MENTAL HEALTH BILL 2013

Third Reading

MS A.R. MITCHELL (Kingsley — Parliamentary Secretary) [3.13 pm]: I move —

That the bill be now read a third time.

DR A.D. BUTI (Armadale) [3.13 pm]: We finally come to the third reading stage of the Mental Health Bill 2013 after a marathon consideration in detail. The Mental Health Bill is very large; it has 585 clauses. The opposition sought to move between 50 and 60 amendments to the bill. Unfortunately, we were successful only on a few. We are very disappointed in the sense that the purpose of our amendments was to try to improve the workings of the bill and to provide the appropriate safeguards to patients. We have to remember that the fundamental and core power of the Mental Health Bill is to detain and treat people with mental illness without their consent. That is the core power of this bill. It is incredibly important that we get this legislation correct.

As I stated during the second reading debate, the Minister for Mental Health and the government should be complimented in the sense that aspects of the bill will improve the Mental Health Act that currently operates in Western Australia. However, we are concerned about a number of areas that our amendments sought to address. I would like to compliment the parliamentary secretary in the sense that she was always very courteous, to me at least anyway, in the marathon consideration in detail stage and she always sought to provide further information, but I was disappointed with the general attitude of the government, more than necessarily that of the parliamentary secretary, which was to basically oppose nearly everything we proposed. I had the view that it was because the opposition had moved the amendments. There were even occasions that amendments moved by the parliamentary secretary were surprisingly quite similar to some of the amendments the opposition moved. They were moved after the government had seen our amendments. But anyhow, the amendments moved by the government that were similar to ours have improved the bill.

The opposition is concerned about some of the amendments that the parliamentary secretary moved and which were subsequently passed. As we know, politics is all about numbers and that is why it was very difficult for us to have any of our amendments passed. Clause 28 relates to detaining a person to enable them to be admitted to an authorised hospital. In the metropolitan region, that still remains 72 hours, but it was increased to 144 hours for people outside the metropolitan area. It was very disappointing that no National Party member spoke on this bill. Many people in country or regional areas of Western Australia will be subjected to the jurisdiction of the Mental Health Bill. The amendment moved by the parliamentary secretary to increase the ability to detain a person for up to 144 hours is quite a significant interference with the rights and freedoms of regional people. Although National Party members did not speak on this bill, Labor regional members did. That aspect was very disappointing.

The opposition has major concerns about the Mental Health Bill. We had a mammoth debate over the issue of electroconvulsive therapy and psychosurgery, and our concerns still remain. If I can deviate for a second, I also would like to pass on to the parliamentary secretary my appreciation for her advisers' work. They of course had to sit for long periods at the dispatch box. I appreciate their efforts as well. Our concerns about ECT and psychosurgery remain strong. Professor Patrick McGorry, a former Australian of the Year, expressed great concern about the bill and said that there would have to be a very carefully argued case to say that anyone under 15 years of age would be able to consent to ECT treatment or psychosurgery. Professor Jon Jureidini from Flinders University, an expert on child and adolescent mental health, stated that the legislation we have debated seems to be "bizarre" and "absurd". He is reported as saying —

> "How could you be so psychologically impaired you're considered for psychosurgery yet be considered competent to give consent?"

How can a person so in need of psychosurgery have the ability or the capacity to give informed consent to psychosurgery? It does not make sense, especially for someone 16 years of age. In regard to psychosurgery, part of the definition relates to deep-brain stimulation. Deep-brain stimulation has been approved in the US by its Food and Drug Administration only for non-psychiatric conditions, not for psychiatric conditions. In addressing our concerns, the parliamentary secretary stated —

> Deep-brain stimulation has not yet been approved by the Therapeutic Goods Administration, but studies are being undertaken mainly in Victoria and we are following those. As I said, we are really futureproofing this bill for when these treatments do become available, so that if people in Western Australia so choose, they will be able to access those treatments.

Let us be clear: the state government, through this Mental Health Bill, is legislating for the approval of deep-brain stimulation for people as young as 16 years of age even though it has not been approved for psychiatric use by the US Food and Drug Administration or by the Australian Therapeutic Goods Administration. It is doing this simply on the hunch that it may be approved in the future, and that is very, very disconcerting for the citizens of Western Australia.

The opposition is incredibly disappointed about the criteria that can be used to define someone as an involuntary patient; we are concerned because the Minister for Mental Health has actually backtracked on this issue. I have referred previously to an interview between Paul Murray and the Minister for Mental Health on 6PR on 25 May 2012, during which she stated that the Mental Health Bill as it was then being drafted would significantly change the criteria by which people could be made involuntary, and would remove areas relating to damage to reputation. That may have been the case with regard to the 2011 draft of the bill, but the issue of damage to reputation as a criterion for allowing someone to be admitted as an involuntary patient has reappeared in the bill before the house today, which has already passed the second reading stage. The Minister for Mental Health has broken her commitment, but has not explained why, so we have no understanding as to why potential damage to reputation should constitute a criterion for admitting someone as an involuntary patient.

Throughout this debate the parliamentary secretary went to great lengths to reassure the house that the Mental Health Bill 2013 would make the mental health system better and that all the historical abuses that we have read and heard about were a thing of the past that we no longer needed to worry about. Of course, that may not necessarily be the case because, as we know, during the three-week parliamentary recess a coronial report into a number of suicides at Graylands Hospital was released. The government has, through the Mental Health Bill, increased the number of people who can advocate for patients. Under this legislation there is to be a Chief Mental Health Advocate and it is my understanding—the parliamentary secretary can correct me if I am wrong—that that role will replace the current Council of Official Visitors. Debora Colvin, head of the Council of Official Visitors, wrote an opinion piece in *The West Australian* on 28 April, after the release of the coronial report to which I just referred. She stated —

> At the Council of Official Visitors we regularly take complaints from involuntary patients about things such as medication side effects and boredom.
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> Patients are forced to live on a usually crowded, grotty and noisy ward, with up to 15 other people, (men and women), sharing bathrooms, meal times and TV time. They regularly witness strange behaviours, assaults and security guards restraining patients. They lose control over their money, when and what they can eat and when they can leave the ward to go outside. They have little or no say as to their treatment or when they will be discharged.

That is why I moved amendments time and again to ensure that patients could have appropriate legal representation, because in this legislation lawyers are not included in any of the lists of people who can represent patients. Of course, lawyers are mentioned in the legislation, but they are not included in the various listings of people who can represent patients. However, the Mental Health Tribunal can allow other parties, not listed, to represent patients. That means that lawyers do not have an automatic right to represent a patient, whereas a carer or a mental health advocate does. Lawyers have to be vetted through the Mental Health Tribunal. The parliamentary secretary's response to that was to say that a lawyer can represent a patient if there is an agreement between the lawyer and the patient. However, they cannot. The parliamentary secretary is effectively saying that a private agreement between two people will override the legislation, and that is obviously not true. Common law does not override legislation, so how can a private agreement between two people do so? Time and again it emerges, through the various clauses of this bill, that lawyers are to be restricted from having the ability to represent both voluntary and involuntary patients. That is an alarming outcome of this legislation.

Of course, lawyers may have a bad name and people may see them as causing more trouble than good, but I have no doubt that one of the reasons that the government has drafted this legislation in the way that it has is to restrict access to lawyers, because when lawyers are involved, there is more scrutiny of people's rights. I refer to a paper prepared by Sandra Boulter of the Mental Health Law Centre; it is very interesting. I relied quite extensively on her paper in my contribution to the second reading debate. She talks about how involuntary patients are very vulnerable to having their human and statutory rights abused and refers to former High Court justice Michael Kirby, who stated in his "Mental Health Law Reform" lecture of 1980 —

> There is probably no function upon which lawyers have more to offer than representation of the individual when his freedom is at stake.

Lawyers understand the human rights structure of our legal system; they have the ability, through their training, to properly advocate on behalf of involuntary patients. They understand when there has been a potential or actual breach of statutory or human rights, and they understand when there is a lack of procedural fairness. They understand when an involuntary patient's rights and freedoms have been infringed and, as we know from clause 10 of the bill, which deals with the objects of the legislation, it is the government's intention that the rights and freedoms of patients should be interfered with only if they must be interfered with, and at the most minimal level possible. However, unless there is the ability for lawyers to freely represent patients, there is a problem. That is a problem in this legislation because, on many occasions, lawyers have not been included in the lists of people who can represent patients, and they have to be vetted and receive approval from the Mental Health Tribunal. That is completely unacceptable in a situation in which a fundamental and core power of the Mental Health Bill is to detain and treat people with a mental illness without their consent. Because of that, clients should have the ability to have legal representation without the lawyer having to be vetted by a third party.

I also raised the issue that, under this legislation, the president of the Mental Health Tribunal does not have to be a lawyer . That is contrary to the convention in many other tribunals in Western Australia through which people's freedoms and rights can be affected. Usually, the president is an experienced lawyer, because an experienced lawyer has the capacity and experience to ensure that the procedural fairness aspect of a hearing is appropriate and that natural justice is complied with. An experienced lawyer also has the ability to properly explain and communicate to other tribunal members their roles in the decision-making process and in issuing orders. There is a need to balance the protection of the patient's rights with the protection of the health and safety of the patient, while ensuring the safety of the community. By providing that a lawyer is president, we would ensure maximum utility in the tribunal in its obligations not only for procedural fairness but also to properly take care of the human and statutory rights of patients. This document I hold represents a compilation of all the amendments moved in consideration in detail and, as I stated, it was very disappointing that time and again the government refused to agree or cede to our amendments and only passed amendments proposed by the opposition on a couple of occasions. On one occasion, I was so shocked that I sat down and stuffed up the proper procedure, which required that the amendment be recommitted at the end of consideration in detail. It is so important that we ensure we get right legislation of this magnitude and with the power that this legislation will have. The mental health legislative framework is a major piece of work. We know that the government has been working on this legislation for a number of years, and we have had a number of drafts and extensive consultation. The government also wants to get this right. As I previously stated, this bill contains some improvements compared with the current Mental Health Act, but the opposition still retains many concerns about this bill.

My voice is failing me. I am sure the parliamentary secretary will say that it is a shame it did not fail me during the consideration in detail stage!

I will refer to some of the issues that the opposition raised in debate on this bill. Clause 28 of the bill provides for the detainment of people for up to 72 hours, or 144 hours if they reside in regional Western Australia. A referral can be made if a medical practitioner or authorised mental health practitioner is satisfied that because of a person's mental or physical condition, that person needs to be detained to enable them to be taken to an authorised hospital or place. It is interesting, and I need to read this carefully, that under clause 28(1) —

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

A plain reading of that subclause means that a person can be detained—eventually up to 72 hours, and through the amendments to subclause (3) moved by the parliamentary secretary, up to 144 hours for regional patients—because of their physical condition. Subclause (1) refers to "the person's mental or physical condition." I want to get this straight: we have a Mental Health Bill that basically deals with mental health illnesses, but because of the way that clause 28(1) has been drafted, a person can be detained on the basis of a physical condition and taken to an authorised hospital or other place. That is absurd. We had a lengthy debate about that in which the member for Eyre chipped in with his medical knowledge, and even he had to concede that in an emergency of a physical nature, a doctor can engage in emergency treatment. The member was implying that including a person's physical condition in clause 28(1) was necessary because the mentally ill patient may not consent to physical treatment. That may be the case, but it does not mean we have to write "physical condition" into the criteria to allow a person to be detained. We can say that a person is acting ultra vires of the legislation if one

does not accept the plain reading of the clause, but a plain reading of this clause does not make it ultra vires for someone to be detained because of a physical condition.

It is incredible that a person with a physical condition can be detained under this legislation. The government may say that only people with mental illness can be detained for a physical condition. That is still absurd, because we will discriminate on the basis of mental condition. If a person has a mental condition, as a result of clause 28 they will be able to be detained because of a physical condition and not because of a mental condition. The opposition moved an amendment to remove that absurdity and I am still dumbfounded that the government did not agree to pass that amendment in order to remove the absurdity of someone being able to be detained under mental health legislation because of a physical condition. That is surely an absurd situation.

Another area I have spent considerable time discussing is the issue of informed consent. A person cannot give informed consent if they are not made aware of all the information. The parliamentary secretary sought to make a distinction between consent as a medical term and consent as a legal term, whereas consent is a legal term. We are talking about consenting to medical treatment, and we cannot have informed consent if the person consenting to the treatment is not fully aware of all the facts that may have an influence on whether they give consent to treatment. I am talking about the issue of the removal of the obligation on a doctor or mental health practitioner to disclose financial interest. It is something that really worries me about this bill. It concerns me enormously that this bill does not obligate the practitioner to disclose financial interest. An earlier draft of this bill that was released in 2011 for public comment did contain that obligation, but the current bill does not require treating doctors to disclose to the patient any financial advantage over and above the normal professional fee for service they will receive for providing the treatment and that may be gained by the medical practitioner or mental health service in admitting the patient or administering the treatment. Therefore, under this bill, a medical practitioner does not need to disclose to a patient that they may have a shareholding or will receive a commission from a mental health service or treating regime, nor will they need to disclose to the patient any relevant research relationship to the practitioner, mental health service or pharmaceutical company. That is contrary to the code of practice advocated by the Australian Medical Association's "Practitioners' Relationship with Industry 2010. Revised 2012" and also the Medical Board of Australia's "Good Medical Practice: A Code of Conduct for Doctors in Australia".

The parliamentary secretary said that we do not need that disclosure clause in the legislation because it is contained in the code. That may be true, but the code does not have the same legal form or ramification as legislation. Also, it was contained in a previous draft. We have been given no reason, bar that the Australian Medical Association said it did not need to be there. I do not want to verbal the parliamentary secretary, but I think that is what she said. The AMA does believe that its members need to disclose financial interest; it is saying that it does not need to be specified in this legislation. It should be in this legislation! If we do not disclose financial interests, we are setting up a possible conflict between the doctor's duty to the patient and their own personal interest, and moreover, we are putting in jeopardy the trust relationship between the doctor and patient. This can have serious legal ramifications for medical practitioners, and it makes a mockery of the genuine informed consent that the government has stated we have in this bill. I repeat: there cannot be informed consent if the patient is not fully aware of any financial advantage that the doctor may receive as a result of engaging or advising on a certain form of treatment or administering or admitting someone to a certain emergency health service, and that is a problem.

This bill has some good aspects, as I said, but it has many, many problems, and it is incredibly important to have a good legislative framework for the delivery of mental health services. We on this side of house hope that when this bill moves its way to the other house, many of the amendments that we argued for and sought to be passed here will be revisited and will receive a better reception in the other house. It is incredibly important that when Parliament legislates to enable the incarceration and involuntary treatment of individuals who have not committed any criminal offence but are merely suspected of having a mental illness, that those people are not treated worse than suspected criminals. Under the legislation, the rights and freedoms of a mentally ill patient can be less than those of suspected criminals, and, in fact, they do not receive the same protections that are offered to suspected murderers and rapists. That is not what the government wanted, I am sure of that, but as a result of the bill, there are occasions when the rights and freedoms of people will be impacted upon enormously.

MR P. PAPALIA (Warnbro) [3.43 pm]: I rise to make a reasonably brief contribution to the third reading debate on the Mental Health Bill 2013. At the outset, I would like to commend and thank the member for Armadale for his magnificent contribution and acknowledge the effort and certainly the time contributed by the parliamentary secretary on behalf of the government. It was a marathon innings by the member for Armadale,

and it was a vitally important one. Sadly, I have to mirror the comments that the member for Armadale made about the very few amendments that were accepted by the government. That is disappointing. I articulated that during the course of the debate. The concerns presented by the opposition predominantly through the member for Armadale were representative of community concerns. They were not ones that we thought up on our own. They were not flighty. They were not actually that controversial in many respects, and they were not intended to cause the government harm or embarrassment or to dissuade the minister or the government in any way from modernising the legislation governing mental health. They were well thought out; they were consultative.

The member for Armadale had done a tremendous amount of work. He sought advice from key stakeholder groups—namely, the Mental Health Law Centre; he has already referred to Sandra Boulter. We know that the Health Consumers Council made a significant contribution, and a large number of the amendments pursued by the opposition were drafted in large part by those people with direct interest in this matter. They were intended to represent and primarily defend the interests of those people who are most vulnerable and who will be impacted upon by this legislation.

Throughout the debate, the member for Armadale and others on this side of the house acknowledged that legislation in this area was old legislation, and that it was long overdue for an update. We commended the government for taking the time and making that effort to bring in new legislation. But we were wary and we remained wary of the potential for harm to be done inadvertently, I believe, through that part of the drafting of the legislation that allows vulnerable people to be exposed to what could be harmful treatments. The legislation allows potential concealment of inappropriate treatment—not through an intended drafting of the legislation, but just through inadvertent consequences of the way the system operates. On several occasions, I raised the matter of particularly juveniles in care of the state who might be offenders incarcerated in Banksia Hill, for instance. I still remain unconvinced that those individuals in those circumstances will be protected as well as they could be from potential negative outcomes as a result of this legislation. I feel enough evidence suggests that in the course of treating mentally ill juveniles in Western Australia—people deemed to be suffering from some mental illness—we do not often have enough oversight, and if we leave it to the profession or to some people or individuals practising within the profession, there will be negative consequences. As I referred to on a number occasions, we have the studies and the practical outcomes as a consequence of compelling clinicians to notify prescription of ADHD drugs to juveniles and the subsequent immediate reduction in the number of prescriptions. This indicates I think overwhelmingly that prior to that compulsion for reporting, there was just a willingness to overprescribe. That willingness to engage in that type of activity can easily be applied to other means of treatment. I am not suggesting that that would always be the case or even in the majority of cases be the type of behaviour that would be undertaken by clinicians, because I know they are dedicated professionals who seek to do the best for their patients. Historically, individuals have been willing to push the bounds of what is allowed in order to pursue their own view or, sometimes, what is subsequently revealed to be folly. In those cases, the people who suffer are the patients.

I want to place on the record and reiterate the opposition's concerns about electroconvulsive therapy for the treatment of juveniles. I think the potential for long-term harm from and the potential negative consequences of psychosurgery are of more concern and relevance. As indicated by the member for Armadale, deep-brain stimulation still is not—the parliamentary secretary has acknowledged this fact—an accepted form of treatment of mental illness, yet we are authorising it under this legislation with no other justification beyond the claim that we are futureproofing the bill. I have concerns about that, and I do not think the parliamentary secretary mollified those concerns in any way. Nothing she said nor the government offered by way of evidence, discussion or debate, even with the very good support—I mirror again the member for Armadale's acknowledgment—of the parliamentary secretary's advisers, who did a wonderful job with a very demanding task, suggested to my mind that our concerns have been unfounded.

I do not believe there is a need to futureproof any legislation, let alone legislation that will result in vulnerable mentally ill juveniles being subjected to what is in many regards experimental treatment, for the purposes of avoiding having to bring the legislation back into Parliament. That is what the government means by futureproofing legislation. When the government says it is futureproofing legislation, what it actually means is that the government does not want to encumber the Parliament with the difficult task of reappraising this legislation in a few years' time. So the government will open up the floodgates as far as the types of treatment that this legislation authorises, because that way the legislation will not have to come back into Parliament if the treatment is proven to be effective and safe or something that we might want to do in future. The government is going to be lazy. That would have been a more honest representation of the government's position. Had the government said it was too lazy to bother to come back to Parliament in a few years' time, once this treatment has been identified as worthwhile and safe, so it was going to pass the legislation now, that would have been honest. For the government to say that it is futureproofing a piece of legislation is dishonest. It is just spin. It is a

way of countering the criticism and well-founded community concerns about this legislation. If the government had evidence that suggested that this type of treatment was safe, appropriate and justifiable for the treatment of juveniles with mental illness in the cases detailed in the bill, then that evidence would have been presented. Undeniably, this would have been the easiest path to take. The government would have been able to come into this chamber and slap the opposition down if it refused to accept the government's facts and in the face of the government's evidence to object to this legislation. The government would have had the moral high ground with a significant weapon at its disposal in the course of the debate. But the government did not have that; all it did was fall back upon the repetition of some pretty spurious and unconvincing arguments about the need to futureproof the legislation and the odd one or two examples that were never really convincing.

It is worthwhile to reiterate those observations, beyond the fact that I do acknowledge there is a lot of good in this bill. It is good that the legislation is being dealt with and updated. I know the motivation behind the legislation is good. I am saddened that at least in this place the government has refused point blank to countenance the vast majority of a large number of very considered and well-structured proposed amendments. That is disappointing. Again I reflect the observations of the member for Armadale and hope that in the other place, where the minister herself will deal with the matter and where perhaps some other thoughtful members of the upper house—I am sure there are some on the other side of the chamber—might consider appraising this legislation a little more thoroughly, they may look at the very substantial, well-considered and well-consulted amendments proposed by the opposition and may take them into account and there may be some change to this legislation. I hope that that is the case. I hope we see a little bit of ego at play from the minister. Once she gets her hands on the bill in the other place, she will be able to acknowledge that the opposition's proposed amendments are quite reasonable, at least in more occasions than has been the case to date. That is not a criticism of the parliamentary secretary. I have no criticism of the parliamentary secretary's handling of the bill; her tolerance and endurance of a very sustained and demanding debate was second to none. The parliamentary secretary did well, but it was clear that she had very little latitude to change, reflect or respond to the opposition's proposals. That is sad, and I hope that in the upper house things change and as a result the bill is improved.

MR P.C. TINLEY (Willagee) [3.55 pm]: Like the member Warnbro, I am keen to add some short observations to the third reading debate on the Mental Health Bill 2013. I commend the parliamentary secretary, as did the member for Warnbro, for her patience and forbearance in the debate on a long and complex bill with lots of different stakeholders represented in its constituent parts, who sometimes had quite divergent views. I have a passing interest in this subject, both at the electorate level and through previous lived experience, and have been approached and had to manage a range of different views on what this bill is attempting to do. I note the great contribution of the member for Armadale in carrying the debate. In quite a masterful display, he ensured that all the relevant issues were incorporated and that the voices of all the stakeholders involved with this bill were heard in this Parliament. That stakeholders' voices were heard when this bill was being considered by the Parliament, and that the stakeholders, for good reasons or other, were duly represented in the debate is a function of this place that we all take very seriously as individuals and collectively as members of political parties.

Much of the debate on the Mental Health Bill 2013 revolved around some of the more controversial issues in relation to voluntary and involuntary attendance. There is still the unresolved issue of the rights and obligations of both patients and practitioners to preserve a semblance of privacy and/or dignity for a patient who might present and be deemed to be an involuntary patient. Debate and amendments on this issue raged for some time. It was days of sitting in relation to some of this stuff. The issue of involuntary patients is very interesting. I mentioned involuntary patients in my speech in the second reading debate because they are over-represented in the people whom we deal with in our electorates. This bill cannot attend to the preconditions that occur and are involved in creating the patients who will enter the mental health system. I am talking specifically about people on community treatment orders who are not meeting the criteria and relevant treatment regimes that were set down for them for a range of reasons. This bill cannot attend to the multilevel and complex needs that often attend the diagnosis of people with a mental illness, even if they are subject to a CTO. I find more often than not the cases that I deal with in my electorate are problematic because of these other issues—typically, people's employment, housing and financial stress. These other things sometimes invariably involve some sort of substance abuse, not least of which is the overuse of alcohol. These things are fundamental to some of the lifestyle choices that people make that either originally caused their diagnosis or contribute significantly to exacerbating the symptoms of their diagnosis. The issue of making a patient an involuntary patient and submitting them to a range of treatment will always be contentious. There will never really be an answer to this issue.

Another issue that occupied an awful lot of our time in the debate on this bill was electroconvulsive therapy. The use of electroconvulsive therapy on juveniles was very controversial. The Department of Health's presentation

on the Mental Health Bill 2013 refers to psychosurgery and ECT. It refers also to the myth that ECT is unproven, and states that it is false to say that ECT is unproven. However, when we ranged around the stakeholders that we engaged with in relation to this bill, we discovered that ECT is in fact unproven, and that the statements relied upon by the department seem to be centred on just a consensus view of professionals rather than an empirical scientific study of the effects of ECT. That gave rise to the amendments that we proposed and the concerns that we raised about the use of ECT on juveniles, or young people over the age of 16, which seems to be the arbitrary number around which the line has been drawn.

During the second reading debate, the member for Armadale, in his marathon effort on this bill, quoted from a letter that he had received from Professor McLaren, a consultant psychiatrist to Northern Psychiatric Services in Queensland. I will explain later why her comments are relevant. This may well be known to members who are close to this debate, but this letter is very important, because it is about the idea that ECT is a proven therapy for mental health. The letter states —

> **RE: Debating ECT in Mental Health Bills.**
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> People who advocate wider use of electro-convulsive therapy (ECT), such as the proposal to not fully ban the use of ECT on children in WA, often point to the position statement issued by the Royal Australian and New Zealand College of Psychiatrists to justify their views.

Hence the department's own commentary. The letter continues —

> Despite the widespread misunderstanding, this is not a scientific statement; it is a consensus opinion derived by an overtly political process. It draws on some scientific facts but not all.
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> The statement asks a series of questions such as whether it is safe (generally) and effective (in the short term) or who should do it but the one question it does not pose is this: Is ECT necessary? It must be understood that many psychiatrists do not use it at all, that its use varies dramatically from one hospital to another, or one part of the country to another. Some practitioners use it so commonly that it is almost routine; others, practicing in the same setting seeing a similar if not identical population of patients, never use it.

She then went on to talk about her experience, and this is why what this person in Queensland has to say is relevant to Western Australia —

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

This letter from Professor McLaren, who was in charge of the delivery of psychiatric services in one of the health institutions in this state, is very interesting, because it refutes the idea that ECT is an established and proven therapy. It seems to me, and this bill seems to give expression to this idea, that nobody really knows. That can be seen from the way in which the parliamentary secretary answered questions about what constitutes a juvenile and why the age of 16 was chosen rather than the age of 18, and also when we talked about the impacts of ECT—there are any number of quotes—on the developing brain. I find that a particularly difficult set of circumstances. I hope that when this bill leaves this place and goes to the other place, there will be a second opportunity for the minister to have a good, hard look at the bill, and hopefully have some significant consultation with the parliamentary secretary, who has been following this debate very closely and very competently, to see whether there is any latitude for the making of modest amendments, or perhaps even the excision of some clauses, until such time as we can reach a consensus view on the empirical data about the delivery of some of these services. We have seen that occur with some other complex bills that we have debated

in this place. The building bill left this place unamended, and it arrived in the other chamber with some 50-plus amendments that the government had attached to it.

I made the point during the second reading debate that one thing that this bill cannot attend to is the contributory effects of lifestyle and professional choice on the number of patients who present in the psychiatric health system. I spoke specifically about the knowledge that we now have around post-traumatic stress disorder and its effects on the mental health of individuals who are exposed to sometimes short and small, but often deep and sustained, trauma and risk or implied trauma and risk. I referred to the longitudinal study that was undertaken by the Brain and Mind Research Institute at the University of Sydney on Vietnam veterans and their partners, and now their families, on the effects of PTSD. PTSD is obviously one end of the spectrum. It might appear to be quite odd to move from ECT to PTSD. However, we need to consider the total impact on the community and on the health budget of both ECT and PTSD. The Brain and Mind Research Institute studied about 600 Vietnam veterans and discovered that they are over-represented in a range of ways, not only for alcohol abuse and other forms of substance abuse, but also for PTSD. A very surprising finding was the impact of PTSD on the partners of those veterans. Their partners are four times more likely than the general population to develop or have a depressive episode and/or other subsequent mental illness, and their children are two times more likely to be represented in the suicide and attempted suicide figures. Therefore, a lot more research needs to be done to discover the impacts of PTSD. We can only imagine how many veterans and defence personnel who have long since left the Australian Defence Force and are resident in our community—we see them on Anzac Day; we saw them just recently—are carrying deep problems that may not present, as we have found out, for 10 or 25 years after separation from the Defence Force. Many of those veterans have developing problems that present themselves at work, mildly, and at home, typically and more clearly—through violent reactions, irrational responses, irritable behaviour and substance abuse—and the next thing we know is they are bowling up at a veteran's hospital with an undiagnosed case of PTSD. But it goes beyond that.

If we know that sustained exposure to a trauma and/or implied risk creates a circumstance in which PTSD can fester, we start to get really worried. We only need to look at members of our emergency services, particularly our police, who attend highly traumatic events and/or directly violent events, especially police officers involved with a shooting incident, and the impact that has on their quality of life. If the same thing applies to Defence Force personnel, and I am not just talking about the individuals who signed up, wore the uniform and carried the risk but also the innocent bystanders—the partners, spouses and the children—and it happens with those people in the Defence Force, it will absolutely happen to our police officers, whom I probably worry about more, and those members of the firefighting service who have to attend very traumatic activities, not least of which are multiple vehicle accidents. I took the issue further when I asked the Minister for Police a question on notice, which I was grateful to get an answer back on today, about whether we know how many police officers in the service have been diagnosed with PTSD and what the results or impacts of that were in relation to the department and its approach to a range of things. If members bear with me, I will find that answer. For the record, to make sure we are really clear, the question from me to the Minister for Police was —

> (1) Do Western Australian Police keep statistics on the number of officers, or former officers who have suffered from Post-Traumatic Stress Disorder, and if not, for what reason?
>
> (2) Does the Minister agree that statistics on occurrences of Post-Traumatic Stress Disorder should be kept by Western Australian Police, and if not, why not?
>
> (3) Will the Minister table current statistics on occurrences of Post-Traumatic Stress Disorder in the Police Force, and if not, why not?

Those questions were specifically about serving or recently separated officers and I have made the point before that quite often PTSD does not present for some time—as long as years and years after service—because a range of things, which we are yet to find out about, happen to the chemistry of the brain, or lifestyle or life circumstances change and the sorts of behaviours that are symptoms of PTSD start to present themselves. The answer to the first question about whether police keep statistics was no, although I should add that the answer states the following —

> However, statistics are maintained on the number of officers who medically retire with a diagnosed mental illness.

Obviously PTSD is grouped into that. We owe a bit more to those people who put on the uniform and serve our community in such a demonstrable way as police officers do. When we think of all the experiences each and every one of us as members of Parliament have had with our local police, and there are difficult situations we see them getting into all the time, I think we owe them a bit more than just saying we collect all the data under one

thing called mental illness, and, more importantly, not doing anything further to follow-up and understand. The Defence Force has a very good lead in this because it has dealt with PTSD. Post-1972, at the end of the Vietnam War, it dealt with it poorly but eventually came onto it, understood it and funded the sorts of studies that the Sydney Brain and Mind Research Institute did. They are not expensive studies. I suspect that if we want to make this sort of legislation, the Mental Health Bill 2013, redundant in part, we should be making it redundant because it is not needed to serve those who have served us the best. We should be able to at least have not only a study into those on separation from the service, but also follow-up studies for those who present a red flag. The Australian Defence Force does it in relation to a whole range of exit arrangements around mental health, starting from the moment a person indicates they will separate from the Defence Force, in which case a person goes through a series of mandatory gates.

The ACTING SPEAKER (Mr P. Abetz): Member for Willagee, I am just reminding you that this is the third reading debate. I find what you are talking about very interesting, but perhaps try to restrict yourself just a little more to the bill, thank you.

Mr P.C. TINLEY: Thank you, Mr Acting Speaker; I note your point in relation to contributions to third reading debates needing to be relevant to the bill, but also relevant to the second reading debate, during which I extensively covered this area. I intend to ensure that it is on the record of the third reading debate that we do not let down the people who provide service to our community in the most difficult of circumstances, either with a gun on the hip or a fire axe in their hand. They deserve far more than we seem to be giving them at the moment. I know it is a very difficult area because it invariably involves discussions about compensation, which have occupied the time of this house in the past. On that note, noting the Acting Speaker's advice in relation to the relevance of speeches, I have said enough to get the issue back on the record again. I note we support the bill but that we proposed innumerable amendments. I hope to see some of those amendments that were seen as reasonable, effective and appropriate reappear on the notice paper as this bill moves from this house to the next. Finally, again, I commend the parliamentary secretary for her forbearance and professionalism. Her conduct in this debate is an example to ministers on how it is done and how the opposition's concerns can be dealt with. Of course, I also give a great mention to the member for Armadale for his forensic-like approach to this bill to ensure that all the stakeholders had their voice carried in this chamber.

DR G.G. JACOBS (Eyre) [4.17 pm]: I would like to make a few comments in support of the minister, the parliamentary secretary and indeed the government in presenting this Mental Health Bill 2013. It has been a long time coming, but an enormous amount of work has been done in providing a bill that recognises essentially the patient central to the bill and, of course, carers, relatives and people associated with the person who is unfortunate enough to suffer from a mental illness, both in voluntary and involuntary care. I think I am on record as saying that this is probably as good as it gets in this complex area. There is a balance, of course, between the bill being prescriptive enough, but not too highly prescriptive, to make it useful for the potential issues that arise with involuntary care, voluntary care, community care, all the issues of having carers and their involvement in the process, the medical attendants and their responsibilities in treating people who have a mental illness and the time lines by which we expect people to be treated. In days not far gone, of course, we basically secluded people and threw away the key. Particular time lines are definitely prescribed in this bill as to how long a person is in involuntary care before review, as they should be. Having worked in this area and also as the first Minister for Mental Health in this government, what came across my desk time and again was the call from carers and relatives to be not only informed of their loved ones' treatment, but also involved in their treatment. Again, the days are gone when the medical profession operated in a silo and when doctors were God and whatever they prescribed would be done unquestioned; now it is so important to involve carers, families, relatives and loved ones in the treatment of patients, particularly in the mental illness area.

There is recognition in the Mental Health Bill 2013 of the involvement of carers in the newly named Mental Health Tribunal, which will replace the Mental Health Review Board that, traditionally, reviewed the status of an involuntary patient. It was a bit hit-and-miss as to the involvement of carers and nominated people at that review, but, pleasantly, this bill recognises their role in that forum. A mental health advocacy group will replace the Council of Official Visitors, which had a brief only in involuntary institutions around the concerns of patients and relatives about treatment; it will now also be involved in voluntary care. Its brief has been broadened, and rightly so.

During my time as a practitioner I had experience of the deficiencies in discharge planning. Members might say that is a minor issue, but it is actually very significant for a person who has been released from care. There was a deficiency in the system in that comprehensive discharge planning was not provided to the ongoing practitioner and carer in the community. As a rural general practitioner, I often had patients arriving in my home town on the Transwa bus without a discharge plan or any documented communication for me about the treatment that had

been occurring in Perth, usually at Graylands Hospital. It was really encouraging to see clause 186, "Treatment, support and discharge plan". This is my point about how prescriptive things can be; obviously, we do not want to be overly prescriptive, but it is very important to mention ongoing care. It is often said in the mental health area that perhaps the acute care as such—when a person becomes acutely unwell—is probably not the main game, if I may say so. It is very important to control an acute episode, but what is highly important and perhaps even more important is the ongoing treatment and follow-up as that person returns to the community. We have probably all heard the statistic about the number of people who go into acute care; more than 25 per cent of people who go into and are discharged from acute care end up going back into it within three weeks. That revolving-door concept must be resisted, and this bill is all about the ongoing treatment of people. Clause 187, "Preparation and review of plan", is a call on the profession that reads —

> (1) A patient's psychiatrist must ensure that a treatment, support and discharge plan for the patient —
>
> (a) is prepared as soon as practicable after the patient is admitted by the hospital or the community treatment order is made; and
>
> (b) is reviewed regularly; and
>
> (c) is revised as necessary.

Further, clause 187(2) reads —

> (2) The plan must be prepared, reviewed and revised having regard to the guidelines published under section 545(1)(e) for that purpose.

Subclause (3) is a list of things that a patient's psychiatrist must ensure around discharge planning.

Clause 188, "Involvement in preparation and review of plan", describes the involvement of the patient and their carer. These are very important concepts, and I think this a landmark work. The D'Arcy Holman report was almost 10 years ago, and this bill will, hopefully, be enacted in a very few weeks.

The bill refers to checks and balances and the rights of people, and prescribes very clearly the issues around seclusion and constraint. I think all those matters go to the protection of the rights of the patient, which is central to this bill.

The bill contains some controversial issues, such as electroconvulsive therapy and psychosurgery. I think the point to be made about those two interventions, as members may like to call them, is that they are not treatment modalities used in the first instance. They are for people who are refractory to all other forms of treatment. I think it was important to leave in the bill the potential for those modalities of therapy for those very severely refractory cases. In relation to psychosurgery, it was important to make the distinction between the *One Flew Over the Cuckoo's Nest* scenario and psychosurgery in the twenty-first century. Psychosurgery in the twenty-first century has already been developed particularly for treating people with Parkinson's disease, and it is about electrode therapy of the brain. Again, it is thought to be a developing modality and it should be left in the bill for use with patients who are refractory and do not respond to any other form of treatment. There will be very comprehensive checks and balances in place in and around the Mental Health Tribunal before that surgery and ECT takes place.

A lot has been made of the use of ECT on children. I heard the parliamentary secretary make the interesting point that the current act is absolutely silent on ECT and children; at least this bill prescribes its use. There have been arguments about whether the age limit should be 14 years old or 16 years old, and I think we can go around and around that mulberry bush for a very long time; however, if I had a child with a very severe illness and we had tried absolutely everything—this child with the potential to, if you like, take a very long jump off a short pier and was potentially suicidal—and we were actually beside ourselves about what we were going to do, after the advice of independent psychiatrists that had been to the Mental Health Tribunal, I think we would try it in conjunction with our child's consent. No similar cases from the past few years have been provided as evidence, which just shows that it will not actually open the gates on a modality that will be used regularly, every week or even every year, but it is there for very severe cases for which no other treatment modality has been successful.

In closing, yes, this is a rather long bill, but it needed to be prescriptive and a lot of work had to be done in and around patients' rights, involuntary care and children. It had to prescribe the functions of the Mental Health Tribunal, the mental health advocacy role and the role of the Chief Mental Health Advocate. These are all very important components. Again, the patient—the person who is suffering the illness—is central to this legislation, as is the involvement of the patient's carers or nominated persons, who have the patient's welfare at heart. Carers were calling out for involvement in the processes, including treatment plans, discharge plans and decisions about patients' status, whether voluntary or involuntary.

I commend the Mental Health Bill 2013 to the house and the parliamentary secretary for her work in presenting to the house this rather large piece of legislation. I hope that it will have rapid transition to and from the other place.

MR D.A. TEMPLEMAN (Mandurah) [4.31 pm]: I rise to make a contribution to the third reading debate on the Mental Health Bill 2013, which is a very significant piece of legislation. Those members who were present in the house for most of the debate on this bill will know that the debate ran for many hours; about 10 hours, or maybe more. This is a significant issue, and the bill is significant in respect of what it seeks to do. I listened with interest to the member for Eyre and I note and acknowledge the importance of this bill being centred upon people with mental health needs. I also acknowledge the importance of ensuring that there is greater involvement of carers and loved ones in the patient's journey towards health.

I am always aghast at statistics that reveal the sorts of things that will challenge communities into the future, and mental health treatment is a growing need within the community, especially with regard to the need for support for families in which a member may be experiencing a mental illness. In his contribution to the third reading debate, the member for Armadale spoke about the various impacts of mental illness on communities. I think the figure is still one in four —

Dr G.G. Jacobs: One in five.

Mr D.A. TEMPLEMAN: One in five members of our community will, at some stage of their life, be impacted by a mental health condition, which is very significant. As legislators and members of Parliament we need to be very mindful of this issue as we try to respond to community need and ensure that we are building resilient communities. I am concerned about initiatives that focus on ensuring that the mental health of young people, in particular, is at the forefront of the minds of members of local communities, the Mental Health Commission, the Mental Health Commissioner and, indeed, the Minister for Mental Health. I congratulate the parliamentary secretary for her carriage of this bill; it is no mean feat to carry any bill through this place, let alone a bill that is of such significance and thickness!

In my contribution to the second reading debate I mentioned a program in Mandurah run under the auspices of the Peel Health Foundation and general practitioners in the region. Last week I attended an event that was part of a broader plan to highlight the importance of mental health in the Peel region, at which Heath Black was a speaker. I was absolutely impressed by Heath Black's presentation; for those who are unaware, he had a successful AFL career but, by his own admission, sank to the bottom of the bottom, and his life crashed around him. On Friday last week he gave a presentation to about 450 young people from schools, youth centres and youth services all around the Peel district. He told them the story of his particular mental illness, and demonstrated why he is a shining example of what can happen when people recognise their mental health condition and have a loving family and support base, and how people can, in fact, pick themselves up and make a positive contribution to the community. His message to those young people last Friday is one of the most powerful messages I have ever heard as a member of this place. In fact, I will go so far as to say that of all the events and initiatives I have attended in the 13-plus years I have been a member of Parliament, that was the best one I have ever been to. It was heartfelt, and the way that Heath Black was able to very quickly build a rapport with these young people was remarkable.

The program he presented is the first of a three-tier project for young people in the Peel region. Unfortunately, despite writing to the Minister for Mental Health after my contribution to the second reading debate to ask her and the commission to again look at this project, the letter I received in reply informed me that the project had not been successful in terms of funding. However, if we are going to make a difference to young people, in particular, in respect of giving them a very clear message about what they can do if they or any of their friends are "not all right"—as Heath Black put it—we need to be able to put in place programs that are preventive and can help build resilience, because they are worthwhile programs. The funding the project is asking for is not a huge amount—a bit more than $300 000 over four years—but it would deliver the first tier of the project, which is the Heath Black presentation. The second and third tiers are very much about Heath and others working very closely with schools in the Peel region at a much more intensive level.

The young people and community leaders who were at the presentation were unanimous in their resounding support for such a program. My plea, again, is for the Minister for Mental Health to support this program in this budget. It is the sort of project that royalties for regions could easily fund. It is a tremendous regional project that is not Mandurah-centric but would encompass all schools. We had schools from Waroona, Pinjarra and Mandurah; they were all there. The worthwhile aspect of this program cannot be underestimated. I make this appeal to the minister, through the parliamentary secretary again tonight, to please revisit that. I will write to the minister again. As I said, I am so pleased that I attended the presentation, because until we see how

this program is rolled out and presented, we will not have an understanding of its impact. Luckily a staff member from the Mental Health Commission was present. I talked to her afterwards and told her that I would be raising the issue in Parliament because I wanted to reiterate how important that program is to the young people of Peel.

Members must remember that areas like the Peel region have experienced the population explosion we have seen in this state. Mandurah and the Peel region is now an area with increasing numbers of families with children. It is not just, as it has been projected over many years, the retirement centre of WA. That is still an important component of the population, but we now have a bulge at both ends of our demographic bell curve that starts with young children and families and at the other end of the spectrum are our older citizens. As we have heard from other members in this place, mental illness affects people of every age, in every demographic and every economic sector. When we know that one in five people will suffer with mental illness, and when that is compounded by the impact that that may have on their families and loved ones, it also highlights just how important this issue is. As members know, as with many people who have children with disabilities who are now adults, people who have children with an ongoing mental health condition worry, as they would, about what will happen when they are not around to offer the ongoing support that they give their loved ones who may suffer from a mental health condition.

Parliamentary secretary, I will write to the minister again, but please look at the need for funding that program. It is not a lot of money. It should come from royalties for regions. It is a regional project. It will deliver immeasurable benefit to young people and their families in my electorate and the electorates of the members for Dawesville and Murray–Wellington as an important program.

I want to acknowledge the breadth of this bill. As has been said previously, members have grappled with a range of issues in this bill. The member for Eyre highlighted a couple of those, including the issue of age, in a debate that went on for a number of hours. I agree with the member for Eyre's comment that at least in this bill there is a definition that covers children. They were not mentioned in terms of treatments, including psychotherapy, in previous legislation and this bill at least defines that. The opposition put forward some amendments, which were defeated, and it will be interesting to see whether those matters are reignited in debate when this bill passes to the other place.

I want to acknowledge the member for Armadale, who has had carriage of this bill in this place on behalf of the opposition. Of course, he not only brought to this bill expertise from his professional life but also raised a number of important issues, including suggested amendments. Although those amendments may not have been successful, his contribution highlighted a need to revisit in the other place some of the issues we have gone through comprehensively in this place.

I will be honest that I was a little disappointed there were not more government members making contributions in the second reading debate, even if just to acknowledge the importance of this bill. I understand that tactically government backbenchers are not always given the opportunities to speak, but if there was a bill they needed to speak on, quite honestly, it was this bill, because this bill is a significant milestone in how the state and ultimately the government responds to the needs of people with mental illness and the needs and considerations of their families, carers and loved ones. If ever there was a bill that government backbenchers needed to jump up on, it was this bill, because this bill will affect, statistically, at least one in five of their constituents. We know that in rural and regional areas mental health issues are a concern as well. I would have liked to have seen more regional members on the government side speak on this bill.

During my contribution to the second reading debate, I also noted some local people in my electorate who I believe are inspirational advocates for people with mental health conditions and for families with loved ones with mental health illness. I mentioned Alan Robinson, a person whom I consider a friend, and his family. Alan has been a magnificent advocate for not only his son, but also the needs of people with mental health and associated issues. He is one of those wonderful people who has been advocating for a couple of decades at least. He has his knocks, and he has been knocked down a few times, but he gets back up and dusts himself off. He does not hold any malice against ministers or ex-ministers. He recognises the good in people and he has been a tremendous advocate for his son and other families and people who have loved ones who are affected by mental health and other related health concerns. I salute Alan again, because he is among those unsung heroes in this story, and we should acknowledge them.

I also want to mention Kaye. I will not mention her last name, but Kaye is another person who has always maintained the rage about ensuring that we get a commitment to justice for people who suffer mental health conditions. She is a very strong advocate for carers and families of loved ones. I agree with the member for Eyre when he talked about the need to involve these people in the overall treatment processes affecting the person on

their journey, hopefully to ongoing good health. I also want to acknowledge, because it is intrinsic in this whole issue of mental health, some other people, whether they make a difference in their own local communities or in a broader perspective. One of them is June O'Connor. June O'Connor is a remarkable woman. I did not know whether she was a real person or simply a name that had been picked out. I met her one day, as she came and saw me not long after I was elected in 2001. June is one of those remarkable people who saw a need and established a model that operates in a number of centres in WA. They are mainly Perth based but there is one in Mandurah. They are affectionately known as JOCCs—the June O'Connor centres. June, of course, is getting a bit older and is not able to get out to all the centres all the time, but her passion for the whole issue of mental health is maintained stoically. I think she was nominated for a few awards in the past. She is the sort of person who is worthy of Australian honours–type acknowledgements. She is a New Zealand citizen—I hope I do not offend her by saying that I do not think she is an Australian citizen. She is a long-term resident here in Australia, so she is not able to be nominated for an honour. She is certainly the sort of character and the sort of person who we should be holding up as a contributor to our community. I salute June O'Connor for the work that she has done to establish her centres and the people who run those centres now. We have had a long fight over many years to try to keep the Mandurah June O'Connor Centre running. We have demonstrated the ongoing need for that centre down in Mandurah and the Peel. Sometimes the model is tweaked and changed, but those sorts of places serve an important role in the delivery of quality support and services. I know that the June O'Connor Centre plays an important part in the lives of many of its attendees and, indeed, of their families' lives, and I salute that work.

I also want to acknowledge Graham Mabury, who will retire from 6PR after 30-plus years of the *Nightline* program. *Nightline* has been running since the late 1980s. From memory, he took over from a fellow called Neil Adcock in either the late 1970s or the 80s. He has been on the announcer's desk at 6PR for over 30 years. I remember listening to Graham Mabury when I was 16 or 17 when I used to go to Mandurah after mum and dad first bought their holiday house there. I used to go to bed at night listening to him. This is when he first started.

The ACTING SPEAKER (Mr P. Abetz): Member for Mandurah, this is very interesting, and I love what Graham Mabury does, but I remind you that this is the third reading debate. Try to restrict yourself to the bill and any issues around the bill.

Mr D.A. TEMPLEMAN: I will. One of the things that I want to talk about, and the reason I mention Graham Mabury, is advocates. We will lose a passionate advocate for mental health from the public airwaves. I do not think he will ever stop advocating in his own personal way or in his forums, which I am sure he will continue to be involved in, whether it is in the Baptist congregations that he leads or in other public life. It is significant when this bill is passed in this place that we remember and acknowledge those who have been advocates. Graham Mabury has been a tremendous advocate for people with mental health conditions and illnesses for well over three decades. It is appropriate that we acknowledge in Parliament the work that he has done. I know that people with mental health illnesses have rung Graham Mabury and he has saved their lives. That is the reality. He has saved their lives purely because he was a person on the end of the phone and took their call. I know we have the Lifelines of the world. They are very important organisations. I think Graham was involved in helping to assist with the creation of Lifeline in Western Australia. Even before its time, those sorts of people were advocating for people with mental health conditions. We have to remember that in past generations and in past times mental health and mental illness was something we preferred to hide away. That is not the case anymore, thank goodness. People like Graham Mabury and other advocates continued to highlight the need to support people with mental health illnesses and conditions and needs. I want to put on record my admiration for Graham. On many occasions he has assisted The Compassionate Friends in Mandurah, an organisation of which he is a long-term patron and which he helped to establish. That organisation is there for those who lose loved ones in tragic circumstances. I want to acknowledge him. Thank you for giving me a little leverage, Mr Acting Speaker. As Graham Mabury prepares to hang up his announcer's headphones and turn off his microphone for the last time, which I think is coming up in the next few months, it is important that we acknowledge the contribution that he has made.

I rang Graham Mabury a number of times, not telling him who I was. I would always ring up as Dave from Mandurah. I have done it a few times, hands-free, on the way home to Mandurah. All you lot have gone to bed by the time I have left and am travelling back to Mandurah. I listen to either Graham Mabury or Tony Delroy on the way back.

Mrs G.J. Godfrey: You said you caught the train home.

Mr D.A. TEMPLEMAN: Sometimes I do. We can make phone calls on the train, except at Wellard where there is no reception.

I have been coaxed into digressing, which is not something that I am very good at; I am always known for sticking to the point. I have been coaxed away from my line of thought.

I conclude by saying that this is an important bill. It will be interesting to hear what happens in the upper house when it is debated. I want to put on record my admiration for those people I mentioned and many others who are tremendous advocates for people with mental health illnesses. I certainly look forward to this bill becoming law and seeing its benefits in our wider community.

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [4.57 pm]: Sometime in the future some very diligent PhD students may look back on this debate on the Mental Health Bill 2013 and reflect on its length and the detail, particularly in the consideration in detail stage. Generally, those students will conclude that we did not do a bad job and, all things being even, we gave it a pretty good nudge. We are trying to strike that balance that the member for Eyre was talking about between the processes of treatment and the rights of the patient.

As other members have observed, in mental health we do talk about the deprivation of someone's personal liberties because we are intervening for their own good. From that point of view, it is a very serious piece of legislation. I commend the government at least for trying to strike that balance. The government did allow itself to be thrown to the four winds of public opinion in relation to this bill. I think I described it as a bit of a Frankenstein in the second reading debate. We do have a bill which, by and large, has tried to be all things to all people. As we know from time to time in politics, we can do that; we have to make decisions about where we think public policy is best served. In this case, the government, with all best intents, tried to be all things to all people in the mental health debate and because of that we now have this behemoth of a bill that we will come back to time and again to continue to reform and finely tune.

I commend the parliamentary secretary for her patience in the debate. It is no mean feat to go up against the member for Armadale, with his forensic attention to detail, particularly when things become of a legal nature. I think the member for Armadale did an extraordinary job of cross-examining the government on this bill and proposed some very good amendments. Equally so, I think the parliamentary secretary did a pretty bang-up job to resist some of that debate and manage the questions that came her way. It is fair to say that our side was given a good hearing on the bill.

I also thank the advisers who participated in the debate. There were some very late night sittings. There were times when the consideration of this bill was shelved and the advisers had to get as comfortable as they could in the corridors while we considered other parliamentary business. I think they have done a commendable job in helping us in our deliberations in this place. I feel very sorry for them because once this bill passes through this chamber, they will have to undertake the same process in the upper house. The work that our public sector workers do is extraordinary, particularly in relation to these issues. I think they do a great service for our community in working in this space.

I recently had cause to attend the opening of the new headspace office in Rockingham, just outside my electorate. As many members will be aware, headspace provides a subacute retail or high-street clinical service that focuses predominantly on young people seeking help for a mental condition. I was really pleased with the way that this headspace clinic came together; it was a collaboration between a range of agencies. It was headed by the Perth South Coastal Medicare Local and funded in part by the Mental Health Commission and the federal government. Other organisations were represented at the opening because they have also played a part. Sheila McHale, a former member of this place, represented the Palmerston Association, which was also involved. The Peel mental health service was represented at the event, as was the Richmond Fellowship Western Australia. I think that bodes well for a sector that needs a collaborative and cooperative approach from a range of agencies, departments and levels of government to ensure that mental health services are accessible right across our community. Of course, this bill will support a lot of that work, and long may it continue.

This bill provides the foundation for the rollout of public sector mental health services. We have to be cognisant of the fact that this will be the most demanding aspect of our health system in the future. We will continue to face challenges with the ageing profile of the population. As people get older, they will continue to confront and grapple with a range of physical health issues, such as cancer and other forms of disease. However, mental health is one issue that is simply overtaking our community. As public health advocates, spenders of public money and stewards of government programs, we will see those resources placed in the mental health system. In my contribution to the second reading debate, I spoke about the tsunami of mental health issues confronting our community, particularly in emergency departments. I urge this place to look at not only assisting people in subacute or step-down facilities by resourcing those facilities, but also continuing to resource acute mental health facilities to make sure that those who are most vulnerable are looked after. Of course, this bill seeks to strike a

balance for people who will have to be hospitalised or detained in some way and receive treatment that they may not understand or appreciate given their state of health at the time. Therefore, it is important that we make sure that not only are the checks and balances in the legislative framework right, but also the resources are brought to bear so that people can bring this legislation to life.

One of the things that I am particularly concerned about is the number of psychiatrists practising in the public sector. Recently, I was fortunate enough to be at the farewell cocktail function for the president of the Australian Medical Association at which he talked specifically about this issue and the fact that the community and the government in particular have to step up with workforce development planning and implementation to ensure that psychiatrists are available to the public sector. We can legislate to our heart's content, but if we do not have the resources or the facilities or the clinical staff are not available, what we do in this place is almost of no great relevance. We need to heed the call of the AMA and its president, Richard Choong, to significantly boost our efforts in mental health services.

In my contribution to the second reading debate, I spoke about the need to look at not only the subacute mental health services, but also the acute mental health services, because I am particularly concerned about the state of affairs in acute mental health services. I note the review done by Professor Bryant Stokes, which indicates that there are enough tertiary beds in the mental health system but we need to continue to expand the number of places in the subacute facilities. I get that; I understand that. That is one of the reasons that Victoria has been so successful with its mental health services. But it is also the fact that some of the mental health beds in our tertiary system are substandard. Although the government pats itself on the back for investing in subacute services, I implore the government to consider also the needs of patients in secure facilities, particularly in the Murchison and Smith wards at Graylands Hospital.

While this bill was making its way through this place, an article in *The West Australian* drew our attention to the report of the State Coroner on an investigation into a range of deaths at Graylands Hospital. The State Coroner, Barry King, was quoted as describing the life of a patient, who had spent more than 20 years at the hospital because she had nowhere else to go, as an unmitigated tragedy. He found that there was overcrowding, a lack of privacy for patients, unsuitable facilities, no alternative for difficult cases and boredom for long-term patients. Debora Colvin, the head of the mental health advocacy group the Council of Official Visitors, said that the conditions in some of the wards at Graylands were dire. Indeed, if members ever have the good fortune to visit Graylands and meet the dedicated staff who work in those facilities, they will be shocked by the conditions in which they have to work and the conditions in which those patients exist. The Minister for Mental Health was quoted in that article as saying that the state government was very seriously considering the future of Graylands.

I am absolutely astounded by the gall of the government's attitude towards mental health. I cannot believe that the Minister for Mental Health had the gall to say in the media that she had plans, or was actively considering plans, for Graylands, given the minister had sat on those plans and withdrawn the resources to bring to fruition those plans throughout the life of this government.

I will take us through the situation with Graylands Hospital. In the estimates hearings in May 2009, I asked the then Minister for Mental Health about the expansion of the number of mental health beds at Osborne Park Hospital and how the government intended to resolve this issue of Graylands. One of the advisers to the Minister for Mental Health, Dr A.L. Hodge, said —

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

I remind members that on 28 April the minister said that the government was seriously considering future plans at Graylands, yet in May 2009 the minister's representative said that the government was actively considering the planning for Graylands. The adviser goes on to state —

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

The adviser goes on to say —

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

I then asked —

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

The minister at the time said —

> The whole issue of the redevelopment of Graylands Hospital has yet to be decided on. There are concerns for me and the government in that whole development and how —

It would work —

> better for Western Australia.

Although on the one hand the government is defending this bill by talking about how the government is moving forward with great clarity, vision and purpose with mental health, we see on the other hand that it is actually stuck in a time warp back in 2009, trying to work out what it will do with Graylands Hospital.

In June 2010, I asked the then minister once again for an update on Graylands Hospital. The minister said at the time —

> I share some of the member's concerns and expectation about the Graylands redevelopment.

He went on to say —

> The Osborne Park Hospital has the potential to expand its mental health unit and take 50 beds from Graylands Hospital so that the process of redevelopment of Graylands Hospital as a truly purely forensic specialist mental health service can begin.
>
> …
>
> The potential is there to take beds and patients from there and put them into a more appropriate mental health —

Facility. However, he went on to say —

> That cannot be done until we can actually move some beds into a potential Osborne Park development.

That was in June 2010. In June 2011, I once again asked the government what was happening to the redevelopment of Osborne Park Hospital so that beds can be taken away from Graylands so the government can implement the plans it has for Graylands. In questions during estimates, Mr E. Bartnik, the Mental Health Commissioner, said —

> With Osborne Park Hospital, the principle that I was very keen to establish was that relocation of activity from the Graylands site at no additional cost was perfectly fine, but that any additional cost would need to be found within the current arrangements, not as part of future Mental Health Commission growth funding.

The government is saying that the updating and redevelopment of Graylands Hospital and the implementation plans for it are entirely dependent upon the redevelopment of Osborne Park Hospital. Indeed, Dr Russell-Weisz on the same day said —

> It was very relevant consultation because it related to the future of the Graylands site and what we were going to do at Graylands and the shift of correct beds and services from Graylands to Osborne Park. I think we have got to an extremely good outcome with the service and building at Osborne Park, which will be in place by 2014.

In May 2012, the Minister for Health, when commenting on Graylands, said —

> In fact my preference would be to redevelop Graylands, and I have said that to the minister.

The fact of the matter is that this government has no commitment at all to those poor souls sitting in Graylands Hospital—no commitment at all. It can legislate here as much as it likes, but money talks. Let us see what has happened to the money for Osborne Park Hospital. In 2009–10, $44 million was allocated for the redevelopment of Osborne Park Hospital to develop these 50 mental health beds. The predominant amount of that spending was to take place in 2010–11. Also, $600 000 was earmarked for planning at Graylands Hospital. In 2010–11, that $44 million was still sitting on the government's books, but the significant portion of the spending had been shifted to 2012–13. I might add that the $600 000 for redevelopment planning at Graylands Hospital was still sitting on the books at that point as well.

In 2011–12, it gets a bit interesting. Members may or may not be surprised to hear that the $44 million was still sitting in that account unspent and now the bulk of that money is due to be spent in 2013–14. But there is one

very great difference in the 2011–12 budget—the Graylands Hospital planning money is no longer there. We can only assume one of two things has taken place. Either the government has used that money to do the planning around Graylands Hospital or it has ripped out that money altogether and there was no intention to do the planning for the redevelopment of Graylands Hospital. This is the same hospital that was condemned by the coroner in April this year.

Members may or may not be surprised to hear that in 2012–13, the $44 million allocated to Osborne Park Hospital was still there, but the predominant amount of the spending was to occur in 2015–16. This money is still sitting there. The Minister for Mental Health is standing around saying, "We're doing these wonderful things in mental health", but the government is just fudging the situation at Osborne Park Hospital. It is pushing it out to the out years. Let us not forget that every time that is done, it is another year those poor souls will be left sitting in Graylands in dilapidated conditions—what I would call Victorian era standard of conditions—that are quite inhumane and abhorrent. It is bad enough that we can now see that the government has very little commitment to Osborne Park Hospital—at least the funding was still in the budget—but in the 2013–14 budget we really see the home truths because there is no money at all for the redevelopment of Osborne Park Hospital.

Dr G.G. Jacobs: This is not in the bill.

Mr R.H. COOK: It is in the bill. The reason that this is important in the third reading debate is that this bill predominantly deals with the rights of involuntary patients in clinics. The plight of those involuntary patients sitting in clinics and facilities in subhuman conditions should be highlighted in this debate. We can talk about this legislation till the cows come home, but unless the government puts resources into these facilities, it matters for nought. Members opposite can talk about the rights of the patients till the cows come home and about the balance between the rights of the patients and what avenues they have to appeal to forever more. But the fact of the matter is that they have no rights while they are sitting in these substandard conditions—conditions which the coroner has said represent an unmitigated tragedy, and which the Council of Official Visitors has said are simply dire. Therefore, member for Eyre, what I am saying is very relevant to this bill, because although this bill has sought to strike a balance between people's legal rights in relation to the receipt of mental health services, if we do not have psychiatrists who are practising in the public sector, and if people are being treated in subhuman conditions, it matters not how we strike a fine balance in this particular legislation.

I have been banging on about this since 2009 when I first became the shadow Minister for Mental Health in this place. We talked in those days about the mental health strategy and about this legislation, which has taken a good five years to come to this place. But I say again that until we put the necessary resources into these facilities and look after those people in our society who are most vulnerable, it matters not one jot what academic exercises we get into in this place. As I said during the second reading debate, how we treat the most vulnerable in our society is the most sincere demonstration of us as a civilised society. There can be no more vulnerable person in the community than a person who is suffering from a mental health condition. There can be no more vulnerable person in our care than a person who is detained in an involuntary capacity. So while we sit in this place and continue to fine-tune the legislation around these things, I want the members of this chamber to pause for a moment and think about the resources that we provide to these facilities, because that, member for Eyre, has a direct impact on the rights of mental health patients. Later this week, we will hear from the Treasurer about the expenditure in this particular area. I may be a cynic, but I asked questions about this issue in 2009, 2010, 2011, 2012 and 2013, and I think that we will, once again, let down those people in our community who are most vulnerable and least able to fend for themselves because we have taken away their rights.

I commend the members of this place for the way they have applied themselves to this very important issue over the last few weeks, as the government seeks to have this legislation passed, and as we seek to cross-examine this legislation to make sure that it strikes the right balance. We still have the view that some elements of this legislation need to be tweaked, and some amendments need to be made. But the government has resisted that. That is okay. That is what this place is about. As the member for Eyre said, this is about striking a balance. But I remind members of this place that once this bill passes this place, we have not finished our job. It is one thing to legislate these rights. It is another thing to make sure that people who are in mental health facilities are able to exercise their rights, have physicians and clinicians to treat them, and are provided with the proper care and the necessary resources. Until we do that, what we do in this place by legislating around these issues will not matter one jot.

MS L.L. BAKER (Maylands) [5.25 pm]: I want to raise a number of issues on the Mental Health Bill 2013. Unfortunately, some time ago, when we started this debate—I think it was in medieval times—I was ill. I was sick for the whole of the second reading debate.

Mr I.C. Blayney: You were sick for all of medieval times?

Ms L.L. BAKER: Yes, for the whole of the second reading debate—I was ill during medieval times. The issues that I will raise today were, however, raised in the second reading debate on my behalf by the member for Mirrabooka and other members in this chamber, and if there is any doubt about relevance, I will cite those clauses of the bill.

I want to start by congratulating the parliamentary secretary. I know that it is hard to get compliments from the opposition, or from the government if we are on the other side of the house, but I do remember saying to the parliamentary secretary after we had gotten through the second reading debate that congratulations were in order. This is no mean feat. This is a huge bill, and it is highly sensitive, and I think the parliamentary secretary has done a great job; so well done.

The issues that I want to raise come directly from the community sector involved in the delivery of mental health services at the beginning of the process, and they are about the resourcing implications of this bill. This is an immense piece of legislation, and it is very much needed. There are a number of new processes in this bill, too many to list. As we all know, every change in processes costs money somewhere along the line. Therefore, we need to make sure that the necessary resources are provided. When the sector was briefing me and I was talking with stakeholders months ago about this bill, even back then, and before what we suspect the budget might carry with it, genuine concerns were raised by the community sector about the resourcing implications of this bill. The people in the community sector love this bill, of course, and are very supportive of it; they see it as their bill as much as it is the government's bill. However, they are deeply concerned about the resourcing implications of this bill. I will run through half a dozen of the things that will change and that will require funding. The Mental Health Tribunal will have the power to issue involuntary orders. The time frame for those orders will now be significantly shorter than it was previously. It will be a cost to the tribunal to get that shortened time frame operational. Another change is the issue of compliance notices. If, for instance, a carer finds that they have been denied information or have been denied access to or involvement in a case that they are interested in, they can approach the tribunal and get a compliance notice issued to the service to ask for that involvement. However, that will cost money. The tribunal will need to have dollars in the bank to set up these new processes.

The Mental Health Commission website is a vital vehicle in getting the message across about these substantial and significant changes to the way mental health is looked at in this state and the way families will work with this legislation. However, it will cost money to set up that service, and, as everyone who has a website knows, there will also be an ongoing cost for maintenance of that website. There will also be a cost to market these changes to the community and service users. The Mental Health Advocacy Service will need money to enable it to visit or otherwise contact a person. That is one of the new opportunities that is provided for in the bill. However, that will cost money, because the Mental Health Advocacy Service does not currently have to do that.

I should just say that I know that modelling was done of the costs of administering this new service. That modelling was done some time ago. A lot of things have changed over the last six months in relation to the state budget. Everyone in this house has heard about the implications of that, and their suspicions are right in terms of how that might impact on specific categories in the budget.

I know that an implementation reference group will report to the Mental Health Commission and the Chief Psychiatrist about the implementation of this bill, about how effectively it is being run, about the new processes, about whether the new standards and key performance indicators around the implementation are being met and about whether the money is appropriate. Rather than just a report to the Chief Psychiatrist and the Mental Health Commission, I want Parliament to find out how this is going as well. It is imperative. Certainly from my position in the community—members have the same position in their communities—I know that people want to know that this bill is working and to know how well it is working. Many of our constituents have a vested interest in understanding how this legislation is being implemented. Of course, there will be problems. When anything is implemented, there are teething problems. I think Parliament needs to have a clear understanding in 12 months of the results of the work of the implementation reference group. What has it found? How are the standards being complied with, and are the key performance indicators that the new system has set being met, but, most importantly, is the resourcing appropriate and sufficient?

I make these points at the beginning of my comments on this bill, because when I spoke to people in the sector today, these were the most significant issues raised. This budget has to have capacity for clinicians at every level of the system to make these changes and to follow-up with the new practices. We already know that clinicians are under a great deal of stress. I remember hearing in sector discussions held months ago that clinicians were leaving practices because of their inability to cope with demand. This legislation introduces some very needed but far-reaching reforms, and it is imperative that we look after the people who are delivering the services. We do not want clinicians walking out of their jobs because they do not have the resources to implement these changes.

From the subject of our ability to provide services through the clinical expertise in this system, I turn to a different aspect of what this reform offers the state. I want to talk about traditional mental health policies and the way funding has been offered in the past. It is safe to say that previous policy under successive governments, not just this government, has focused primarily on providing mental health treatment for older children and adults, which is often at the cost of and ignores the importance of the opportunity to promote, prevent and treat the mental health needs of infants and toddlers. This is clear in some of the literature and evidence that we are seeing at the moment. I quote a research paper by Murray and Lozano et al. "Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010" cited in the article "Preventing mental disorders: the time is right" published in the medical journal *Perspectives* on 21 October 2013. It reads —

> Mental disorders are the main source of the disability burden in Australia and their impact begins early in life.

This comment supports what I want to focus on for the next few minutes—that is, making sure that funding for mental health services in Western Australia is targeted effectively. I have tried to make the point that this bill is clearly going to be an impost on the budget to get it right. If we do not get it right, it will be an immense failure for the government. The government must resource the proper implementation of this bill. I do not want to see money being further misdirected or taken away from the services for prevention and early intervention in Western Australia. Funding to the state's infant, child, adolescent and youth mental health services already needs to be increased so they can provide early intervention and treatment services for children across Western Australia. I am talking about making sure that while we focus on getting this bill right, which is a big ask, the government should not take its foot off the pedal with early intervention services, because they are absolutely crucial. Earlier we heard from a former Minister for Mental Health on resourcing and funding for mental health and the system changes, and I agree with much of what the former minister said. Mental health is clearly one of the greatest issues for zero-to-18-year-olds in our state. The age when mental health issues are most effectively and efficiently dealt with successfully is the early years—zero to eight years. The need for those services then is immense. I refer to the article "A crying shame" by Adjunct Associate Professor Caroline Zanetti, who is the director of psychiatry to St John of God Subiaco Raphael Centre, published in the medical journal *Medicus* November 2013. Professor Caroline Zanetti writes —

> Child and adolescent mental health services are struggling to cope with an apparent epidemic of suicidal adolescents. Already this year, around 1000 children and teenagers have been brought to Princess Margaret Emergency Department for psychiatric assessment. Eighty to 90 per cent of these children have come because they are thinking about killing themselves, or have already made a recent attempt on their own lives.
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> ...
>
> Western Australia has only eight beds available at PMH to treat children and adolescents who have mental illness, or severe psychological problems requiring admission—plus another 12 at Bentley Adolescent Unit.

When Professor Caroline Zanetti wrote this article, those beds were constantly full, so in the article she poses the question: where are the resources for dealing with suicidal children or adolescents? The article goes on to state —

> Unfortunately, funding for proper early intervention in the lives of families with young children has not been made available by successive governments.
>
> …
>
> Proper support and treatment requires the government to meet the needs of the current generation of adolescents by providing more beds for acute services and funding community services with the capability of working in a more long-term fashion with a greater number of the adolescents and their families.

There is significant need to ensure that the pedal is to the metal on this one. This is about the lives and healthy development of children and young people and it is simply not possible to withdraw funding from these areas. It is a crisis at the moment, and is in really dramatic need of additional funding. Professor Zanetti continues —

> At present, it is not possible for children and families to access community mental health services in unless their needs are at an extreme level. This inevitably leads to crisis-driven responses aimed at moderating risks, rather than transformational treatment.

Finally, she states —

> The government is currently operating in an expensive and ineffective manner. There needs to be clear planning for the future, based on all the available evidence of what works and what doesn't, and involving child and adolescent psychiatrists in a collaborative manner, that sees our society valuing its children more, and diverting those at risk away from the path that is currently leading them to chronic mental and physical illness and the juvenile justice system.

That article was written in November last year by Associate Professor Caroline Zanetti, who is a very esteemed person in our community and someone who, it could be argued, probably has the most intimate knowledge of the system and how it is treating children. She wrote about the need for child and adolescent psychiatrists, and the member for Kwinana stole my thunder in some respects because I also wanted to talk about the issues around this sector's workforce, and that the reforms in this bill clearly need the right skill set behind them so that the standards can be met for the increasing number of children, adolescents and adults presenting with a mental illness. The October 2013 *Medical Journal of Australia* article headed "Crying shame" by Annabel McGilvray reads —

> A chronic shortage of child and adolescent psychiatrists is leaving vulnerable children and young people without necessary treatment
>
> …
>
> But while child and adolescent psychiatrists (CAPs) are now identifying the need, chronic workforce shortages in child psychiatry and inadequate resources appear to be getting in the way of effecting even the small differences that may be of great benefit.

I think that is directly relevant to how well the Mental Health Bill 2013 will work, because if we ignore workforce shortages in this critical area, we simply will not be able to deliver against the high standards the government has set in this new bill.

The article continues —

> While there is gross underservicing in NSW, and similarly in Victoria, … the Northern Territory, Western Australia and Queensland the shortage is even more acute.

Western Australia is doing worse than other states in trying to address this problem. The article continues —

> Looking ahead … the need for psychiatric expertise in children is only likely to increase —

We know that, and we know that the bill is trying to set up new standards and new processes to deal with the increase in demand. But if we do not have the staff or trained psychiatrists in the profession, particularly in the child and adolescent health area, we will not see the improvements this bill offers come to fruition.

The article continues with a quote from Dr Nick Kowalenko —

> "There's been an explosion in the recognition of child and adolescent mental health problems — part of that has been the recognition of youth problems. And the second wave of early intervention, which is going to be about younger kids, those under 8 years, hasn't really even started yet."

That will be coming through in the next few years.

The article continues —

> All the research is pointing to the importance of providing early and ongoing help for children subject to abuse and other forms of trauma in the hope of avoiding incarceration in facilities —

This is facilities such as juvenile detention centres.

That is all I will say on the subject of workforce. It is a critical issue. Other members have spoken about it, so I feel like I have put my concerns and those of the sector on the record. I think that the workforce and the proper resourcing of the bill are the two critical areas.

I turn now to look at the objects of the bill, as found under clause 10. I remember some elements of the very robust debate around the objects of the bill, particularly to do with involuntary patients and making sure that people with mental illness are provided with the best possible treatment and care. Clause 10 states that the act hopes to respect their dignity, to ensure the protection of people who have or may have a mental illness, and to ensure the protection of the community. I am talking about those things because I think there are two specific areas where there is a gap at the moment, and they are worth putting on the record. After consultation with the sector, one of the areas this Mental Health Bill crosses into another area of government responsibility is through the disruptive behaviour management strategy released by this government in 2011. The rationale behind that strategy was that if disruptive behaviour was not dealt with quickly, it would lead to increased tensions and

conflicts in our communities, and therefore the government introduced its disruptive behaviour management strategy to address public concern. We all see people from our communities who are greatly stressed because the behaviour of tenants—not necessarily always public housing tenants, I must add; they can be tenants of all sorts—is impacting on their quality of life. The problem arises when this strategy interfaces with mental illness. Two disruptive tenants in my electorate have been evicted as a result of their mental illness. On the first occasion the family of one of my constituents contacted me to say that he had been going through a psychotic episode, I assume—I cannot really remember what the diagnosis was, but I think that was it—and threatened another person. He ended up in a mental health facility on an observation basis, I assume, for several weeks. His tenancy was terminated while he was in this facility; all his things were packed up and this guy had nowhere to go. When he was released, his family was simply beside itself because he had been locked up for probably all the right reasons because he was exhibiting aggressive behaviour, but it was because of a mental health issue. He found himself in an institution, unable to leave, and the Department of Housing's response at the time was to terminate his tenancy. Obviously, there were other things around that, but that interface between mental illness and the disruptive behaviour management strategy is simply not okay and does not result in an acceptable outcome. Secure housing and housing support is consistently identified as the most important issue for mental health consumers, with 42 per cent of people with a severe mental illness living in tenuous accommodation, and only 27 per cent of people with a psychiatric disability able to buy a home, compared with 70 per cent of the mainstream population.

I think the Minister for Mental Health; Disability Services, along with the Department of Housing and the Minister for Housing of the time, recognised that access to affordable housing was important, that people with mental illness often languish unnecessarily in a psychiatric hospital bed, and that stable, well-supported accommodation is pivotal to the wellbeing of the lives of the mentally ill, as it allows for independence, recovery and provides peace of mind to families and friends. They were the statements of the Minister for Mental Health, Hon Helen Morton, and she was quite right to say so. The minister developed a protocol between the Department of Housing and the Mental Health Commission to address these matters, and two things came out of that process that I do not have a sufficient answer for. After the sector applied some pressure to get that protocol developed, the protocol revolved around referring a person with a mental illness to the Mental Health Commission after they had received a second strike. The two obvious problems are: firstly, how does the Department of Housing make a mental health assessment; and, how does it have that expertise? There is a clear problem there for the way in which this protocol will be implemented.

Secondly, when a client is referred to the Mental Health Commission, what is it going to do with the referral? It will be interesting to see what will happen, because it does not deliver services. What is its protocol for trying to address these situations and to stop them from happening again?

In the few minutes I have left—again, in the spirit of the objects of the legislation about respecting dignity and ensuring protection for the community—I want to raise an issue that was raised with me a couple of weeks ago by the chief executive officer of the RSPCA. The issue relates to the psychiatric disorder of hoarding; I spoke about this issue recently in the house, and other members nodded in agreement. Hoarding is not currently classified as a mental disorder; it is a by-product of other conditions, such as obsessive-compulsive disorder. With regard to affording protection to the community and respecting the dignity of the individual and being able to intervene more quickly in cases of hoarding, particularly in situations in which there are sentient creatures involved such as cats, dogs, horses or whatever, it would be very beneficial to have this condition recognised by the Australian psychiatric community. David van Ooran from the RSPCA told me that that organisation is currently holding 519 animals in its centres, some of which have been held for at least 12 months, while going through court processes to prove that, in some cases, the people involved actually have a mental disorder and should not be allowed to keep animals in these circumstances.

This is another instance in which two issues of great concern to me—mental health in the community and the welfare of animals—overlap. I am sure many of my colleagues have heard similar complaints, but this issue is costing the community a massive amount of money. I think I can say that $700 000 is the figure that was quoted to me by the RSPCA in respect of the cost of keeping those animals while court cases progress. Under the law, the animals cannot be rehomed or fostered out; they have to be kept. That is a massive amount of the RSPCA's budget and fundraising activities, and that is clearly not a sustainable way to go. If this disorder were more readily recognised under the law, there would be far better outcomes for the people involved and for the community. If someone has 92 cats, several thousand pigeons and is living in not the best conditions, it is very clear that community safety is at risk. It is very important that this area of the law is changed, and I urge the government to consider it. I will write to the association involved to hopefully get it to consider including hoarding in the classification system for mental illnesses.

Before I sit down, I very much thank the people from the department who briefed us on this extensive bill, and I most of all thank the wonderful community sector, which supports most of the Mental Health Bill 2013. I look forward very much to seeing some positive outcomes from this massive reform of the mental health sector.

MR C.J. TALLENTIRE (Gosnells) [5.54 pm]: I rise to contribute to the third reading debate on the Mental Health Bill 2013 and focus on a couple of areas: the issue of detaining people without their consent, and the issue of guardianship. A number of other issues have also come up during the course of debate, but I want to begin by acknowledging the contributions of other members to the debate on this legislation, the very careful consideration in detail, and the manner in which the parliamentary secretary allowed that thorough consideration to take place. I especially acknowledge the member for Armadale and all the work he did on the debate on this bill on behalf of the opposition.

I turn firstly to the issue of detaining people without their consent because they have some form of mental health condition; it is a very serious issue and really does create a number of problems, especially when it is not clear who the person's family members are—those people who would in normal circumstances be called upon to give their consent. I noticed that the legislation provides under clause 281(2)(a)(i) for consent to be given by a person who is a spouse or de facto—a close family member, as defined in the bill. However, during the time that this bill has been debated in the Legislative Assembly, a constituent has come to me with an example that highlights the ambiguities around the term "de facto", and a real issue that has arisen as a consequence. The situation is that her de facto husband was detained at Graylands Hospital because of an act of domestic violence that he visited upon his de facto wife. As a result of going to hospital he has received some level of treatment, but it is unclear just how extensive that treatment is. The man's de facto wife, who came to see me, was very concerned that her partner should receive a certain type of medication that would soften his tendency towards violent acts. She is very concerned because there will come a time when he is released from Graylands and will naturally think of returning to the family home. She is concerned that if he has not been receiving the right medication, he could come home and perpetrate yet another act of violence on her. That is a real problem because she has not been given the necessary recognition of status to be told about the type of medication that he has received. As a consequence, she has no confidence that he has been receiving the right medication. She is not allowed to know what the medication actually is, but she fears that it may not be the right medication, and that when he comes out he might again attack her.

That is a real problem; on one hand, we have to respect the privacy rights of the person who has been detained, which of course makes sense, but we must also have a degree of transparency when inquiries are made as to what kind of treatments someone is receiving and what kinds of medication in particular. One might well say that someone's de facto wife would not necessarily know what the best medication would be, so why not just leave it to the experts? However, the person in question was already under some level of treatment and surveillance by people within the psychiatric profession, yet he was still prone to bouts of violence against his de facto wife, and that led to him injuring her and being detained and taken to Graylands. We need to make sure, when people are receiving treatment, that it is a treatment recommended by members of the medical profession and that it occurs in consultation with family members who may have made observations about the receptiveness of the person to that medication and about how effective the medication is. That is where I have concerns about the definitional arrangements for what constitutes a "close family member". I am concerned that the definition under clause 281(1) does not provide the necessary clarity; that is why my constituent had the problem of not being told what her partner's medication was. That is an issue of concern.

Sitting suspended from 6.00 to 7.00 pm

Mr C.J. TALLENTIRE: Before the dinner break I related a story a constituent had brought to me concerning the detention of her partner in Graylands Hospital and the difficulty she had experienced in gaining knowledge of the sort of medication he was on and the problems that that had posed. I do hope that the provisions in this bill that we have debated long and hard will help to allay that kind of concern and that some greater clarity will be brought to the definition of who is a family member who is entitled to know those kinds of details. As I was saying before, it is sometimes, sadly, essential that we detain people in hospital because of mental illness, and while we want to respect their privacy, we also need a degree of transparency about the nature of their treatment.

I move to another case I heard about recently concerning people held in the mental health wing of the Armadale Health Service. A constituent told me of her concerns with that ward. She had been a patient there and had been detained at the hospital against her wishes, but she has now recovered well. Her concerns are around the level of access that other patients can have to rooms on the ward that she was on. As a female, she was very concerned by the fact that male patients who were detained on the ward were able to wander into her room. As she pointed out to me, it would be quite easy to arrange for a system using swipe card technology that would meet the need

for medical staff to be able to access a person's room at any time, especially in an emergency, by staff having swipe cards that would enable them to get anywhere on the ward, but which would stop male patients from having free access to a female ward. That was her concern. She is working on a petition to fix this problem. It perhaps summarises the situation best if I just read the content of her proposed petition. Her proposed petition reads —

> We the undersigned say
>
> That we are deeply concerned that male and female patients in the Mental Health Inpatient Facility at the Armadale Health Service are not segregated by gender.
>
> At the Armadale facility patients of both sexes are housed in individual rooms, however the doors of these cannot be locked making patients venerable to assault and harassment. While toilet facilities are gender specific doors cannot be secured due to the need to ensure staff access in case of emergencies and male patients have been found using the female facilities. Again this leaves female patients vulnerable to harassment and assault.
>
> Now we ask the Legislative Assembly
>
> To ensure that newly constructed mental health facilities include single gender wards. These could take the form of separate male and female areas separated by a common recreation area.
>
> To safeguard female patients in existing mental health facilities we ask that electronic locks be placed on the doors of patient rooms. These could be opened with a swipe card limiting access to the person residing in that room and to staff who would still be able to enter at will in order to respond to an emergency.

That is a very good summary —

The ACTING SPEAKER (Mr N.W. Morton): Just a reminder, member; this is the third reading debate and comments need to be directed to the bill itself.

Mr C.J. TALLENTIRE: Thank you, Mr Acting Speaker; I appreciate that advice. I just wanted to clarify issues around authorised hospitals as defined in the bill and the need for them to ensure gender segregation. That is the request from my constituent, because she has concerns. It is all very well for us to put in black-letter law a definition of an authorised hospital, but we have to make sure that it meets the needs and concerns of people, and, indeed, perhaps the cause of an illness. My constituent is particularly concerned, as she describes it in the petition, by the sense of vulnerability that some patients feel and the fear that harassment or, indeed, an assault could arise. It is all very well for us to have these definitions but we must make sure that they work with the needs of people who are suffering from some form of mental illness.

I will move on to other areas in this bill. There was much talk about psychosurgery and the provisions in clause 205 of the bill. One issue concerned at what age a person would be able to access this kind of treatment—the so-called stimulation by intracerebral electrodes. It is clearly an issue that engenders fear amongst us. It is something that would terrify most of us. I gather from the discussion that there is still a lot of debate about the validity of this kind of medical procedure. I feel that this is an area of the bill that we may well have to revisit as further medical advice becomes available. We have made a first pass at this issue. I just hope that people are not harmed as a result of the legislation we are enacting.

I want to turn to another example. This relates to the definitions around people who are given some form of guardianship. Again, this can relate to close family members, but not necessarily. The Guardianship and Administration Act defines those people who may have some form of enduring power of guardianship. I have a constituent who suffers from a mental illness—he does not leave the family home. This is a middle-aged man who is living with his parents. I hear from his parents every time there is an election because he duly receives a notice from either the Western Australian or the Australian Electoral Commission advising that he has failed to vote. We have assisted the gentleman with the preparation of letters requesting some form of exemption from the obligation to vote. What has been more difficult to deal with has been jury duty. There has been less leniency with that; it has been harder to get him out of doing jury duty than to avoid a fine for failing to vote. I mention this because guardianship is an important issue in these cases. It seems that the bureaucracy partly acknowledges that this gentleman has a mental health problem but, on the other hand, it does not want to recognise that his parents, who are in their mid to late 60s, are his guardians. In fact, the bureaucracy really wants to deal with this person who is not prepared to deal with the normal administrative procedures that are required to live in our society. It is a difficult situation for him, and I fear that the structures that we have put in place with this legislation around guardianship and enduring powers of attorney are quite rigid. I do not think there is the flexibility in this bill to enable my constituent to be helped.

I will move on to deal with an organisation in my electorate, Citizen Advocacy South Metropolitan. This organisation helps people who have mental health problems to deal with the day-to-day challenges that they face. It does a tremendous job, and I am very fortunate to have this organisation —

Mr W.J. Johnston: It used to be in my electorate.

Mr C.J. TALLENTIRE: It was previously in the member for Cannington's electorate. It is a wonderful organisation that is now based at the Thornlie Community Centre. I really want to recognise the tremendous work that it does, and also recognise that we have a growing problem on our hands, especially with elderly people. Other members have also spoken very well on this point. As our population ages, people with various geriatric-related illnesses such as dementia will require more assistance of this kind. I hope that we can provide the funding. I heard the member for Maylands put very clearly that the central need with this legislation is, as is so often the case, good funding to make it all become a reality, to make it all become possible.

Finally, I want to touch on something that I do not believe is strong enough in this legislation; that is, breaking down the silos that we have in our government structures and in our society structures. Very often mental health conditions will be perhaps detected or seen first by, say, the Department of Housing or perhaps by the police or perhaps by, in the case of young people, a schoolteacher or a health professional. We need to be able to ensure that those people who do that first detection job have a process under which they can advise other agencies of the need for some form of intervention and assistance to be provided to someone. Perhaps that is a case in which an organisation such as Citizen Advocacy South Metropolitan can step in and do it on a less formal basis—that is, it can do it on that non-siloed, across-agency, whole-of-government type of approach that is so vital in dealing with these kinds of issues.

I will conclude my remarks. I again acknowledge the work of many of my colleagues, but especially the member for Armadale and, indeed, the parliamentary secretary, for their work on this bill.

MR W.J. JOHNSTON (Cannington) [7.14 pm]: I rise to make some remarks on the third reading of the Mental Health Bill 2013. I do so noting that I was not able, during the last period of the debate, to be present for all the debate, so I want to home in on a few specific issues. Firstly, I want to draw the parliamentary secretary's attention to clause 493, which, when it was first debated, was debated as clause 492. The clause states —

> **493. Determination of questions of law before Mental Health Tribunal**
>
> (1) In this section —
>
> ***question of law*** does not include a question of mixed law and fact.
>
> (2) The Mental Health Tribunal may apply to the State Administrative Tribunal for a determination on a question of law that arises in a proceeding before the Mental Health Tribunal.

I point out that clause 439, which, when it was debated, was clause 438, states —

> (1) In this section —
>
> ***question of law*** includes a question of mixed law and fact.

We can see that a cross-definition question arises because the two clauses have a different definition of "question of law". When this matter was dealt with in debate, it was raised by the member for Armadale with the parliamentary secretary. I am sorry that I do not have the page number because, in the printing, it has been cut off the top and the bottom. However, in the *Hansard* of 10 April, the member for Armadale drew the parliamentary secretary's attention to what I have just talked about. He asked —

> Could the parliamentary secretary explain why?

That is, why there was a difference between the definitions of what a question of law was under what are now clauses 439 and 493. The reply from the parliamentary secretary was —

> We have taken advice from Parliamentary Counsel and that is how it has been recommended it be written.

The member for Armadale asked —

> Why did they recommend that?

The parliamentary secretary said —

> We just took the answer; I do not know.

That is fair enough, because she is not the minister. The member for Armadale then asked —

> Are you able to make a commitment that you will provide that at some stage?

The parliamentary secretary said —

> At a later time, rather than holding up proceedings now.

The member for Armadale asked —

> When we reconvene?

The parliamentary secretary said —

> My advisers just asked me when the member for Armadale is asking for the information to be provided. I presume the member is talking about the next sitting, not today.

The member for Armadale was very generous and said —

> Of course—we are going to proceed with this bill, unless you want to adjourn.

The parliamentary secretary said —

> No; this is just a clarification.

The member for Armadale, very helpfully, said —

> All I am asking is that you provide that information by the time Parliament reconvenes in three weeks' time so then I can refer to it with my colleagues in the other place.

The parliamentary secretary then said, "Yes, we will." Then the clause was put and passed.

I spoke to the member for Armadale prior to the dinner break, and he advised me that that information has not yet been provided to the opposition. I wonder whether the parliamentary secretary is currently in a position to provide the advice that she agreed to provide at the time of the —

Ms A.R. Mitchell: I was going to comment on that in my third reading response, but I am happy to give it to you now, if you wish.

Mr W.J. JOHNSTON: Whatever is convenient to the parliamentary secretary. Why does she not provide it just by interjection?

Ms A.R. Mitchell: Certainly. The parliamentary counsel who has been involved with the drafting of this bill all the way through has been on leave and is not yet back at work. He is due back at work either tomorrow or Thursday. It is our intention to hand the information to the member for Armadale next week.

Mr W.J. JOHNSTON: Okay. Given the procedures of the other house, I understand that if we pass this bill today or tomorrow, it cannot be debated this week; it will be debated next week. On that basis, I think that will satisfy the opposition. Certainly, I appreciate the advice that the parliamentary secretary has provided. It has sped things up because I can now clarify my remarks. There may be a good reason why the definition is different in each clause. There may be a perfectly reasonable explanation for the fact that it is defined for the purposes of each clause, and we look forward to having it, but it is clearly not automatically apparent, when one reads the bill, why those two definitions are provided. However, I appreciate the undertaking by the parliamentary secretary, and I am sure the member for Armadale does likewise. As I said, we had a bit of a conversation before the dinner break about what happened in that regard.

I want to go on to the question of the qualification of the president. Mr Acting Speaker (Mr N.W. Morton) will remember clearly the debate on the question of the qualification of the president, and will recall the division on the amendment moved by the member for Armadale, as he voted with the government and defeated that amendment. The opposition's amendment sought to require the president to be either a judge or former judge of the Supreme Court, District Court or Family Court of Western Australia, or an Australian lawyer as defined by the Legal Profession Act 2007 and have at least eight years' experience. It was the opposition's view that the best way to protect the interests of people appearing before the tribunal was if the presiding officer had a legal background. That was resisted by the government, not on the basis that the president should not be a lawyer, but rather the government wanted a procedure that would deliver somebody of talent and quality to be the president. The problem is that we want the tribunal to make legal decisions, so it would appear that the best person to lead that tribunal is not, in fact, a medical practitioner but a person with legal experience. I make the point that we are talking about legal rights. The capacity to take advice and make sure there is proper medical understanding is important and absolutely essential to the proper operation of the tribunal, but the point is who should preside over it and who is best capable of understanding not the medical consequences of the decisions that are being made but rather the legal consequences. The tribunal makes decisions based on the law, and it does that by

informing itself of the various medical issues involved, but fundamentally it is applying the law. That is why, if we had a case that ended up on appeal to court—guess what?—the decision would be made by lawyers because the judges sitting on the Full Bench of the Supreme Court are all lawyers. It seems logical to have a person with that legal experience—people who are trained to think in terms of the law. The opposition put its position very strongly, and it was very sensible. I still think it is sensible, notwithstanding the fact that the amendment was defeated and the arrangement that the government proposed will continue. I will again read from *Hansard* of 8 April. I cannot provide members with the page number because it has been cut off in printing. I will read in part the parliamentary secretary's contribution. She states —

> As I have said before, it may well be that a very qualified lawyer is chosen through the selection process to become the president. We also believe that throughout the bill we have other avenues to ensure that the Mental Health Tribunal can obtain assistance from persons with the relevant knowledge and experience—that is, clause 439—in the areas they may want. Also, clause 492(2) allows the Mental Health Tribunal to seek determinations on questions of law from the State Administrative Tribunal. Therefore, there are a number of avenues by which the Mental Health Tribunal can seek professional legal advice.

I also point out that clause 438 states —

> The presiding member of the Tribunal as constituted for a proceeding is the member of the Tribunal as so constituted who is a lawyer.

The bill already contains a provision that the tribunal needs to include a lawyer, and clause 439(1) defines the question of law, and then the clause states —

> (2) A question in a proceeding (other than a question of law) must be resolved according to the opinion of the majority of the members constituting the Tribunal for the proceeding.
>
> (3) A question of law in a proceeding before the Tribunal must be resolved according to the opinion of the presiding member.

Clause 439(3) of the bill acknowledges that questions of law will be determined by a lawyer anyway, but that may not be the president. It seems more sensible that the president is a lawyer, so the tribunal has that detailed experience. I am not a lawyer, but clearly a person with background, experience and training in the law is the best person to lead a tribunal that deals in the law. I make the point that it is not a unique arrangement. Many specialist tribunals are led by lawyers, and it seems that is the most sensible way forward. I also point out that at the time the parliamentary secretary referred to this clause it was clause 439 but because of other government amendments that were passed it is now clause 440. It reads —

> **Assistance from persons with relevant knowledge or experience**
>
> The Tribunal may engage or appoint one or more persons with knowledge or experience that the Tribunal considers relevant to a proceeding to assist the Tribunal in the proceeding.

Again, I make the point that the parliamentary secretary drew our attention to that clause as being a method, effectively, for the tribunal to get legal advice. I do not think that is the aim of that clause because, if it were, the preceding clause, which I have read out and will not read again, would not make sense. It states that when deciding a question in a proceeding, questions of law are uniquely resolved according to the opinion of the presiding member as opposed to any other member of the tribunal, and it says that they do not have to act by majority. It would not be sensible for the construction of the bill to have the lawyer on the tribunal making decisions on questions of law and then point to the second provision as the provision that allows legal advice. If that is what the bill intends, it does not make sense. Again, that is why the opposition moved that amendment.

I also want to point out that the opposition again moved amendments to make the presiding officer effectively the responsible officer for the tribunal. The member for Armadale explained in some detail the benefits of that.

[Quorum formed.]

Mr W.J. JOHNSTON: The member for Armadale quoted extensively from a letter written by Merranie Strauss, which I have had the benefit of seeing. I will not go back and quote all the same words because it can be read in *Hansard*, but great powers are specified for the tribunal under this bill. Potentially, people without knowledge of the law will be given these extensive powers. The instant question will be: what is a question of law and what is a question of fact? We look forward to the explanation, particularly because clause 439(1) states —

> ***question of law*** includes a question of mixed law and fact.

As a layperson who used to operate in industrial tribunals and in the Federal Court of Australia, I can tell members that what is a question of fact and what is a question of law is very complex. For example, a tribunal can have a decision overturned when there is only an appeal over questions of law and not of fact if the tribunal has made the decision in such a reckless manner that the finding itself is unsafe. I only know that because I have had to deal with industrial tribunals. I am no lawyer but I can read all the different decisions. What becomes a question of law is actually much broader than one would think—things that we would think are actually questions of fact. Let me say it again: a court has and does overturn the decisions of a specialist tribunal when it has made a finding of fact, if, in the opinion of the court, that finding was reckless. My learned colleague, the member for Armadale, is nodding in the back row. What is a matter of law is actually much wider than one would think and again, it is much wider because of the definition given in clause 439(1). If it is a question of mixed law and fact, then it is a question of law and only the presiding member, not all the members, gets to make the decision.

If this issue cannot be clarified there is potential for appeals to the State Administrative Tribunal—which I understand are heard on a de novo basis, which means without regard to anything that has preceded it —on the powers of the tribunal to make a decision. I will give an example. The tribunal decides that a person is mentally impaired and therefore needs to be involuntarily held in a prescribed place. There is then an appeal against that decision at which it will be argued not that the person is not mentally impaired but that the decision that the person was mentally impaired dealt with both issues of fact and law. After all, we only have the right to determine the person is mentally impaired because of the act. We need these things resolved. Again, having a lawyer as the president would assist everyone in making those decisions.

I now comment on clause 493. This was not a question asked of the parliamentary secretary by the member for Armadale, but subclause (2) states —

> The Mental Health Tribunal may apply to the State Administrative Tribunal for a determination on a question of law that arises in a proceeding before the Mental Health Tribunal.

This does not go to the question that we have already talked about, which is the definition of what a question of law is, but rather, can the decision by the tribunal to ask the State Administrative Tribunal for a determination only be made by the presiding officer? If it is a question of law, it appears that it cannot be done by a majority vote but only by the presiding officer making the decision. Another clause, clause 439—"Deciding questions in proceedings"—states the way decisions are made. That will be an interesting issue to have clarified. The parliamentary secretary may not want to do that in her third reading response, but at some point in time that will have to be clarified, whether in Parliament or elsewhere.

I now move to other topics. I go to the question of the general administrative function of the tribunal. Again, these matters were canvassed extensively in the consideration in detail stage so I will not canvass all those things again. For example, selecting the constitution of the tribunal, when and where it sits, giving parties extended time for applications, making the rules and directing the registrar are all types of administrative matters that in normal tribunals are conducted by the president. People familiar with other tribunals will assure members that is the case. It does seem that they are matters that really should be done in that way by the president of the tribunal. Again, that is a good reason for the president to be a lawyer.

I draw members' attention to the letter from Ms Strauss which the member for Armadale quoted from extensively, in particular this paragraph —

> There should be additional clauses stating the President's general function and powers to run the Tribunal and engage staff such as —
>
> > "The President is responsible for the administration of the Tribunal, with the assistance of the members and the registrar and other staff of the Tribunal".
> >
> > "The President is responsible for the appointment of a Registrar and such other staff as he or she decides is required for the Tribunal to function effectively and efficiently."

Again, I make the point that they are the sorts of procedures that are found in most specialist tribunals. It should not be seen as particularly unusual to place those types of provisions in this tribunal. Although we are dealing with mental health, which is a very specialised area that very few people have a detailed knowledge of, that is not what we are talking about. We are talking about who best could administer the procedures that deal with people suffering in those circumstances. It is very important to separate those two issues.

I now turn quickly to a broader issue that arises from the bill—the lack of an administrative decisions judicial review process in Western Australia. The commonwealth has had an ADJR for a long time, since 1974 I think. It

has been around for a long time. I may have the year wrong but it was certainly in the 1970s. There is a huge case law build-up through the ADJR process. That requires all public servants to give reasons for a decision. It is not that they cannot make a decision but if they make a decision they must provide an explanation. That is a powerful tool. I am a former federal public servant, at junior levels quite frankly, but from the moment a person starts in the public service they are always reminded of the ADJR because it is not a limit on their power, but a limit on their ability to act capriciously. I do think that that style of process is something that would be welcome for the exercise of all laws in Western Australia including what we are dealing with here in mental health.

The SAT, which, of course, is extensively referenced in the legislation that we are dealing with, does in some ways equate to the commonwealth administrative tribunal but there is still not a process of requiring an explanation for decisions made by public servants in Western Australia. That is a weakness for everybody who deals with public servants in this state. The more we can focus on that type of approach the better it will be for the citizens of our state because it will give citizens more rights. When we look at these issues—that is, giving authority to detain people because of their mental state rather than for what they have done—they are the sorts of things where giving people rights is very important.

I finish by noting that there has been a long period of change in the handling of mental health. As you may remember, Mr Acting Speaker, I referred to the circumstances of my own father and what happened to him in the 1950s and 1960s compared with what occurs today. We all benefit from and should all welcome the deinstitutionalisation of mental health. People should not have to have the same personal experience as my family to support the modernisation of the processes of handling mental health. This bill aims to further that progress and that is why the Labor Party welcomes it. However, that does not mean that we have got everything right, even in a bill of 585 clauses. The one thing we know is that no matter the level of goodwill on both sides of the Parliament on this bill—from what I have read and from participating in the debate, it is clear that there has been a large level of goodwill on both sides of the chamber—even when the government has not agreed to opposition amendments, it is not because it has dismissed them out of hand, but, rather, because it believes there is a better approach. That is fair enough, because the Labor Party believes it knows a better approach. But, one way or another, it has all been done in good spirit.

The one thing we all know, I would suggest, Mr Acting Speaker, is that we have got some things wrong, and there is a review procedure in the bill. A presiding officer, if they were a judge, a former judge or a lawyer, would have been ideally placed to do the review, because we know in five years when we have a look at the bill again, there will need to be changes, we will have had experience, we will have noticed the way things operate and we will have worked out improvements. However, I commend the work that has been done to this distance. I particularly congratulate the parliamentary secretary on her handling of a very complex piece of legislation. I do not know whether it is her first, but I imagine it is probably the most complex bill she will have to deal with for a long time, so congratulations on doing that.

I also want to acknowledge the hard work of the member for Armadale. He is not our shadow minister, but the shadow parliamentary secretary in this chamber, and I know that he has worked hard with a number of members of the caucus, including Hon Stephen Dawson, our shadow minister. I acknowledge the hard work they have done together. The great thing about the member for Armadale, as an incredibly well-regarded lawyer, is that he is not going to stand in this place and talk about things that are not important. The fact that so many highly technical amendments have been produced by the member for Armadale, the shadow minister and others on the Labor side is testament to the hard work of the member for Armadale and Hon Stephen Dawson.

Dr A.D. Buti: By way of interjection, because I forgot, I acknowledge the hard work of the clerks and also the parliamentary counsel.

Mr W.J. JOHNSTON: Absolutely; in respect of the parliamentary counsel, I look forward to seeing the answer to that question. I have been critical of parliamentary counsel in this chamber a couple of times, and on a couple of occasions amendments came back basically reflecting the criticisms that I had been making. I look forward to hearing from the parliamentary secretary at the appropriate time.

MR D.J. KELLY (Bassendean) [7.44 pm]: I rise to make a contribution on the third reading of the Mental Health Bill. I take up from where the member for Cannington left off and acknowledge the work done by the member for Armadale on this bill. It is a very large and complex bill. The member for Armadale put in a tremendous amount of work, a great amount of detail, and I commend him for the work he has done not only in a technical sense—because it is good to have someone on our side of the house prepared to put in the work—but also because it ultimately leads to a better outcome for the community. The limited number of opposition amendments that the government accepted at least means that the bill is a little better than it would have been

had it not been for the member for Armadale's work. I would also like to congratulate the parliamentary secretary who, likewise, put in a tremendous amount of work on the bill. I also acknowledge the work that she has done.

I would also like to mention the work done by the Mental Health Law Centre. It has done an enormous amount of work in this area. It is an organisation that has limited funds to respond to an enormous community issue. It provides an invaluable service to people, some of the most vulnerable in our community, who at times are trying to pick their way through a very complicated legal and medical maze when they find themselves confronted by issues of mental illness. For a lawyer there would be far easier places to work than the Mental Health Law Centre, where the strain of the job would be less and the remuneration much more. To the legal staff and the non-legal staff who provide support at the Mental Health Law Centre, I add my appreciation for the work they do.

I also mention the Youth Affairs Council of Western Australia for the contribution it makes in this area, particularly in the area of mental health issues for young people. Mental health issues are a growing and troubling issue. It is almost an epidemic in some areas among young people. It is not always the case that the services are designed to be appropriate for young people, so it is important to have an organisation such as the Youth Affairs Council to advocate on behalf of young people to ensure that the services the community provides are most appropriate to youth.

Suicide is now the leading cause of unexpected death for youth between the ages of 12 and 25. That may come as a surprise to a lot of people. Given people's perception of young people, we would assume that alcohol-related accidents, drink-driving or car crashes in general would be the leading cause of unexpected deaths for young people in our community, but it is now youth suicide. That shows how important it is to get right the services that we provide to youth in this area, so I thank YACWA again.

Before I go into some of the detail of the bill, I want to comment on funding. This bill will do nothing to improve the way we deal with this issue unless we get the funding right for mental health services. The member for Cannington referred to the deinstitutionalisation of these services to more community-like settings to deal with these people. Some people think that would lead to a reduction in spending in this area, but that is no guarantee. Often when people are taken out of big institutions and are put into a community setting, more support is needed to ensure that they do not simply fall through the cracks when placed in the community. We have to make sure that when we deinstitutionalise mental health services, we still have the funding and the support so that once people return to the community, they do not go backwards. The mistake has been made in many countries around the world; big institutions have been abolished and mental health services have dissipated into the community. They are then less visible and funding can be lacking. I certainly support placing these sorts of services in a more community-like setting, but it does not mean that we can spend less on them or that mental health patients need less support. In fact, it might be quite the opposite. I am certainly concerned that because this government has made a mess of the state budget, it will look for cost savings, and when a government is in that mood and asks every agency to make cuts, cuts will inevitably be made in areas such as mental health, which can ill afford them. Although the government has had the opposition's in-principle support for this bill, it will not amount to any real improvement and there may be a diminishing of mental health services if funding is taken from this area. Members on the opposite side might congratulate themselves on the passage of this bill, although it contains some significant errors, as pointed out by the member for Armadale, but they should not think that once the bill passes, the job is done. If this bill is to really improve the services we provide to patients with mental health issues, we need the funding in place to make sure it works.

I am not a medical practitioner or someone with particular expertise in the area of mental health. However, after having listened to the debate and the positions put by experts in the field, some provisions in this bill still give me cause for concern. Obviously, to involuntarily detain a patient is one of the most, if not the most, serious powers that this bill attempts to provide and regulate for practitioners. One of the issues that has been raised with me is the ability for a person to be made an involuntary patient on the basis that their condition may result in them doing serious harm to their reputation. That provision is in the current bill even though it was certainly the understanding of some of the patient advocate groups in the sector that that would no longer be in the bill. I understand that they had that understanding based on comments made by the minister. The removal of that provision has not been followed through on and it is still in the bill now before the house. It is my understanding that a patient can be still made an involuntary patient on the basis that a practitioner believes their behaviour has the potential to cause serious harm to their reputation. If we just think about that for a moment, if somebody is made an involuntary patient on the grounds of mental illness, regardless of where they live or with whom they associate, most people would consider that in itself as something that would do serious harm to someone's

reputation. Making someone an involuntary patient for reasons of mental illness seems a pretty peculiar way of protecting someone's reputation when we know that in the general community that would be a detrimental mark against someone's reputation. It seems to be a self-defeating provision. A practitioner might think that as a result of someone's behaviour—maybe they behaved peculiarly in public or whatever the justification—people may consider their reputation damaged. What will we do to protect that person's reputation? We will make them an involuntary patient, and we know the consequences of that. Members on this side of the house are very disappointed that the government has not seen fit to remove that provision from this legislation. Advocacy groups in the sector strongly advocated for its removal. In Parliament the opposition more than adequately argued for the provision's removal and the response from the government was very limited. I still do not understand why the potential of serious harm to someone's reputation, which is very hard to measure and very subjective in the first place, can justify making someone an involuntary patient.

Dr A.D. Buti: Member, the Minister for Mental Health did go on radio and make a commitment that she would remove that as a criterion.

Mr D.J. KELLY: I understand that is exactly the case. The Minister for Mental Health, Hon Helen Morton, went on public radio and said that that would not be a provision in the new bill. I know there is some commentary that we do not really have to abide by what we say on FM radio. I am not sure whether the minister was speaking on FM radio or AM radio.

The ACTING SPEAKER (Mr N.W. Morton): I think we are talking about the detail of the bill here, member.

Mr D.J. KELLY: I will go back to the detail of the bill. The government, through the minister, made a public commitment that this provision would not be a feature of this bill, but it appears as though the government has reneged on that, and that is a great disappointment. If the parliamentary secretary had been able to come into this place and give a cogent reason and an evidence-based argument for why this provision should remain, maybe people on this side and the community would be satisfied. But that was simply not the case.

The issue of the bill allowing a person to be made an involuntary patient on the grounds that it is determined that they have unreasonably refused treatment also causes us on this side some trouble. On the face of it, we might say that a person refusing treatment that is essential to their wellbeing may be a reasonable ground to make them an involuntary patient, but the problem, as I understand it, is the process in the bill for coming to that conclusion. The bill allows for a practitioner to determine the appropriate treatment and then, if a person refuses the treatment, it can be the same practitioner who then makes the decision that the refusal to accept the treatment is unreasonable; then the same practitioner participates in the decision to make the person an involuntary patient. That to me does not provide suitable checks and balances to make sure that that chain of decisions is appropriate. Obviously, a practitioner who makes a decision that a particular course of treatment is in the best interests of the patient will have some personal and professional ownership of that course of treatment. If the patient then says, "Well, thank you very much for your advice, but I am not going to go down that path", there is potential for that medical practitioner to see the patient as going against their professional recommendation and they may think to themselves that as the expert they know better and, therefore, they may determine that the patient's refusal is unreasonable. That does not seem to provide the patient with the independent check of having the question of unreasonableness determined by another medical practitioner, for example, so that a different practitioner is required to participate in the decision to make the person an involuntary patient. The bill allows one medical practitioner to determine the treatment and determine what is unreasonable and then make the person an involuntary patient. That seems to me to be lacking in checks and balances to ensure that this incredibly serious sanction—that of making someone an involuntary patient—is not made in a way that is not in the best interests of the patient.

Another issue I would like to talk about is informed consent. It is my understanding that a provision in the 2011 draft bill required practitioners to disclose to patients whether any financial benefit would come to them for a patient choosing a particular course of treatment. That seemed to us on this side to be a very sensible way to go. If a patient is going to make a decision to accept the course of treatment, in order for their consent to be informed they have to be in receipt of all the relevant information. I do not want to suggest that every medical practitioner who prescribes a course of medication, for example, will be swayed when making that decision by whether they attract some benefit from the company providing it, but it certainly would be a rare occasion if a medical practitioner was not influenced by these sorts of matters when they prescribe drugs. It seems to me that it was an eminently sensible provision to have in the bill that informed consent included practitioners disclosing to patients whether they had any financial benefit, or benefit of any other kind, accruing to them from a patient consenting to a course of treatment. I understand that the Australian Medical Association argued that that provision should

not be in the bill. If that is the case, I am very disappointed, and I am also disappointed that the government would accede to that sort of request. That causes me considerable concern.

Another issue with the bill that I want to mention is the right to legal representation. I know this is an issue that the Mental Health Law Centre is very concerned about and it argued quite strongly for enhanced rights of representation in the bill. In order to try to achieve this, the member for Armadale moved a range of amendments that I understand were not accepted by the government. The amendment to clause 446, which would have clearly stated that a person before the Mental Health Tribunal would have the right to legal representation, was rejected by the government. As I understand it, the bill states that people "may" be represented, but "may be represented" is something quite different from saying people shall have a right to represented by a legal practitioner if that is their choice. Again, a tribunal such as the Mental Health Tribunal should deliver outcomes that are in the community's interest and I cannot see a circumstance in which denying a patient before that tribunal legal representation would be in the public interest. I am disappointed that the government did not see fit to ensure that that takes place. I was very disappointed that the amendment moved by the member for Armadale in respect of representation when the party before the tribunal is a child was not accepted either. Ensuring that a child before the tribunal has a right to legal representation seems to me to be fairly basic. I listened to some of the debate and I do not believe that the government has made a case about why that should be a matter—almost a discretionary matter—for the tribunal. I do not think this bill does enough to ensure that mental health patients have proper access to representation, and that they have best possible access, as they try to work their way through what will still be a very complicated process, especially given that they are allegedly suffering from a mental illness.

The member for Armadale also moved new clause 450A entitled "Access to Tribunal's records". That proposed new clause states —

> For the purpose of conducting a proceeding, a party appearing in person or a party's representative under section 446, 447 or 448 is entitled to inspect, and to take a copy of the whole or any part of, the Tribunal's records relating to the proceedings —
>
> (a) at any time the office of the Tribunal is open for business; and
>
> (b) at any other time by arrangement with the registrar.

I am disappointed that the government did not accept the new clause moved by the member for Armadale. Clearly, if a person is to be properly represented before the tribunal, one of the basic foundations of that proper representation is that the person has full access to their file—to the tribunal's records—as they relate to the proceedings. That should not be something that any person, including any member of the tribunal, should be able to stand in the way of for someone represented by the tribunal. I am really at a loss to understand why the government would not accept a new clause like that. To have no doubt that a person can simply make the request and receive access to the tribunal's records as they relate to the proceeding seems to me to be a no-brainer. Having worked for some time in the industrial field, I know about the amount of time wasted for tribunals by parties trying to get access to various records that are relevant to the proceeding; it is just an absolutely enormous waste of time. The legislation would benefit significantly if that matter were simply dealt with by those records being made available to parties. On this side, a number of our speakers made the point that in some respects under this bill people with a mental illness will not have the same rights as people who have been charged with criminal offences in the courts. There may be others that I have not mentioned but certainly rights to representation is an area on which that criticism can rightly be levied against the government in respect of this bill. A criminal before a criminal court has a right to legal representation. A mentally ill person before the Mental Health Tribunal does not have an automatic right to legal representation. That seems peculiar.

I will say one other thing about the Mental Health Tribunal on the question of whether the president of the Mental Health Tribunal should be a legal practitioner. The member for Armadale moved an amendment that would have provided —

> The President must be either:
>
> (a) a judge or former judge of the Supreme, District or Family Court of Western Australia, or
>
> (b) an Australian lawyer as defined by the *Legal Profession Act 2008* and have at least 8 years legal experience.

The government rejected that. For the life of me, I cannot understand why the government does not want to make it a requirement that the president of the tribunal is a legal practitioner. I understand the argument that the government would like this tribunal to focus as much as possible on questions of medical importance rather than legal importance, but I am concerned that by not making the president a person with legal qualifications, we do two things. Firstly, this tribunal will deal principally with people's legal rights, so whether it is a tribunal that

deals with medical matters, housing matters or whatever, essentially it will deal with people's legal rights. Secondly, if we want medical issues to be at the forefront of the work of a tribunal and someone medically qualified is the president of the tribunal, we run the risk that in making a decision, the president will put their medical view ahead of what is legally proper. If the person thinks the medical outcome that is being imposed, recommended or delivered to the person before the tribunal is correct, their belief that that is correct may colour their view about whether it is legally the right outcome for the patient. If someone says that the process might not have been right or the tribunal might not have done this right, but the outcome is the right medical outcome, that is absolutely not good enough. If the person believes their legal rights have been infringed, that should be the question that is foremost in the minds of the tribunal members. That is potentially compromised. I caught the end of the member for Cannington's speech about the difficulties of determining a question of law versus a question of fact. We can argue that today is Wednesday. That might seem to be a question of fact, but depending on what time zone we are in, or the act we are talking about, it may in fact amount to a question of law. It is a very complicated area.

I commend the government in general for this bill. We put up sensible amendments in many areas, and I regret that not enough of them were accepted. Principally, my concern is that we ensure the funding is there for this bill to make sure it delivers better services.

MS S.F. McGURK (Fremantle) [8.14 pm]: I would like to take the opportunity to make a contribution to the third reading of the Mental Health Bill 2013. I commend all the other speakers who have spoken and whom I have had an opportunity to hear speak on this bill. It is a significant piece of legislation. I take the opportunity to reiterate some points I made in my second reading contribution. I think they have been reiterated by some speakers on the third reading this evening.

I understand it is a commonly held professional view, but it also seems a commonsense view, that mental health is not the responsibility of any one agency or person; in fact, a multi-facetted response is needed to properly care for people with mental illness. Proper housing support, income, employment services and drug and alcohol treatment are all crucial. Without all those proper and robust support mechanisms in place, I would go so far as to say that it is quite likely that the framework outlined in this substantial piece of legislation will be ineffective if not certainly weakened. As I said in my second reading contribution, I am concerned that cuts or reductions to services in any of those areas will have an adverse effect on the people we are trying to assist in the mental health system. Obviously, as we head towards the state budget later this week when we will hear the state Treasurer hand down the overall resource allocation for the finances in our state, I think a number of us will be looking with interest to see whether there is any change in resource allocation for the mental health area. It is one thing to go through what I understand has been probably a five-year exercise to embark on a substantial rewrite of the Mental Health Bill, which contains 585 clauses, but what will that mean if there is a cut in the resource allocation to mental health specifically as well as in the service areas I have referred to?

A number of other speakers, including the member for Kwinana, spoke about promises made previously about bed allocations in the mental health wards in Osborne Park, for instance, and promises that have been made in relation to Graylands. In fact, reference was made to budgetary allocations made but not spent and the additional resources have not been given to make those funding allocations come to fruition in the form of better services, more beds et cetera. I understand, as I hope all the other members in this house understand, that our state government finances are not a bottomless pit; there are many, many demands on those finances and lots of demands on the public health dollars, and therefore they are under pressure. Having said that, I think it is fair to say that there is frustration, as we have debated many times in this house, that this state government has elected to invest in gold-plated CBD infrastructure projects while at the same time basic services in education and health, including mental health, are suffering. We will see later this week when the budget is handed down whether there will be additional funds for mental health. Will it be too much to hope that additional funds will be put into the mental health area or proper consideration given to the resource allocation that is needed, particularly in the mental health area, to make sure the services that are needed and the staff who do this important work are properly resourced to do the job properly?

I also pointed out during my second reading contribution the need for the proper coordination of mental health services. This is crucial, as is the proper involvement of patients' families in care and treatment plans of people with mental illness. I spoke about the impending coroner's inquiry into the suicides of five Alma Street Centre patients soon after discharge. A number of other suicides of Alma Street patients could have been included in this inquiry, which is still scheduled to take place, but those additional deaths simply fell outside an arbitrary specified period so will not be included, much to the frustration of their families. We still have an outstanding inquiry into the deaths of five Alma Street patients. In late February I asked how a rewrite of the Mental Health Bill was justified when a review not only into the Alma Street suicides but also 10 deaths at Graylands Hospital

had not been handed down. Since then, there has been a report into the patient deaths at Graylands Hospital. It was not complimentary to the hospital, although I note it made the point that there were no systemic failures on the part of the hospital. In Coroner Barry King's conclusions about the 10 deaths that occurred over seven years, he talked about tragic insights into the plight of WA's mentally ill including problems of overcrowding, a lack of privacy for patients, unsuitable facilities, no alternatives for difficult cases, and boredom of long-term patients.

In addition to the comments that were made by the Coroner, Debora Colvin, head of the Council of Official Visitors, said the conditions in some Graylands wards were dire. The quote that I think other people from this side of the house have repeated is —

> "We find ourselves in this very strange place of people banging at the door to get into mental health services, with people at the other end banging to get out … but with nowhere to go," Ms Colvin said.

There is no doubt that the theme arising from the inquiry into those 10 suicides was that there were real problems with the Graylands facility. The member for Kwinana noted that there has been a budget allocation made into the number of beds required at Osborne Park and Graylands Hospitals. Either additional funds or whatever resources are required, whether it is human or financial, have not been put together to ensure additional beds will be realised. The coroner's inquest into the suicides that occurred shortly after Alma Street patients were discharged, as far as I know, has still not commenced. It will certainly be watched closely not only by those people's families but also by people in my community, who take a keen interest in what happens at Fremantle Hospital. They are also concerned about what happens to Alma Street patients and how that facility is operating. We will watch that with interest.

The framework of the bill has been debated and will soon be legislation of this state. The resourcing of allied services, including employment services, income support, drug and alcohol services, housing services and police, and how police are resourced and trained to deal with people with mental illness, is crucial to effectively deal with the very complex problem of people with mental illness in our community. Resources and the proper coordination of those services is crucial, as are the resources that go into the mental health system itself and the coordination of those services amongst agencies.

During the second reading debate, I also raised concerns about the fines associated with staff of a mental health service who are found to have ill-treated or neglected a patient. I know it is a very specific point, but I made the point that the fines under this bill are a maximum of $15 000 or a penalty of two years' imprisonment. In the Animal Welfare Act, a fine of $50 000 and a much longer period of imprisonment applies. I was keen to ask the parliamentary secretary whether consideration was given to that comparison. I am sure it was not intended this way, but it is so clearly insulting to mental health patients and their families. The parliamentary secretary confessed that she had not been made aware of that comparison, although it was raised by the Mental Health Legal Centre with our side so I am sure it was with the government as well. The parliamentary secretary simply said that the fines in this bill represented a doubling of fines to what occurred previously. The Animal Welfare Act was amended not that long ago. The comparison is something that should be considered by the government. I do not think anyone has a problem with severe fines under the animal welfare legislation. I am sure Madam Acting Speaker (Ms L.L. Baker) would not. I do not think anyone has a problem with that, but when we compare the fines in the Mental Health Bill that could be charged against a staff member of a mental health facility for ill-treating or neglecting a patient, it is insulting.

They are some of the issues that I raised previously. I was keen to hear what was said during consideration in detail but the issue was not addressed. I was a little disappointed not only on that point but also a number of others. I participated in consideration in detail on various clauses. I observed the member for Armadale raise what I thought to be a number of very sensible suggestions. I was a little concerned that there did not seem to be any real consideration of those suggestions by the government. I am not sure that that is always the case with legislation, but it seemed to be the case with this bill.

Another debate that I participated in was whether it was mandatory for someone to receive independent legal advice before they were made an involuntary patient and whether someone would be required to examine their case to make sure that the act was being complied with. The bill now says that someone may receive advice, but an independent person has not been built into the system to look at whether the inpatient who is to be made an involuntary patient is being done so in accordance with the future act and that all the provisions are being properly adhered to. They seem to be questions of very basic civil liberties. I hope there is a check in the system that it should be adhered to, but I note that was not an amendment that the government was prepared to entertain.

Out of 585 clauses any number of sensible suggestions were penned by the member for Armadale and, I imagine, Hon Stephen Dawson who both worked together to try to make some improvements to the bill. The government did not agree with some of them and said, "Thanks, we've considered them and we've got advice

and we don't agree with them." However, I thought the position taken by the government on other amendments was a little disappointing. Having said that, it is a difficult area of health.

We have heard the statistics on the degree and incidence of mental health illness in our society. There would not be a family or an individual who at some stage in their life is not affected by mental illness, either personally or by someone in their family or circle of friends. Obviously this Parliament just this week has been affected by that issue. How we treat mental health issues is complex. How people are properly cared for, whether their condition is managed or treated, and how we deal with the conflicting obligations to protect an individual and the people around them and at the same time respect the individual's rights are very complex demands. I understand that. From advice I have been given and from what people who have spent a lot of time dealing with the mental health system say, there are a lot of good things in this bill, and I accept that advice.

In Fremantle, I think later this month, an international conference will be convened by a former health minister and former member of the WA Parliament, Hon Keith Wilson, who has long been an advocate of proper mental illness services. He has worked with others to bring together a conference that is called, I think, "Meeting for Minds". It has been convened with some quite highly regarded international speakers to look at the best practice for treatment and consideration of mental health patients. I am hoping to get along to some of that conference although it is taking place in a sitting week. I do not know whether the government will also be represented at that conference that I think will be held at the Western Australian Maritime Museum later this month. I recall there was some coverage on it in *The West Australian*.

I therefore imagine that the whole question of how to properly legislate to get the system to work towards the best treatment of mental health patients is never a static issue; it will always be a matter that we can improve on and learn from what is happening in other countries, and I look forward to participating in that debate with my community. As I said, people in Fremantle take these issues quite seriously not only because of the Alma Street facility, but also because there are people with mental illness living and working around the Fremantle area. However, I imagine that many communities have family members who come across mental health patients. As I said, I also look forward to seeing the budget and whether complementary consideration will be given to the need for the allocation of proper resources to the mental health area to accompany the rewrite of this bill.

MS A.R. MITCHELL (Kingsley — Parliamentary Secretary) [8.33 pm] — in reply: I thank all the members of the chamber for their involvement, interest and genuine support for the issue of mental health in our community, and in particular for this legislation. It is very important legislation, as people have acknowledged. I am sure that, given the number of people in the community with a mental illness, most of us have had at least an indirect if not a direct association with people or with a family or carers of people who have a mental health issue.

A number of members commented on the size of the bill. As I said at the beginning of this debate, this bill is the result of extensive consultation with stakeholders, families, carers and community organisations, and the debate has been an important part of the development of this legislation. It is very important that the debate continue on. You referred to implementation groups, Madam Acting Speaker (Ms L.L. Baker). They are ongoing and will continue. It is important that we do not get to this stage of the legislation and forget about it, but be involved all the way along.

I also want to emphasise that every clause in this bill was given very serious consideration and very close attention to make sure that it was as correct as it could be. At the same time I want to reassure the opposition that every amendment offered by the opposition was also given very serious consideration in the context of the whole bill and not just in the context of a particular clause. I will say again that all the proposed amendments were given very serious consideration and that if an amendment was not accepted, it would have been accepted under the principle that it was unnecessary as the issue was covered throughout the bill. Of course we were happy to improve on a couple of amendments and also to accept some. It is very important that we now get the next stage of this bill into action, which of course is to send it to the other place. We are very keen to see changes occur and I can assure the opposition that much work is being done now on implementation and to make sure that we can achieve a great deal out of this legislation.

I once again thank members for their involvement, interest and support, and I commend the bill to the house.

Question put and passed.

Bill read a third time and transmitted to the Council.