the patient or the person suffering the mental health illness—is that the power balance between the patient and the doctor is so dramatic. Unless someone is an expert in mental health, they are utterly reliant on the advice they receive from that psychiatrist, and a large responsibility is placed on those medical experts. Similarly, it is our responsibility in this place to ensure that the rights of those consumers and people suffering from mental health illness are indeed protected. The member for Armadale made the point—I think he was correct—that despite this legislation reducing the criteria from five to two, we are actually perhaps broadening the criteria upon which a person can be made an involuntary patient. Again as outlined by the member for Armadale, the submission of the Mental Health Law Centre to the minister expressed those concerns and stated that in its view it actually does arguably broaden the criteria and will result in more people coming under the jurisdiction. It is obviously in that case not necessarily a clinical decision, but a factual or social decision. The 1996 act specifies what constitutes serious harm, but the bill before us does not. I understand that we want to place a lot of that decision-making discretion in the hands of psychiatrists—people qualified to make decisions around a mental illness when one is presented before them—but it does seem to also contradict the commitments made by the minister on 6PR radio on 25 May 2012. The minister said that she would be removing “damage to reputation” as one of the criteria upon which someone can be made an involuntary patient, but the explanatory memorandum goes on specifically to state that “damage to reputation” can be one such criterion.

Another of the points made by the member for Armadale that I wanted to re-emphasise was the issue around when a person unreasonably refuses treatment. Ultimately, the question and the concern from the opposition is: who makes that decision about whether a person suffering from a mental illness is unreasonably refusing treatment? Clause 25(2)(ii) deals with that issue. Page 3 of the Mental Health Law Centre’s submission in respect of the Mental Health Act 1996 reads —

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

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

The submission of the Mental Health Law Centre further reads —

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

I think all members of this place should have some concern about that. The member for Armadale very articulately outlined that the person who makes the decision around the mental illness of a particular patient also makes the decision about whether their refusal of treatment is reasonable. It seems to me that that leaves us, members, open to the potential breach of rights of a person suffering from a mental illness. The member for Cannington outlined obliquely some of those concerns as well. As the member for Cannington pointed out, because people are not going to rapidly progress to, for example, ECT treatment, there will be a process and time will pass when there should be an independent or separate person who makes that decision about the reasonableness or unreasonableness of somebody who refuses treatment. Ultimately, as the aims of the act state, this is all very much about the rights of the mental health consumer. I strongly endorse the comments of the member for Armadale on this issue surrounding who gets to decide when somebody is reasonably or unreasonably refusing treatment for a mental illness.

I also want to make some comments around informed consent and treatment. Perhaps because I and the member for Armadale have legal backgrounds, we tend to focus on things like this. The member for Armadale made the point that the Mental Health Bill 2013 is unusual for the Parliament because we are changing, effectively, the mental health system. Normally, legislation comes before us that deals with particular aspects of a part of public policy; this is a very comprehensive, sweeping piece of legislation that has gone through a number of iterations and forms over the last number of years. The 2011 draft of this bill imposed very important disclosure requirements upon psychiatrists, including the requirement to disclose any financial advantages that could be gained by the medical practitioner—I know the member for Kingsley has had this put to her before, and no doubt she will deal with it in her response—so why has that been removed from this bill? Why have we removed those issues around disclosure by a treating psychiatrist regarding whether they may or may not have a financial interest in the treatment that will be given to a particular mental health consumer? The member for Armadale outlined this, but I also want to quote the submission from Martin Whitely at the Health Consumers' Council, which reads —

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

The member for Armadale is right that it is somewhat odd that the 2011 draft bill had these requirements that have since been removed, because there has certainly not been a political push-back from members in this place or members in the broader community about requiring doctors to disclose that information. The member for Kingsley might be able to let us know why. Maybe there was some discontent from the Australian Medical Association, although I doubt it because the AMA recognises the importance of disclosure and the issue of informed consent, and no psychiatrist would object to this issue of disclosure of any financial interest they may have in treatment.

I move on to perhaps the most controversial component of the legislation—that is, psychosurgery and electroconvulsive therapy for children. I want to thank a very good friend of mine whom I went to school with, Dr Andrew Jackson, who is and has been for some time a psychiatrist in the ECT area. He has certainly been very useful in providing me, a non-doctor, with information from his perspective about ECT. ECT is not new; it has been around a long time. The controversy in this bill is its application to children and the age at which psychosurgery and ECT can be given as treatment to children. The member for Armadale has already outlined

very well the issues that the opposition has, particularly around psychosurgery. It is the opposition's view that that treatment should not be available to people under the age of 18. The legislation initially had 14 years but has increased that to 16 years, which is a useful change to the original form of the bill.

[Member's time extended.]

**Mr B.S. WYATT:** However, it is the opposition's view that this form of treatment should not be applied to children, simply because of the dramatic and lifelong impacts if health professionals get this treatment wrong. That is something I hope the member for Kingsley can deal with in her response, and perhaps the government is willing to engage with the opposition in its proposed amendments around the age of treatment. Similarly, the bill prohibits the use of electroconvulsive therapy on children under the age 14. The member for Armadale has outlined some of the opposition's concerns about increasing the age to 16 years, but I will let the member for Armadale deal with that when we get to consideration in detail.

One other point, which I have already touched on, is the idea of an independent body making a decision about whether it is reasonable for somebody to refuse treatment. A similar issue applies with a parental veto. I dare say that any parent faced with a situation in which their child suffers from a mental illness and has to have some very invasive treatment believes they should have a right to veto certain treatment of their children. It is my personal belief and, I think, the belief more broadly of the opposition, that parents should have a right to veto certain treatment of their children. Of course, there will always have to be a caveat in this space, and I understand the difficulty in drafting something along these lines and dealing with something as difficult as this because sometimes a parent may not act reasonably in the care of their children, particularly around something as emotional and dramatic as mental illness. The member for Armadale has pointed out that such decisions should be made by an independent body and not by the treating psychiatrist of that child. I emphasise again that it is the opposition's view that psychosurgery should not be carried out on children at all.

The member for Armadale outlined some issues around the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* that I do not intend to now revisit, because the member has outlined his concerns very well. However, I found the member for Armadale's discussions with Allen Frances, who chaired the DSM-4 task force very interesting. In his critique of DSM-5, Mr Frances made the point that, effectively, we all went to bed one night only to wake up the next morning with a mental health issue as a result of a significantly broader application of a mental health illness being outlined in the DSM-5.

I would like to raise one other point. This follows on some thoughts that the member for West Swan and I discussed after we had the pleasure of meeting with Logan Howlett, the Mayor of the City of Cockburn, and Mick McCarthy, who is the director of South West Group. We had an interesting discussion about the potential for planning to impact on mental health. I raise this point because we read in the newspapers and we discuss what happens because our society is moving at such a pace and to such a place that it is increasing the incidence of mental illness. The member for West Swan and I reflected with Logan Howlett and Mick McCarthy on how we design apartment living, not only in Perth, but also around Australia. When we look around the city, we see very tall apartment complexes and over time more and more people will move into that style of accommodation, which is very much designed to isolate people from each other. The member for West Swan made a very good point that the only common place in many of these buildings is the gym, and we see other people in the gym, as opposed to perhaps the traditional European style that is designed around communities and a common space. I spent some time living in London, which has commons, and Mediterranean countries have piazzas, which are areas designed to bring people together. Perhaps we need to have a think about town planning and how we build places in which people live that can have an impact on bringing people together, as opposed to deliberately ensuring that we live in isolation from each other, even though we may live very close to each other. I am reminded of the late 1990s when I was living in the suburb of Leichhardt in Sydney, where a very Italian-style development was built. The 30 or 40 apartments on probably four or five floors all focused in on a piazza, which had restaurants et cetera. It was an incredible place to visit—I did not live there—and it attracted people because of the commercial and common activities there. I emphasise that I am not an expert in mental health, but it struck me, the member for West Swan, Logan Howlett and Mick McCarthy from South West Group that perhaps there is something in the way we live our lives that is causing us to isolate ourselves from each other despite living so close to each other. I wanted to take the opportunity, in debate on the Mental Health Bill, to raise that very interesting conversation.

The member for Armadale has outlined the opposition's view on this bill. We support the legislation and will move a number of amendments, and we hope to convince the government of the merit of those amendments.

I conclude on one final point: Aboriginal mental health and suicide rates in the Kimberley. The member for Kimberley has addressed this issue. I have regular correspondence with Wes Morris at the Kimberley Aboriginal Law and Culture Centre. Wes focuses very much on the suicide rates of young Aboriginal people in the

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Kimberley. He focuses very much on the importance of culture and the arts and language in fighting the scourge of suicide in the Kimberley, which the coroner determined years ago, and as all of us in this chamber know, is at epidemic proportions. It is the view of Wes and the Kimberley Aboriginal Law and Cultural Centre, and it is an accurate view, that culture and language have an important role to play in ensuring that Aboriginal people are mentally healthy. It is good that the Minister for Culture and the Arts is now here, because I will emphasise a number of emails that were sent to him from Wes over the past few months about a number of culturally based programs that KALACC has run that have been successful, in KALACC's view, in dealing with Aboriginal mental health. I refer to the motion of 13 November last year, which reads —

That this house expresses its concern about the tragic suicide crisis in the Kimberley and calls on governments to do more to address the issue and notes the state government's efforts in addressing this issue.

That motion was passed unanimously. KALACC and Wes have made a number of suggestions and although they acknowledge the work of this and other governments in this area, there is still more to be done. The suicide rate in the Kimberley is something that every member here acknowledges with some guilt, because people look to this place to resolve and address those issues. We simply cannot ignore those issues and hope that they will go away or that the suicide rate will decline, without concerted action from this place and the government of the day. With those few words, I will wind up. I look forward to the consideration in detail stage.

**MS R. SAFFIOTI (West Swan)** [12.24 pm]: I will make some brief comments on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013 because my colleague the member for Mirrabooka also wants to contribute to the debate. I will not go over the issues raised by other members, particularly the member for Armadale, who set out very clearly Labor's position on this issue. I will talk more generally about mental health, the policy area of mental health and the challenges it presents to policymakers across the state.

Having watched and participated in public policy and having developed policies over a number of years, mental health policy is one of the most challenging areas for government to get right. The issues of mental health are presenting in all our institutions in very different ways, but we have yet to get it right. It is a very challenging thing. As the member for Cannington said, members of Parliament are often confronted with situations in which we would like to help, but we do not believe that we have the vehicles to provide the assistance that is required.

The first area I will touch on is our hospitals and their interaction with presentations at emergency departments. I have heard about and personally dealt with a number of cases in which young people have presented at an emergency department. In particular, one young person was given no assistance or support at a hospital, nor was he given the assistance or support in the community that would have allowed him to be in a safe environment. The young man was in his 20s. As a result of a drug addiction, he had a psychotic episode and presented at a hospital. His family had to keep him in their car to keep him safe. They took him to a hostel for travellers because they thought it would be a safe place. We do not have arrangements in place to support our young people, in particular. It is a very confronting and difficult time for parents when their children are going through a difficult time in their lives and they cannot get assistance or help to support them.

A lot of the recent budget cuts that have impacted our schools will reduce the ability of schools to deal with one of the most difficult issues confronting principals and teachers on a daily basis. There is no doubt that some of the mental health issues that present in people from different types of families are much greater than they used to be. I am not a psychologist, nor a psychiatrist. I do not have an explanation of why we have created a less caring and more isolated community that, in turn, has created problems for a number of people living in Western Australia. As a result, our schools, principals and teachers are simply not equipped to deal with some of the issues they face day to day. Some of the recent budget cuts have reduced the ability of schools to provide the support that is required to address the problems that present in children. That will present difficulties in not only our children's education, but also their lives in years to come.

Our hospital system is not geared up to deal with mental health issues and we are not investing enough time and resources to identify the best method to deal with people who present with a significant mental illness at our hospitals. We hear anecdotal stories about people who have suffered a severe psychotic episode and find themselves sitting in a hospital waiting room with people who have broken their arm or their leg. That is not the right environment for people who have a mental illness. We need to have the right number of beds in the right situations to serve and help these people.

The Minister for Health referred to Sir Charles Gairdner Hospital yesterday. Even he acknowledged that many hospitals are not equipped to deal with people who suffer from significant mental health issues when they present at hospitals. That causes enormous stress on not only those individuals and their families, but also the public health system and the hospital system itself. It also presents significant challenges for the staff who work

in hospitals as they try to manage some of the cases that present. It is a policy and an area of government that is completely underdone. People have been grappling with it, but one of the first things we need to look at is our hospital system, because people are presenting with problems but they are not being fixed. There are a number of issues about people not presenting and of communities not identifying people who need support. When people present with mental health issues and they request support because they need support, surely that is the first area we should address. We must help those people because they are on our doorstep asking for help. I do not think our public health system or our health system in general is geared up for that.

There are a number of issues with those who suffer from mental health issues that are hidden from us for whatever reason, but we are not actually helping those who are presenting. That is a major problem that we need to examine. As I said, it is better to deal with people who present with significant mental health issues in our hospitals, because that will help not only those people and their families, but also the hospital itself. It will help staff and other patients and it will probably reduce the waiting time and result in the better running of hospitals. That is one policy area that is completely underdone. We need to develop better policies and put them into practice.

I now turn to the matter of schools and adolescent mental health. I might not be a psychologist, but I have close family members who are psychologists and specialise in child and adolescent psychology. They deal with many issues on a daily basis, including the impacts on the ability of children to participate in school and in the wider community. I do not think we can ask schools to provide all the support, but we need resources in schools to allow them to provide some support and work with other non-government organisations and the community sector as a whole. The government's school resource cuts are reducing schools' ability to assist children and adolescents who are experiencing significant issues.

We have heard about the issue of youth suicide in the Kimberley, which is absolutely tragic. A number of people are dying on a weekly or monthly basis. It is an issue that does not get enough attention. I am glad that the member for Kimberley is in this house to shine a spotlight on a serious problem. I do not want to be too political about this, but I think greater effort could be made in some of these areas with the hundreds of millions of dollars in the royalties for regions fund. Hundreds of millions of dollars are allocated through the royalties for regions program each year. If we cannot use some of that significant amount of money to assist young people and give them some sort of path in life, what are we spending it on? Every time members opposite talk about particular projects and I hear the member for Kimberley mention the number of young people in the Kimberley who have taken their lives over the previous few months or years, I seriously question what we are doing as a state. If National Party members say that they believe in regional WA, what are they doing? The money is sitting there. They could provide better support and better paths for young people.

**Dr A.D. Buti:** It is interesting that you mention the National Party. I do not think one of them has spoken on this bill. They keep going on about the problems with mental illness in rural areas, which is a major problem, but none of them has found it interesting or important enough to comment on the bill.

**Ms R. SAFFIOTI:** That is a very interesting point, member for Armadale. We hear quite a bit about some of the issues that people are facing throughout the wheatbelt.

The last couple of points I want to make are about where we are heading as a community. I am glad that the member for Victoria Park raised the issue of planning. Planning policies are creating a community in which people do not want to help each other. Planning is an interesting portfolio on a number of fronts. One of the key points is that planning matters affect much of how we live and what we do. I do not think the way that our suburbs are being developed is contributing positively to our community and to how well off—not financially, but more holistically—and content we are as a community.

Someone from a European background told me that he lives in an apartment but he does not see anybody else who lives in the complex because the security is quite strict. People who live on the fifth level can get to only the fifth level. People might see someone in the gym, but if they are working out in the gym, it is not really the place to sit around and have a chat. This man lives in an apartment but he does not know anybody who lives in the complex. Although we believe we are building homes close to each other, we are creating other barriers that do not help people to interact. I support infill, but we have to ensure that community spaces are created so that people can work and live alongside each other. The classic example that we talk about all the time is the European way of living in apartments or narrow town houses, but they normally face onto an open space or piazza where children can play together and there is some sense of community.

One of the interesting things that are happening, especially in the newer housing developments, is the construction of cottage blocks. The front door of a house on a cottage block is pretty much on the street and people access the garage at the back of the block. I have talked to a lot of people who live in that type of housing

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and they say that they never see anybody. People who live in the suburbs used to see their neighbours when they got in their car or took out the rubbish, but in this situation, people drive into their garage, the door shuts, they walk into the kitchen through the internal door and that is pretty much it. The sense of isolation is increasing, even though people might live closer to each other. That is quite extraordinary. We need to continually reassess and improve in the area of planning. It is a difficult area. The government cannot just say that everyone will live in a particular way. The government needs to be a bit more imaginative and show more innovation, and it needs to work with the private sector to create developments in which people can feel there is some sense of community.

We are reducing the amount of active open space. We are not creating community halls or community places for people to be with each other because it costs too much or it is too difficult. We are reducing the number of places where people can interact. Although that might not be the only reason that there seem to be greater issues in the mental health area, the types and amount of drugs on the market are key factors. All the experts tell me that although there were drugs out there 20 or 30 years ago, the impact that the types of drugs have on people's mental health today is very different and presents itself in a more violent and extreme way. That is another key issue. The way that we plan our suburbs is not contributing to a sense of community or a sense of belonging. Because people live very busy lives, they do not get a chance to connect to other people in the community. It is an area that I am getting more and more passionate about, frankly. I think the Labor Party will take to the next election some very good policies, not just slogans, on better planning to create better communities. We need to create communities that people want to live in and safer environments for everyone, but they also need to give people a sense of belonging and a sense of community.

**MS J.M. FREEMAN (Mirrabooka)** [12.38 pm]: I, too, rise to contribute to the debate on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. I would like to commend the government on giving this issue priority. However, as we all know, prevention is better than cure. If we really want to consider preventive health, the Health Act needs to be changed. The Health Act is a very old act; it no longer deals with contemporary issues. It still deals with how sewage is picked up from the back of a person's house at night and rats in a person's house, but it does not deal with preventive health. I mentioned in my speech on the Premier's Statement that, despite this, the City of Wanneroo has released a community health plan, which was funded by the federal government, that goes into some of the issues around mental health and preventive mental health. In addition to this bill, which is welcomed and obviously needed, I look forward to the government introducing changes to the Health Act 1911 so that many of the issues relating to preventive health that have been raised here today can be dealt with.

As I said, this bill is welcome but it must be predicated on the underlying philosophy that the intent is patient focused. We canvassed debate about patient-focused legislation extensively in the poisons legislation that was introduced to this house by the Minister for Health. That seemed to take a punitive response to the overuse of prescription drugs, which many of us also know may be the result of mental health issues. It is very important when we look at a bill such as this that we succinctly establish the emphasis of the bill. I think that has been done very well in the clause of the bill setting out the objects. I notice that its purpose is outlined in the title. That is a good thing. Many of the bills that come before us do not have that. It is always good to be really clear about the intent of a bill. After listening to the speakers in this place, it is clear that the intent of this Parliament in this debate is to ensure that this bill is patient focused. By that, I mean it must ensure that as a legislative framework, it guarantees that the most vulnerable—those suffering the effects of a mental illness, in particular the very extreme effects of a mental illness—are not mistreated by any of those who are afforded powers under this bill. We need to ensure during consideration in detail of this bill that those most vulnerable are not mistreated by those who are afforded powers under this bill. We see how that occurs in our contemporary society and the ramifications of how the most vulnerable in our community are treated poorly by those who are powerful. We have seen from the federal royal commission how vulnerable people are preyed upon. These people, who come under this bill as a result of being involuntarily detained, are vulnerable. They need to be assured that they cannot and will not be mistreated. Part and parcel of that is that we cannot legislate for good behaviour; we can make sure it happens only by putting in systems. People know of my workers' compensation background. Systems ensure good behaviour. We cannot necessarily legislate for it. For that to occur, we need to seriously consider how we put those systems in place in our mental health institutions. We may need to consider installing closed-circuit television cameras to ensure that those systems are in place. Therefore, when someone makes a complaint against someone who wields powers given to them under this bill, that person cannot simply be discarded or not given proper scrutiny without seeing the CCTV footage. I am not suggesting this should be monitored by those health professionals who are wielding this power; I think it can be accessed by the Chief Mental Health Advocate.

I would like to thank my colleagues for their considered contributions to this debate, in particular those members who told personal stories. That is always important in these debates. I would like to particularly recognise

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someone who has not had an opportunity to participate because she is sick—that is, the member for Maylands. She was very disappointed that she could not participate in this debate. I wanted to put that on the record.

It is interesting that we have often heard the concept of rights being discussed in this debate—that is, protecting patients' rights and the particular circumstances in which rights to personal freedom can be extinguished. It is always difficult having a discussion about rights in Western Australia because we do not have a basic human rights bill. On that basis, when talking about rights and personal freedom in any context, I would also like to put on record the fact that the lack of many of the basic civil rights that people should enjoy in our community have a major impact on mental health. For me, safe and affordable housing, access to an adequate education and access to health services are basic civil rights. If they do not exist, they also have an impact on mental health.

As pointed out by various members of Parliament in their contributions, many people live with mental health issues on an ongoing basis. I understand that the provisions of this bill will never apply to many of them. Some of them will have only a one-off experience of the most serious aspects of being placed voluntarily or involuntarily into treatment and/or detention. However, one can be pretty certain that many of the people with mental health illnesses will have contact with the police. Under this bill, police have very strong powers that require caution and understanding when exercising them. However, it is my concern that there is no checking or review of the exercise of these powers. This is necessary for the protection of both patients and, in particular, those people who undertake these duties—the police. We give the police a job in which they are not allowed to be vulnerable; they have to be the strength in our community. They cannot show vulnerabilities; they have to deal with all that sort of stuff. When we are in the face of people with mental illness and all of the things that go with that aspect of mental illness, to be strong and not vulnerable when faced with this issue, we make assumptions because that is how we strengthen our own resolve and how we deal with that. When we place the police at the front line of these sorts of issues in many instances, we need to ensure that they have the training that can enable them to deal with that and also that they report so that their actions and their duties in undertaking these quite onerous tasks can be assessed. Without mandatory reporting to the Chief Mental Health Advocate and without the support of a process that can alert the community and policymakers such as ourselves of the impact on officers serving our public in difficult and confronting situations, the responsibility of the police will increase. It also ensures that abuses of such powers can be limited. I know this myself. The police youth liaison officer in Mirrabooka deals with very high level repeat offenders. Many times he has to deal with not only families with mental illnesses whose children are these high-level offenders, but also youth issues around mental illness. I had the privilege of going out with him. One of the people we visited suffered quite extreme mental illness and would not come to the door when he was there. He said that it had taken a long time to establish a relationship with this person so that he could carry out his duties. He had no particular training. He brought skills, abilities and training from Britain, but I understand that he had not been given specific training to deal with the type of mental illness that he was confronted with.

It was really interesting to note the New South Wales police announcement on Monday, 24 February that all New South Wales police will undergo mental health training. The New South Wales reports outline that 90 per cent of front-line police have never done any mental health training despite the view of Superintendent David Donohue that not a shift goes by when police in New South Wales do not have to deal with something that is related to mental health. I would appreciate it if the parliamentary secretary could avail the house of figures on mental health training for police in Western Australia. The commander of the New South Wales Police mental health intervention team, Inspector Joel Murchie, stated on the ABC —

“It’s about trying to provide police with those practical skills, so when they turn up they can make an appraisal of the incident and try and respond appropriately,” ...

I understand the draft Mental Health Bill released for public comment in 2011 required police officers to take reasonable steps to ensure that a medical practitioner or mental health practitioner was present when apprehending people suspected of having a mental illness; however, this has not been included in the current bill.

Debate adjourned, pursuant to standing orders.