MENTAL HEALTH BILL 2013

Consideration in Detail

Resumed from 18 March.

Clause 194: ECT on child under 14 years prohibited —

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

Page 145, line 15 — To delete "14" and substitute —

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Mr P. ABETZ: When we last debated the Mental Health Bill, the member for Mandurah and, I think, the member for Armadale commented that, as a Christian, the member for Southern River should support the amendment. I take some exception —

Several members interjected.

Mr P. ABETZ: Mr Acting Speaker, I do not have much time and I do not want to take interjections.

The ACTING SPEAKER: I will protect you, member for Southern River.

Mr P. ABETZ: The issue is electroconvulsive therapy and whether the age limit should be increased from 14 to 16 years. The question asked of me was whether I would want my 14-year-old child to have ECT. That is like asking me whether I want my child to have open-heart surgery. Of course I do not, but if a situation warranted open-heart surgery, I would certainly need to contemplate that. I want to paint a scenario. Having been a pastor for 25 years, I assure members that I have been with many people with mental health issues and I have been in intensive care wards, so I certainly understand the issues that families face. Let us face the situation of a 15-year-old who is desperately depressed and has had multiple attempts at suicide. Counselling has failed to help and the medications have failed to make any difference. If the expert opinion is that ECT may help, when everything else known to mankind has failed to help, as a father, I would want to be able to entertain the possibility of that treatment. If the age is increased to 16 years, as a father, I would be denied the opportunity —

Dr A.D. Buti interjected.

The ACTING SPEAKER: Member for Armadale, I am going to speak once. You can rebut this in your time, but while the member for Southern River is speaking, let his argument be heard.

Mr P. ABETZ: As a father, I and the family would be denied the opportunity to make that decision with the psychiatrist treating my child. It needs to go through the various approval processes. I cannot make that decision on my own; that is true. The psychiatrist cannot make that decision on their own. There are safeguards in place. I think the parliamentary secretary may be able to shed some light on this matter, but, as far as I am aware, I do not believe that any other jurisdiction in Australia has put an age limit on ECT. It is left to the professionals to make that call, but perhaps the parliamentary secretary can comment on that a little later.

The other thing I want to comment on is the fact that this bill has been a long time in the making. It will probably be another 10 or 15 years before this bill gets re-examined. Certainly, with the amazing advances in medicine I have seen in my lifetime, who knows how much more ECT will be refined over the next few years? I know people who were debilitated by epilepsy and took massive doses of drugs to try to control their epilepsy, but when they had surgery and electrodes were inserted into the brain to check things out and certain things were done, they were able to live a normal life, free of medication. Who would have guessed that that was possible when that surgery was first introduced? There were lots of risks involved with that surgery. Now it is pretty standard, as it has been refined so much more.

I urge the house to be cautious about putting age limits on something that is still in the process of being developed. I certainly speak against the amendment. If anything, perhaps we should drop the age limit altogether. I think 14 years is not an unreasonable age limit. Given that no children in Western Australia have had ECT for many years, it is hardly a real issue.

Ms A.R. MITCHELL: On Tuesday night, I was asked for some specific information that I would like to present to Parliament.

Point of Order

Dr A.D. BUTI: The member for Southern River has just made a contribution —

The ACTING SPEAKER (Mr I.M. Britza): Member, you cannot use a point of order as a debating point.

Dr A.D. BUTI: My point of order is that the parliamentary secretary should be responding to the member for Southern River; otherwise, I would like to respond to him.

The ACTING SPEAKER: You can, but the parliamentary secretary can say whatever she wants.

Debate Resumed

Ms A.R. MITCHELL: Firstly, the member for Warnbro asked about juvenile detention centres. About 13 juveniles have been diagnosed with mental illness. No juveniles have undergone ECT at Banksia Hill Detention Centre. There is a full-time juvenile mental health nurse on-site at Banksia Hill Detention Centre who assesses juveniles. A psychiatrist visits Banksia Hill Detention Centre weekly and also attends on an on-call basis. In circumstances when a juvenile requires external treatment, they are taken to the Bentley Child and Adolescent Mental Health Service, as necessary. There are nine juveniles currently on antidepressant medication at Banksia Hill and 11 juveniles on antipsychotic medication. That is the information I have for the member for Warnbro.

Mr P. Papalia: What was the 13 at the start?

Ms A.R. MITCHELL: They have been diagnosed with some form of mental illness.

Mr P. Papalia: Any form of mental illness. Is that all?

Ms A.R. MITCHELL: That is the information I have for the member.

Mr P. Papalia: Can you table that?

Ms A.R. MITCHELL: The information will be in *Hansard* and I will give the member a copy of it later; I have some other stuff as well.

I was also asked about the Department for Child Protection and Family Support. No children in care have been treated with ECT. This would require authorisation —

Dr A.D. Buti: We know that.

Ms A.R. MITCHELL: I was asked if any had. This would require authorisation from the director general in addition to normal psychiatric protocols. It is disappointing that all children entering care have experienced trauma and display some level of mental disturbance as a result. All children entering care undergo health and developmental screening that indicates whether mental health assessment is further required. In this case management matters are recorded on individual case files.

I was also asked to get some further information about what occurs in other places with ECT. I am pleased to provide some information. It is not always easy to get everything and we have focused more on western countries. In every state in Australia there is no age limit on ECT—they are open, as we are under our current act. In Scotland, which is certainly noted for some very good work in mental health, there is no age limit. There is a United Kingdom act for this, and again there is no limit on age, and New Zealand has no limit on age.

Mr P. Papalia: I think the member for Eyre was asking how many children had actually been treated by it.

Ms A.R. MITCHELL: I had a couple of questions, member for Warnbro, that I needed to respond to. That is the information I can provide on that at the moment.

I also have some research papers here. Regarding research and empirical evidence, I think people would understand that this sort of medical research is not quite the same as other medical research because there usually tend to be two groups, with one getting a placebo and the other getting the real treatment. It would obviously be quite unethical to put someone under ECT with them thinking they will get some treatment when they will not; it is just not done. Also, ECT is used only in emergencies; it is not something that is messed around with on people just to get some evidence. Therefore, the evidence that occurs comes as a result of the treatment and the rating scales available to use within the medical fraternity. At the same time, this does not occur with cancer research either. With things that are lifesaving and urgent—if that is the right expression—the normal practices for medical research do not necessarily apply. Work has been done using the Children's Depression Rating Scale on children aged 14 to 18 years. Once again there are very small numbers, but it has occurred and I have some lists of those I am happy to lay on the table for members to look at.

I also comment on the age limit chosen by Western Australia for this bill. Obviously previously, there was no age limit and in fact many people would still have preferred that there be no age limit and said there was no need for one.

Dr K.D. HAMES: I rise so I can ask for more time.

Ms A.R. MITCHELL: There was a dilemma and there were some community concerns, which unfortunately were often due to misperceptions about what is involved. I think it is probably an area about which there needs to

be more education and understanding so we can allay some of these community concerns. There is no question that some bad press is given to the process, but whether it is founded is always an issue. The Faculty of Child and Adolescent Psychiatry, which is part of the Royal Australian and New Zealand College of Psychiatrists, agreed to a minimum age of 14, although it would have preferred it to be lower, in order to have a balance between its preferences and those of the community. We have gone with the minimum age of 14 years to try to address both of those aspects. That was the lowest age that could be agreed to.

Dr A.D. BUTI: I will respond to some of the comments made by the parliamentary secretary in a minute, but I first want to respond to the contribution from the member for Southern River. He should not try to verbal people. He should look at *Hansard* to see what was said. He made comments this morning that as a father he would like to have the right to have the opportunity for his son to undergo ECT if need be, whether he was 13 or 14 years of age or whatever. Under the bill, member for Southern River, there is no parental veto. Parental wishes can be taken into consideration, but the parental desires for or against cannot be used as a veto. The member talked about lifesaving measures and I ask the member for Southern River: if a 14-year-old girl needed a lifesaving abortion, does he think she should have it?

Mr P. Abetz: If it is lifesaving and she is going to die if she does not have one, yes.

Dr A.D. BUTI: Okay; I would like to put it on record that the member for Southern River agrees that there are some occasions when abortions should be allowed for 14-year-old girls. Should the parents have any say whether a 14 or 15-year-old girl should have an abortion, member for Southern River?

Point of Order

Mr P.T. MILES: I address the question of relevance. The member for Armadale is asking a member other than the parliamentary secretary questions, when we are discussing the Mental Health Bill. I ask whether that is actually relevant to the debate or whether the member for Armadale has wandered off topic.

Dr A.D. Buti: If you had been here for the debate, you would know this is how we have been —

The ACTING SPEAKER (Mr I.M. Britza): Excuse me, member for Armadale. Members, I believe that the member for Armadale has a right to respond to the matters raised by the member for Southern River before he goes to the parliamentary secretary.

Debate Resumed

Dr A.D. BUTI: I can say what I wish; it is up to the member for Southern River whether he wishes to reply, member for Wanneroo.

The member for Southern River then mentioned that he thought that there probably should not be an age limit, but he is prepared to support a bill that does impose an age limit. Why does he not move an amendment that the current situation should be the law if this bill was passed? Rather than coming into this place at a few minutes to 10.30 on Tuesday night to make a flippant interjection, and then coming back this morning to talk about his Christian values, the member for Southern River should read the bill and look at the context of the bill that we have been dealing with for hours.

Mr P. Abetz: I have read the whole bill from beginning to end and I was listening to what you guys were saying on the TV in my office.

Dr A.D. BUTI: If that is the situation, the member for Southern River's contribution to the debate has been absolutely minuscule.

I get back to the parliamentary secretary. I thank her very much for providing some of the requested information, but I think one of the stumbling points in regards to my amendment vis-a-vis what the current bill wishes to impose was that the parliamentary secretary was going to provide research that showed the advantages of ECT. If I remember rightly, the member for Eyre said he was troubled because he wanted to know the advantages in allowing ECT for a child. Nothing the parliamentary secretary has said this morning tells us that there are any advantages. I have also done some research and I cited a paper on Tuesday night. I have here another paper titled "Neuropsychological Effects of Neuromodulation Techniques for Treatment-Resistant Depression: A Review" authored by Jared Moreines, Shawn McClintock and Paul Holtzheimer. This paper does not look specifically at electroconvulsive therapy on children; it looks at ECT as a whole. The authors state that the benefits, if any, are very minimal, and that there are a number of side effects. A conclusion of the article is that ECT is more intrusive and has less benefits than other more benign procedures and that "further research is clearly needed to fully evaluate the neurocognitive effects, both positive and negative" of ECT and other interventions. As the science is uncertain on this, we have to be very careful about allowing ECT treatment on children whose brains are still developing.

Point of Order

Mr D.A. TEMPLEMAN: Point of order, Mr Acting Speaker.

The ACTING SPEAKER (Mr I.M. Britza): While you are on your feet, member for Mandurah—I will take your point of order to give the extension to the member for Armadale—it has been common practice that with 30 seconds to go in a member's allocation, some members are getting up for the call. The line is to wait until the time allocation of zero, and then stand up and be given the call. I am just letting members know that we are aware of extensions.

Mr P.B. Watson: It takes some of us longer to get up than others.

The ACTING SPEAKER: I understand that, member. I take the point.

Debate Resumed

Dr A.D. BUTI: That is particularly so with Collingwood supporters!

The parliamentary secretary mentioned that we are the only state with an age limit for ECT, but this government has made a decision to impose an age limit at 14 years. The government has not proven its case as to why it has set it at 14 years. As the parliamentary secretary herself stated, she has had a day and a half with the apparatus of the public service behind her to provide us with the evidence to show us that ECT on teenagers is beneficial. The government has not been able to prove that.

Mr J. Norberger: Sixteen years is still a teenager. Is the member going to prove to us why 16 is any better?

Dr A.D. BUTI: We did not say 15 years.

Mr J. Norberger: No, the member said 16.

Dr A.D. BUTI: Yes, we did.

Mr J. Norberger: That is still a teenager.

Several members interjected.

Dr A.D. BUTI: It is really interesting. If the member for Joondalup, who has made no contribution, had been here on Tuesday night, he would have heard why we say 16 years. We would prefer not to have ECT used on any teenager.

Several members interjected.

Dr A.D. BUTI: Is the member for Joondalup not amazing?

Several members interjected.

The ACTING SPEAKER: Member for Albany! Member for Warnbro! Member for Armadale, are you willing to take interjections?

Dr A.D. BUTI: If I am forced to, but the member for Joondalup thinks he is a comedian, so I do not mind taking his interjections.

The ACTING SPEAKER: That is not the answer, member. I just want yes or no.

Dr A.D. BUTI: It is hard to say whether I am prepared to take interjections. I probably will be, but if it goes on for an hour while I am on my feet, I might say no. At the moment I do not mind.

The ACTING SPEAKER: If the house disrupts into crossfire, I will start calling people. That is why the point is relevant.

Dr A.D. BUTI: At the moment I am prepared to accept interjections.

The ACTING SPEAKER: Thank you.

Dr A.D. BUTI: Because the member for Joondalup was not here on Tuesday night, let me explain why we came to the 16 years of age mark. The government also has changed its mind about the bill and age limits. We had the view that it would be better not to have ECT on any young person.

Mr P. Papalia: Any child.

Dr A.D. BUTI: Any child—that was our view. However, as we were under the impression that the government was very clear in its determination that ECT should be allowed to be performed on teenagers, we thought that we would try to come to the table in good faith, and that is why we proposed to increase the age limit to 16 years. If the member for Joondalup wants to make a contribution, rather than just yelling out, "Well, why have you got 16?", he should make a contribution about why 14 years is better than 16 years or why an age limit is better than no age limit. If we want to hear meaningful contributions from the government's side, listen to the member for

Eyre, who expressed his concerns about whether there is any benefit from ECT whether a person is aged 14 or 16 years. I repeat for the member for Joondalup: our original preference was that there be no ECT for patients aged under 18 years unless there is scientific evidence to prove that it is beneficial. That has not been proven. We do not think that 16 is ideal either, but at least we think that a person at 16 years may be able to cope with ECT treatment better than a 14-year-old can. A 14-year-old cannot drive. A 16-year-old can get their driver's licence. There are some subtle differences between 14 and 16 years—not that we are great advocates of the limit of 16 years, but we come to the table in good faith; that is why we went for 16 years.

I get back to whether ECT has any advantages. This is the government bringing the bill before the house after years of consultation and so forth, and still at this late stage, it has not been able to show us the scientific evidence that a 14-year-old child will benefit from ECT. That has not been shown. Those opposite talk about the difficulties with empirical evidence in this area. Of course there are difficulties. But the medical profession is generally a conservative profession. The medical profession always talks about "quack" medicine and alternative medicine that is not based on empirical evidence. Give us the empirical evidence that ECT used on a 14-year-old is beneficial. That has not been shown yet.

Ms A.R. MITCHELL: I probably gave the member more credit by saying that I have some research documentation here, but if he wishes me to read some out I will. I refer the member to a book called *Electroconvulsive Therapy in Children and Adolescents* by Neera Ghaziuddin and Garry Walter. This is a text used by the Faculty of Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatrists in treating adolescent children. This book contains a lot of evidence. I will give the member some examples because he specifically asked for some.

Mr P.B. Watson: Does that book reference 14-year-olds and ECT?

Ms A.R. MITCHELL: May I finish reading? I will read some examples from the book.

Tabling of Paper

Mr P. PAPALIA: The parliamentary secretary indicated earlier that she was prepared to table a document so that we can read it. I am informed that she has not tabled it. As she is referring to material that we cannot see, as helpful as it is that she is reading things, it is difficult for us to analyse something without seeing it. Would the parliamentary secretary table it so that we can see the documents to which she is referring?

Ms A.R. MITCHELL: I am happy to do so, but I would like to read the findings.

Mr P. Papalia: Not the book. I do not want to read the book.

Ms A.R. MITCHELL: No, I cannot give the member the book. I would like to read some things so that they are in *Hansard* and then we can move on. I will table it, for sure.

Debate Resumed

Ms A.R. MITCHELL: I quote from a document titled "Effectiveness of ECT" which states —

- Palliere-Marinot et al (1990)

studied 9 adolescents aged 15–19 yrs. 8 out of the 9 had a positive response

Well-known research is a study conducted by Ghaziuddin et al in the United States in 1996 which —

Studied 11 adolescents aged 14–18 yrs. All improved when assessed using standard rating scales …

That is the Children's Depression Rating Scale, which is well used. The document goes on —

- Cohen et al (1997)

Studied 21 adolescents aged 13–19 yrs. All 10 with major depression improved on standard rating scale assessment.

- Walter and Rey (1997) N.S.W.

42 youth 18yrs and younger(1 aged 14 yrs). All with major depressive disorder improved on standard rating scales.

- Strober et al (1998)

10 adolescent females. 9 out of 10 improved

Ghaziuddin in the United States, once again —

- Ghaziuddin (2011)

Large study of adolescent males and females (33) —

This is a large sample for this area —

Aged 14.3–17.3 yrs. 32 had a positive response using standard rating scales

There is evidence.

Dr A.D. Buti: They are very small samples.

Ms A.R. MITCHELL: As we said before, ECT is not used on many.

Several members interjected.

The ACTING SPEAKER: Members!

Dr A.D. Buti: How many 14-year-olds?

Ms A.R. MITCHELL: They do studies by age groups.

Dr A.D. Buti: They might be all aged 17 or 18 years.

Several members interjected.

[See paper 1484.]

Mr D.A. TEMPLEMAN: Can I please bring things back into perspective? Two things were happening on Tuesday evening. Firstly, the opposition was seeking more information and justification for an age limit. Secondly, the government was asked to not take this matter to a vote until that information was provided. I made an appeal, and I am thankful to the Leader of the House and not to the parliamentary secretary because she was reluctant to do this and it was a test of her measure as a potential minister.

Dr G.G. Jacobs interjected.

Mr D.A. TEMPLEMAN: No; the fact of the matter is that the information was requested. The opposition was able to appeal to the Leader of the House and get his ultimate sanction to provide the opposition the opportunity to receive this information. I appreciate that the parliamentary secretary has provided some information in answer to those inquiries, but members have to remember that had we allowed the matter to go to the vote, this information would not have been presented.

Mr P. Abetz interjected.

Mr D.A. TEMPLEMAN: No, it would not have. On Tuesday night we were heading down the road of a political vote without acknowledgement of the legitimacy of the information being asked for. That is the point I make.

It was a good working of the house that on Tuesday night reason was seen and accepted so that we were able to get an adjournment to give the parliamentary secretary time to provide the information we sought, which we did not have before us. I am not going to enter into an argument about the legitimacy of the information and the small samples contained in the information. However, I do want to place on record my appreciation of the Leader of the House for recognising the importance of adjourning on Tuesday to get this information.

I sense that the parliamentary secretary is a bit unhappy that we did that, but, frankly, that is what this Parliament should be doing. It is the role of this Parliament to ensure that we are making the right decisions. That means that when information is requested, the minister of the day, or the person handling the bill, the parliamentary secretary, should try to accede to that. The parliamentary secretary has now presented additional information of some studies that have interestingly been done in Australia, with one New South Wales study in particular.

Mr P. Papalia: On 18-year-olds.

Mr D.A. TEMPLEMAN: Yes. I appreciate that, but is it not interesting and good that we are having this debate on this significant piece of legislation?

Mrs G.J. Godfrey interjected.

Mr D.A. TEMPLEMAN: Member for Belmont, my understanding is that no research was given as a basis for the 14 years. That was the point of the question asked on Tuesday night: tell us and convince us why it is 14 years.

The member for Southern River made an interesting point in his contribution this morning when he said that he is now not even convinced that there should be an age limit at all. The opposition has openly said that it reluctantly arrived at 16 as a number. Can members just cool down? This is a legitimate debate about age limits,

and they need to remember that at the end of the day they will make a decision about how old a child should be before this sort of therapy is applied to them after going through the required processes.

Mr P. PAPALIA: I thank the parliamentary secretary for that information. I do not think she has responded to the questions asked the other night. The prime driver of the determination to delay the decision on this particular clause came from the member for Eyre, when he asked about not the thresholds around the world but evidence of specific treatment, numbers, ratios and that sort of thing. The parliamentary secretary has given some information. It is interesting to note that the information regarding Australian studies is very dated. Does the parliamentary secretary have information on recent treatments of electroconvulsive therapy on children in other Australian states—the numbers and the consequences or results of those treatments? The latest example the parliamentary secretary has given us is from 1998.

I understand that the parliamentary secretary read out studies, but the other night the opposition asked about what is happening in other states and around the world and what are the consequences and results. That is one thing. I thank the parliamentary secretary for the information on the detention centres and on juveniles diagnosed with depression and the treatment they are receiving. That information is very interesting. I find the assertion that only 13 of them are mentally ill extraordinary and it is not in accordance with other suggestions I have heard from other sources. That is not the parliamentary secretary's concern, and I am appreciative of the information. However, I am interested whether the parliamentary secretary has any more recent specific numbers from each of the states, particularly when she says that other states do not have thresholds for treatment. Does she have information on the numbers treated and the outcomes?

While I am on my feet, I make another observation for those members who have been interjecting about the age of 16. As the member for Armadale indicated, at the outset the opposition came to this debate with a view in the party room initially that no child should be treated in this matter. That was not unanimous, but a large number of the caucus held that view. The opposition then sought advice from stakeholder groups. The key stakeholder group that approached us, the government, the parliamentary secretary and the department was the Health Consumers' Council WA. It said that it would prefer that children not be treated with ECT, although it softened its view—and this is where it came from. The Health Consumers' Council softened its view because it acknowledged that the government was tackling a difficult problem and that this bill was long overdue. It recognised the desire within government, the minister's office and among her advisors that there should be an opportunity to treat a small number of children, so it softened its view and suggested 16 years of age as a threshold, which is what the opposition adopted. The opposition took the stakeholders' view; it did not pluck out a number itself.

Mr P. Abetz: Was it the college of psychiatrists?

Mr P. PAPALIA: The Health Consumers' Council sought advice from psychiatrists, people in the field, parents and people who use mental health services in Western Australia. They came to the view that if we were going to do it for children, then 16 would be a more suitable age limit than 14.

The response of government has been to say at the outset, "No, we are not going to accept that." That is what happened. The government's initial response was that it would not accept a threshold; it wanted it for all children. That was the government's first response. It ultimately softened its stance because there was a widespread public reaction. The member for Southern River will recall the widespread public concern in the media. There was a lot of talkback chatter and a lot of commentary in the newspapers to the effect that this could have a detrimental effect on children and that it could be bad and was concerning. Consequently, the government, not the opposition, came to the age of 14. Why did it choose 14? That is what the member for Armadale is asking. There has been no justification for 14 as the threshold as opposed to 16.

Mr P. Abetz: Did the parliamentary secretary not say that the college of psychiatrists said that?

Mr P. PAPALIA: No, the Royal Australian and New Zealand College of Psychiatrists said that it wanted it for all children. That is the advice the minister took and that is why the minister originally rejected the suggestion that it would be 16 years. She ultimately came back to 14 years.

Dr A.D. BUTI: I would like to hear a further contribution from the member for Warnbro.

Mr P. PAPALIA: As a result of public criticism, the minister then imposed an age threshold of 14. That was not the initial advice from the department. That was not the initial advice that was sought from specialists. The people they were listening to said no threshold, because that is what the original draft had. It was changed when public anxiety over the matter resulted in the desire to impose an age threshold. Then they choked. The member for Armadale said that the minister chose it. The parliamentary secretary responded that it was not originally what the minister wanted to do; but why was 14 chosen as opposed to 16? I suspect it was so that the

government did not do what the Health Consumers' Council WA suggested; that is, take the advice of one stakeholder group. It did not want to be seen to bow to that. I think the decision was more political than medical. Perhaps the council is right and perhaps it is wrong. That is the perception I have and I think that is the perception of a lot of people. It is a big deal. Why did the government arrive at 14 in the end? I do not think we will get any absolute confirmation that there is some scientific or medical reason for 14 as opposed to 16. If the parliamentary secretary has one, that is fine. I do not know whether some studies that included 14-year-olds is justification for it.

Mr M.H. Taylor: Do you believe that the positives outweigh the negatives for people aged 16 and above?

Mr P. PAPALIA: My personal view, as expressed in our party room, is that I do not think children should be subjected to it.

Mr M.H. Taylor: So you believe the negatives outweigh the positives?

Mr P. PAPALIA: The Labor Party's decision in the end was that there is an obvious desire by those advising the Minister for Mental Health, and by the minister herself, to provide the opportunity for children of some age to have ECT. I would prefer it to be 16 if that were the case. I would actually prefer none; that is just me. I did not win in the party room either. Ultimately, the position the Labor Party takes to this place is 16. That is based on stakeholder groups and consumers.

Mr M.H. Taylor: But 14 was as well. It is over 14 and 16 —

Mr P. PAPALIA: No, it is not.

Mr M.H. Taylor: We believe that there is a benefit to somebody between 14 and 16 getting treatment, but you do not believe there are benefits.

Mr P. PAPALIA: I concede that the government has bowed to public sentiment, but the public sentiment had concern about any children getting this treatment. People were not clamouring in the streets for a threshold of 14 to be applied. There is evidence that shows stakeholder groups would have liked none, but conceded 16. No-one in Western Australia that I know of, beyond the government and the minister's advisers, says that 14 is the age they want. I do not understand. I will not die in a ditch over it. Obviously the lead speaker on our side is leading the debate and I go with what the Labor Party has determined. It looks like we will be defeated on that one. The question is valid and reasonable. It was not based on us just plucking 16 out of the air; it was based on stakeholder groups advising us that that is what they want. I do not know of a stakeholder group that suggested 14 was the threshold that was wanted. I will sit down because other members want to contribute. I appreciate the parliamentary secretary getting that information about people in detention. That was very valuable; thank you.

Mr W.J. JOHNSTON: I do not want to get caught up in some cross-chamber slanging match. I just want to ask a couple of questions and make a few points. Like everybody else here—the Minister for Health is not in the chamber—we are here as laypeople making decisions. It is actually important that it is laypeople making decisions. If a specialist in any field cannot explain to a layperson why a particular action should take place, it is probably because the specialist is making an error. That is the whole point here. If we look at the area of public policy that I am principally responsible for in the energy sector, if an engineer cannot explain to me why something needs to happen, it is probably because it does not need to happen. It is the same here for psychiatric treatment.

I have looked through the list of studies that have been provided by the parliamentary secretary. I have no doubt that they are all valid case studies. Of course, none of them are double blind; in other words, none of them have a test group in which a different treatment was provided and they were then provided an examination. None of them are.

Ms A.R. Mitchell: I think I have already answered why.

Mr W.J. JOHNSTON: It is because it cannot be done—that is the whole point. That is exactly the point I was about to make. None of these studies prove the effectiveness of ECT. They are the case studies that are provided. They are valid on their own merit but we cannot exaggerate the merit of that.

I have a family member in their 20s who is having ECT treatment. The first couple of rounds of ECT treatment worked for them and improved their mental health state. However, the follow-up ECT treatments are not benefiting that person. We need to think about these things very seriously before we authorise what we are doing here.

When I worked in the commonwealth Department of Health, I remember the shock and horror of people in the department when a senior executive, who was on stress leave, was sent to Melbourne to have nine ECT treatments in two days. I have been out of the federal public service for a long time, but the commonwealth Department of Health used to have a unique situation. It had a departmental secretary and another person of the

exact same standing in the public service called the commonwealth Chief Medical Officer. That was an important process. The commonwealth government did that to make sure that decisions affecting the community were not just being made by doctors. There was a commonwealth Chief Medical Officer with the standing and pay of a departmental secretary and then a departmental secretary who was not a doctor. It is important that these issues are debated.

I apologise to the parliamentary secretary that I was not here for the start of the debate this morning. I understand that the parliamentary secretary has not answered the question that I asked on Tuesday night, which was: who in the consultation process disagreed with the recommended threshold age of 14? The idea that there was unanimous agreement amongst people being consulted is clearly not true. There is no circumstance under which the parliamentary secretary can state that there was unanimous support because we have all been lobbied. Every single one of us has been lobbied against this provision. We all know there are people in the mental health sector who are lobbying against this provision. We all know that because they have written to us all! That is why I asked that question. I think it is a very important question for transparency and honesty, and for making proper decisions as laypeople on this complex area of law. We make the decisions as laypeople because that is our job. I want to know not only who supported the decision to recommend the age of 14, but also who disagreed with the recommendation to make it 14. That will help all of us when making our decisions. Whether the age is 14, 16, 18 or 22, we all have to make that decision as laypeople; that is our responsibility. I would like to have the information available to me so that I can make that decision.

Ms A.R. MITCHELL: I am happy to go over again what I said this morning. I am sorry that the member for Cannington was not here. I will add a bit more to it. Firstly, the Faculty of Child and Adolescent Psychiatry with the Royal Australian and New Zealand College of Psychiatrists actually disagreed with the age of 14—it wanted none. I said that because of community concerns in consultations—mainly through unfounded misconceptions that tend to come out in the media that are not based on evidence—it has agreed. The negotiators put up an age. They wanted it lower, but they accepted it. This decision is not just a group of medical practitioners making a decision about what is going to affect the community. It is a combination of both. I can tell members that that is how it occurred. It was also brought up in the Holman review in 2003 that it wanted the age of 12. That went through for quite a while. Once again, it has been listened to. It is not just medical practitioners who have come up with this age; in fact, in 2005, a Labor health minister accepted the age of 12. It is something that will be constantly moving, but there has been a lot of community consultation. The government has listened to what people have said and has put in safeguards, such as the Mental Health Tribunal, to support the concerns of the community. Those things combine with the expertise of the Faculty of Child and Adolescent Psychiatry and the work it does. The numbers are small and we do not have blind evidence. As I said before, we do not have the numbers to provide that evidence, but there are ways of assessing improvements, and we will use those. The experts use those methods and we rely on those experts. I will not go and do my own studies to come up with an answer for the member. The age that has been presented is fair and has taken into consideration the views of others. The member for Armadale is correct that people—not many—have expressed concerns in one or two areas, but our consultation has been far and wide; we have listened to those concerns and the age is appropriate.

Dr A.D. BUTI: We are probably coming to the end of debate on this amendment, and I thank the parliamentary secretary for delaying the debate this morning. We all agree that this is a difficult decision. The government decided to include an age limit in the bill and that is what we have been debating. We may not have debated this issue had the government not included that age limit, which is ironic. However, once the government decided on an age limit, it sharpened debate on whether it was the appropriate age. As the parliamentary secretary stated, there will be psychiatrists who do not think there should be any age limit, some who believe it should be 12 or 14 years, and some will agree with the opposition's amendment to change the age to 16, whereas some will believe that no child should receive electroconvulsive therapy. If members in this place are honest, they will agree that there is no medical evidence that strongly supports any particular age. Some evidence supports the age of 14, which is the age in the bill, and some will support 16 years. The opposition has erred on the side of being conservative, because our basic philosophical position is that children should not be given ECT. I assume that the government's philosophical position is that either there should be no age limit or ECT should be able to be performed on children, and that is why it has gone for the lower age of 14. We will call for a vote on our amendment, because we believe it is important to record those parliamentarians who support ECT for children. The parliamentary secretary has said that ECT is a life-saving treatment, but it is also a drastic form of treatment. We believe that in situations such as this in which the medical evidence is not conclusive—it may never be conclusive because of the particular problems achieving a control group comprising a particular number to form a significant sample—we should be more conservative than experimental. We believe that 16 years is the appropriate age, if any ECT is to be done on children. That is where the opposition stands.

Division

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

Ayes (19)

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

Noes (33)

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

Pairs

Mr J.R. Quigley	Mr T.R. Buswell
Mr P.B. Watson	Ms W.M. Duncan

Amendment thus negatived.

Clause put and passed.

Clause 195: ECT on child over 14 years who is voluntary patient —

Dr A.D. BUTI: There is an amendment in my name on the notice paper, but as a result of the amendment to clause 194 being lost, I do not see any need to have another five-hour debate.

Clause put and passed.

Clauses 196 to 204 put and passed.

Clause 205: Psychosurgery: meaning —

Dr A.D. BUTI: Division 3 of the bill concerns psychosurgery. It is probably good that we had that very long debate about ECT, because otherwise we would probably have a long debate now about psychosurgery. We will, of course, move an amendment with regard to this. This clause provides the meaning of psychosurgery and outlines in paragraphs (a) and (b) what the treatment involves. We, of course, have major concerns with psychosurgery. It is not a treatment that is normal procedure, one would hope, in the psychiatry world, but it is performed. Paragraph (b) states —

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

We have been told that this is deep-brain stimulation. The government would have received a submission on this bill from the former member for Bassendean, Martin Whitely, on behalf of the Health Consumers' Council WA. As he stated in his submission to the minister, which I have checked up on, deep-brain stimulation, while it has been approved in the US for a number of non-psychiatric conditions including Parkinson's disease, has not been approved for psychiatric use, and clinical trials for its use in treating treatment-resistant depression indicate significant risks including wound infection, worsening mood and increased suicidal tendencies. I would be interested to know whether the parliamentary secretary has a different point of view and why, because our understanding is that deep-brain stimulation, which equates to paragraph (b) of this clause, has not been approved in the US for psychiatric treatment but only for non-psychiatric conditions. I am ready to stand corrected on that. I await the parliamentary secretary's response.

Ms A.R. MITCHELL: Thank you, member. I suppose that psychosurgery does have some connotations, once again, that probably do not need to be in place anymore. The first form of psychosurgery way back in the 1970s concerned frontal lobotomy, which was evidenced in the *One Flew Over the Cuckoo's Nest* era and resulted in that perception. It is certainly not like that now. The procedures have improved vastly since then. What we are trying to do with this bill is almost a bit of futureproofing. Some emerging surgeries under this psychosurgery banner are proving and will prove to be very effective for people who may need psychosurgery. One thing about this is that it is reversible once the electrodes are taken out. There is something quite unique about psychosurgery, which I believe is —

Mr P. Papalia: If they go to the right place.

Ms A.R. MITCHELL: That could apply to any surgery.

Mr P. Papalia: If they don't do any damage on the way in.

Ms A.R. MITCHELL: That would apply to any surgery.

Dr A.D. Buti: But this is the brain.

Mr P. Papalia: It is not guaranteed that it is reversible.

Ms A.R. MITCHELL: That applies to any surgery, so I do not think it would be any different here.

Mr P. Papalia: That is right. That is why psychosurgery is pretty controversial.

Ms A.R. MITCHELL: 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. We believe that is important, particularly in the field of mental illness.

Dr A.D. BUTI: It is not approved in the US. The parliamentary secretary said that some studies are being undertaken in Victoria. We do not know what the outcome of those studies will be, but we are being asked to approve a procedure that is based on what might be a positive outcome in Victoria. That is a really interesting way of trying to support a very controversial procedure. The parliamentary secretary is right; things have changed since *One Flew Over the Cuckoo's Nest*, but this is still a very invasive operation. The parliamentary secretary's response to the member for Warnbro was that there can be problems with any surgery. We are dealing with the brain here, so if something goes wrong, the consequences could be far more severe than for something like shoulder surgery, even though the consequences with that type of surgery can also be severe from a pain and function point of view. My question was not about the fact that there have been improvements since *One Flew Over the Cuckoo's Nest*, which I have never actually seen, but related to the second part of this clause on deep-brain simulation. This type of surgery has not been approved in the US for psychiatric use. I do not believe that we should necessarily follow the US in many medical areas because, if anything, in the US there is a greater tendency to use medical intervention, whether through surgery or the prescription of drugs. However, I would think that there must be some major concerns with deep-brain stimulation if the US is not approving it for psychiatric use. The parliamentary secretary mentioned the studies in Victoria, which have not been concluded. Would it not be better to wait? Once those studies are concluded and the government thinks there is sufficient evidence to support deep-brain stimulation being an option in Western Australia, it could bring in an amendment to the act. We are also considering the Mental Health Legislation Amendment Bill at the moment, which will amend the Mental Health Act. There is nothing to prevent the government from moving an amendment before this house at a later stage when there is more conclusive and sufficient medical evidence that this particular type of psychosurgery, deep-brain stimulation, should be an option in Western Australia. From the parliamentary secretary's own words, it is banned in the US and a trial is being undertaken in Victoria, which has not been concluded. I am very worried about allowing an invasive procedure on the brain when it is banned in the US and the benefits of it have not been proven. As we all know, there is significant risk with any operation to the brain. Under the current Mental Health Act there are no age restrictions on psychosurgery, as is the case with ECT, but I believe it has not been performed since the 1970s on Western Australian children. I will deal with that a bit more when we consider the amendment to clause 207. I still go back to the fact that the second part of the meaning of psychosurgery, deep-brain stimulation, is banned in the US and the parliamentary secretary said that there is an ongoing trial in Victoria. Why are we then approving it at this stage?

Mr P. PAPALIA: I just want to join the member for Armadale in placing on the record my concerns regarding the enabling of psychosurgery. I understand that there may not have been an age limit on this type of treatment before but I also understand that it has not been employed since the 1970s in Western Australia. I acknowledge that, in the parliamentary secretary's dismissal of our concerns, she said this type of surgery is not as crude as a

lobotomy, but I contend that it is still a serious matter regardless of the modern technology available for sticking electrodes into someone's brain. Surgery of any nature is potentially irreversible. As a consequence of deciding to do surgery, there is a chance that someone will be injured in a way they would not have been injured if a non-invasive technique was employed. Therefore, it cannot be dismissed as something of no concern although I concede that it is of far less concern than the treatment used in the olden days. We are not taking a hammer and chisel to someone—they probably are, actually! The treatment is not as crude as it was in the past, but the concerns regarding the potential for irreversible damage are still viable and valid and need to be responded to. I understand that later the opposition will move amendments about psychosurgery for children. I would appreciate, as has been suggested by the member for Armadale, a response to the observation that it is not a lobotomy and it is not as brutal and violent a type of surgery as it was in the past, but there is still a threat of long–term irreversible damage. We are dealing with brain surgery, which is a serious matter. I would appreciate a response to the member for Armadale's questions.

Ms A.R. MITCHELL: I thank the two members. The member for Armadale should understand that this treatment is not banned in the USA; it is just not approved in the USA. It has not gone through that approval, but it is not banned. We need to be quite clear on that distinction.

Dr A.D. Buti: Can it be performed in the USA?

Ms A.R. MITCHELL: It has been approved for Parkinson's disease.

Dr A.D. Buti: We know that; I said that myself. Is it approved for psychiatric use?

Ms A.R. MITCHELL: Not at this stage because it has not been given approval. However, the approval process is being undertaken in the USA, as it is in Australia through the studies being done in Victoria.

Dr A.D. Buti: Which have not concluded.

Ms A.R. MITCHELL: The approval process is being gone through. My understanding is that people from Western Australia have travelled to Victoria to have this treatment. This treatment is considered at the severe end; it is a treatment of last resort. It is considered when everything else has been tried and they know that there is just one further attempt they can make. These are adults, not children, who have gone to Victoria for this treatment of last resort because they wanted to get it. Far more stringent safeguards are in place for this treatment than are in place for electroconvulsive therapy. Those safeguards are there for all the reasons people have expressed some concern about.

A patient can have this treatment only if they have provided fully informed consent. It is not something that can be used on an involuntary patient. Informed consent must be given before a psychiatrist can consider using it on someone. It is not something that can happen to someone without them knowing what is going on. Informed consent is necessary for this treatment.

Mr W.J. JOHNSTON: Does this bill provide for a process that is not approved for use in the circumstances that the bill describes?

Ms A.R. Mitchell: We are futureproofing for this treatment coming up.

Mr W.J. JOHNSTON: What happens if tomorrow there is a new treatment that we do not even know about today? How do we futureproof for that? I do not understand that argument. It is the reverse of the argument we have just had over ECT; the parliamentary secretary argued that we need the provision on ECT for children because it was a demonstrated need and that changing the minimum age from 14 to 16 would potentially disadvantage 14 and 15-year-olds from receiving a potentially life-saving treatment. I understand that argument. However, we cannot futureproof if we specify a specific surgery. If something happens tomorrow that we do not know about, how would that be included? It would get included by a change to the act. Why would we include now something that cannot be done? It is odd that the parliamentary secretary would argue in that way. It does not make any sense. The problem is that the trials in Victoria might not succeed; nobody knows. It is like looking for gas in the basins in the Kimberley—it might be there, but it might be not. The treatment might or might not work. Once we have knowledge of whether a treatment is valuable, we would legislate to allow it.

Ms A.R. MITCHELL: In the medical world there is positive evidence for the deep-brain stimulation area of psychosurgery, which is why we are including it in the bill. Any other treatments will perhaps fall under the banner of psychosurgery, which is a fairly broad definition that covers stimulation in the brain. Another form of treatment may become available and it would still fit under psychosurgery.

Mr P. PAPALIA: Continuing on from that line of discussion, I do not buy the futureproofing argument. In the event that a type of treatment becomes available in the future, surely the government of the day can bring into this place, rush in if necessary —

Dr A.D. Buti: An urgent bill!

Mr P. PAPALIA: The government could bring in an urgent bill, like some of the bizarre ones we had at the end of last year, and we could amend this legislation very quickly. If the government had overwhelming proof, the amendment would be supported by the opposition. The bill would fly through this place and the other house, receive royal assent and be out there in the public domain in no time at all. If the extent of the proof the government had available to it was so overwhelming, any amendment it chose to make in the future would be adequate. There is no need to futureproof a mental health bill for psychosurgery. Shortly, we will come to the debate on the treatment of children.

I question the parliamentary secretary's observation that this treatment is only for people who give informed consent. If this treatment is an option of last resort for someone who is so depressed and suffering in such a way from a mental illness that they are deemed to be eligible for this treatment because nothing else is available, how can they give informed consent? I am talking about adults here because I am outright opposed to this concept for children and I will make clear my concerns about that when we debate that clause. I fear for the most vulnerable people who, invariably, are in state care or detention or both, and the informed consent on their behalf will be given by people who have already made up their minds. Despite the parliamentary secretary's assurances, they will potentially be exposed to irreversible damage as a consequence of surgery. Any surgery has that potential threat. People die quite regularly from minor surgery. It takes nothing at all for a mistake to be made—that is not an alarmist view; that is simply the truth. If someone does not undertake surgery, the threat associated with a flaw or a failure in the course of that surgery is not imposed on the patient. This is a serious matter. Futureproofing might sound snappy. It might be a nice hook for the parliamentary secretary to throw out there when she is talking to the media on a Sunday morning in an effort to get on the news that night, but it does not measure up when she is trying to argue for quite a controversial measure in this clause. If there is a need in the future for some type of treatment that we do not currently allow, let the government of the day bring it on as an amendment to the bill. Let the government of the day present all the evidence and the overwhelming argument at that time. It is not needed now. That is, of course, unless the real motivation from those advising the parliamentary secretary is that they want to conduct the research, they want to be on the cutting edge and they want to be out there pursuing the kudos that is perhaps being attributed to their colleagues in Victoria. If that is the motive, say it. If the motivation is that the government wants to set itself up as the psychosurgery cutting-edge government of the western world, or of Australia at least, and it wants to compete with Victoria in pushing the boundaries, say it. However, if it is not the motivation and the government is thinking that evidence may come up in the future that suggests this is a better treatment, wait until that happens. Let the law go through in a conservative fashion, err on the side of caution and then introduce amendments to this place at a later date when there is overwhelming evidence to support the case. The government should not come into this place and say that it is futureproofing legislation because, quite frankly, that is a load of codswallop.

Ms A.R. MITCHELL: I would like to reassure the member for Warnbro that we are taking this very, very seriously. This is not just about futureproofing a bill. It is about making sure that at all times people in Western Australia who may require this treatment—I say again that it is treatment of last resort—have the opportunity to access the treatment with fully informed consent in Western Australia and do not have to go somewhere else to get that treatment.

Mr P. Papalia: What is your view about their ability to give informed consent when they are in that state of knowing it is the measure of absolute last resort?

Ms A.R. MITCHELL: That is up to the psychiatrist, who can understand that.

Mr P. Papalia: But did you ask them that, or did the minister ask them that?

The ACTING SPEAKER: Member!

Ms A.R. MITCHELL: A voluntary patient with a longstanding major depressive disorder is able to give informed consent. Those sorts of safeguards are there. The member is right that studies are being done in Victoria at the moment, but that is because Victoria has an act that allows it to occur. Studies cannot be done in Western Australia because no act allows it to occur.

Mr P. Papalia: Is that the motivation—to enable some studies?

Ms A.R. MITCHELL: No. There are a number of motivations. I have tried to explain them all. There is the treatment perspective, the study perspective and the medical perspective. There is not just one aspect to this clause; there are a number of aspects. However, at the moment people in Western Australia do not have the ability to do any research but there are people who wish to have the treatment. If we delay bringing in a clause like this, those people will be delayed further. The member should understand that it may be a number of years

before those treatments are available to those people. I say "those treatments" because by then there could be more. There is therefore a combination of reasons for putting this component in this legislation.

Mr W.J. JOHNSTON: I am not quite sure of that answer from the parliamentary secretary. There must be a procedure to approve experiments. There is clearly a procedure to deal with the need to do research.

Ms A.R. Mitchell: I don't think I used the word "experiment".

Mr W.J. JOHNSTON: There was a discussion about research being done in Victoria. We may use the term "experiment" instead of "research" but it actually means the exact same thing. If we are testing out a theory to see whether or not it works, it is an experiment. Even if we do not use the word "experiment", that is what it is. We can put it in a different way. I think the word "question" is used in science—I am no scientist—and another word is "hypothesis". Scientists test a hypothesis so that they have a foundation. Let us assume that there is some radical hypothesis in the area of health care; that would get tested and there must be a set of procedures to deal with that testing. That is not what we are debating. We are debating something else. We are debating the regular process of psychiatric treatment in Western Australia.

I met a guy who has an implant in his brain that is designed to help him overcome tremors from a brain injury caused by a car accident. It was quite interesting meeting him. He was telling me about how much his life has improved. His girlfriend is the mother of a kid who went to school with one of my kids. That is the sort of thing that happens when we randomly meet people. I understand therefore that this is an exciting opportunity for the future of humanity. There are all sorts of opportunities for getting a better understanding and better knowledge of the brain. I am not saying that I am against any particular treatment—I am excited by it—but that is not what we are dealing with. We are dealing with regularising psychiatric treatment. I still have not heard any explanation for why we would include experimental treatment as a specific section in a bill that is about the regular psychiatric treatment of ordinary people in the state. It does not make any sense. Until the parliamentary secretary can explain why it is not an experimental treatment, I do not understand what is in the bill, because experimental studies are dealt with elsewhere in other legislation. We are not dealing with that; we are dealing with the regular psychiatric treatment of patients in the state, and if it is not part of that, why are we including it?

Ms A.R. MITCHELL: I remind the member for Cannington that psychosurgery exists in the act but it refers to old operations such as frontal lobotomies and all that sort of thing. This bill is a much greater refinement and refers to the new forms of deep-brain stimulation that are now being considered in a number of places.

Mr W.J. Johnston: Being considered.

Ms A.R. MITCHELL: They are being used. There is one place in Australia at the moment, and that is in Victoria.

Mr W.J. Johnston: It's a trial.

Ms A.R. MITCHELL: There is much evidence based on the successful work on Parkinson's disease.

Mr W.J. Johnston: That is science based. I agree with the parliamentary secretary that that has an exciting future.

Ms A.R. MITCHELL: Research is well underway on that. I repeat that I did not use the word "experiment".

Mr W.J. Johnston: You said "research", though; it is the same thing.

Ms A.R. MITCHELL: I said "research", and research in medical terms is a real refinement of the techniques and indications for a procedure. I do not think doctors would like their work to be considered as just "experiments". I think the doctors would agree with me on that. Probably a better way to look at what we are talking about here is to say that there is evidence out there and that we are preparing for that and putting it in a clause of the bill so that it can be further progressed.

Mr W.J. JOHNSTON: I acknowledge how this treatment may work in the future. I think it is exciting. As I said, I met a guy who 10 years previously would have just had to put up with the tremors. I therefore understand that these are exciting opportunities for medical research. It is fabulous if there are proven things with Parkinson's and the guy with the brain injury is having success with his treatment. I am not criticising that for one second, but there is a difference. What happens if the trial in Victoria fails? Do we then remove the clause from the bill? Is that what the parliamentary secretary is suggesting? If the trial in Victoria results in a negative outcome, will the parliamentary secretary come back to Parliament to remove it from the legislation? That is clearly the implication if it is based on research being done in a particular trial. The parliamentary secretary does not want to use the word "experiment", but it actually means testing—fair enough! But it does not make any sense.

I use the example of attention deficit hyperactivity disorder. There was widespread use of Ritalin for kids with ADHD. Now there is not widespread use because when its use was exposed, it was shown to be false and was not achieving what the medical practitioners thought it was achieving. This is the same—it is a trial. Let the trial succeed. If it succeeds, fabulous, then let us implement the outcomes of that trial. However, I do not understand why the government wants to pass legislation based on the potentiality of a trial. Just explain it to me. I am not saying that it is not an exciting potential future. I am saying it is an exciting potential future and if it works it will be fabulous. But there are two ifs in that sentence.

Ms A.R. MITCHELL: I am not sure whether the member for Cannington missed the last bit, but I said that this is not just about the research; this is about treatment for people, often with severe obsessive–compulsive behaviour, who would use it as a last resort. Certainly, they are able to make an informed decision. They have been waiting for 10 years or so for a treatment that is a last resort. There is no reason why we would ban something that can be effective. The treatment for Parkinson's disease is into the brain. It is very close to what would occur for mental illness. The treatment for Parkinson's disease, which is probably more at the end of concerns, is coming further forward. It is still internal brain surgery. It happens quite regularly. The important thing to remember is that we are also putting in place stringent safeguards, so it will not be open to abuse. Those sorts of things are important. It is not just about the research; it is about people who are waiting now. From a government point of view, if treatment is available to people who want to use it as a last resort, it is probably quite inappropriate if we do not give them the right to access that treatment.

Dr A.D. BUTI: As we have stated, we do not oppose psychosurgery in a blanket fashion. We will talk about the age limit later, but we are particularly concerned about deep-brain stimulation. The parliamentary secretary mentioned that it has been used for Parkinson's disease and that it is nearly a mental illness.

Ms A.R. Mitchell: No.

Dr A.D. BUTI: The parliamentary secretary did say that. The point is that it cannot be "nearly". We have to be more precise than "nearly". There have been clinical trials in which significant risk has been played out when this treatment has been conducted in psychiatric settings. We cannot take this as an approximate science. I am sure that when people started performing lobotomies all those years ago, they thought it was state-of-the-art, progressive medicine and that its use should go ahead. That was proven, of course, to have disastrous effects. Whenever we allow a new form of medical procedure, especially one that is invasive, of a surgical nature and into the brain, we have to be a little more guarded and a bit more precise than just trying to extrapolate that, because it is used for Parkinson's—which is very exciting—it can automatically be of benefit for a psychiatric condition. The parliamentary secretary's advisers would know that clinical tests have been done on the use of deep-brain stimulation on psychiatric patients during which significant damage has occurred. We are not saying that we oppose psychosurgery in a blanket fashion, but we are talking about deep-brain stimulation, and we will get to the age limit in a later clause. We have to be precise. We cannot say that medicine or science is not about experimenting, studies and so forth. Studies in science are experiments as a whole. Studies that are not experimental can be done, but the studies are usually a review or statistical analysis of the empirical evidence that has been gathered. The practical experiment has to occur. It is an experiment. There is an aim, a hypothesis, a treatment method and then a result.

The parliamentary secretary said that this treatment is not banned in the United States; it just has not been approved. People always criticise lawyers for playing around with language, but non-lawyers play around with language much more than lawyers do. It is not banned, but it is not approved. If it is not approved, that means that it is not being used, because if it is being used and it has not been approved, people would be doing something that they are not licensed or permitted under law to do. There is a difference between whether it is explicitly banned and whether it is explicitly approved, and it has not been explicitly approved in the USA for the treatment of psychiatric conditions. We know it is being used for Parkinson's disease, but that is not the same thing. It may be similar, but it is not the same. It is a real worry that we are going on what I would call a "gut feeling" that it might be beneficial in the future. That is even more worrying when we consider that it will be allowed to be performed on children, which we will deal with in a moment.

I come back to the point about why it has not been approved. Again, I ask the question: why has it not been approved in the USA for the treatment of psychiatric conditions? I will repeat that because the parliamentary secretary's advisers may not have heard it: why has deep-brain stimulation not been approved in the USA for the treatment of psychiatric conditions?

Ms A.R. MITCHELL: I did say before that it is not banned; it is going through the approval process in the US. I apologise for not being clear when I talked about the relationship between Parkinson's disease and deep-brain stimulation. Electrodes are placed in the brain in a similar way and the location in the brain is close to the same

area. It is very close; it is nearby. That treatment is being used widely and regularly, on a weekly basis. This next phase is very close to that.

Clause put and passed.

Clause 206 put and passed.

Clause 207: Psychosurgery on child under 16 years prohibited —

Dr A.D. BUTI: I seek your direction, Madam Acting Speaker. I have amendments on the notice paper to clauses 207 and 208. Can I move them together?

The ACTING SPEAKER (Ms J.M. Freeman): No; you have to move them separately.

Dr A.D. BUTI: Clause 207 deals with the age of the person on whom psychosurgery is allowed to be performed. The bill before us states that a person cannot perform psychosurgery on a child under 16 years of age. The Mental Health Act 1996 sets no age restrictions for psychosurgery, but due to the controversial nature and terrible history of psychosurgery, it has not been performed on children in Western Australia since the 1970s. As we know from earlier drafts of the bill, the government proposed to allow psychosurgery to be performed on children aged 14 years. I imagine that the rationale behind that was that it is not illegal at the moment and there is no legislative restriction, so if the government bans its use on children under the age of 14 years, it shows that the government is being prudent because it provides more safeguards than are in the current legislation. That might be the rationale utilised by the government, but, as the parliamentary secretary has admitted, medicine progresses. Maybe there has been a feeling as time has progressed that psychosurgery should not be performed on children. Although there was a view once upon a time that it could be performed on children, maybe the evidence is that it should not be performed on children and that is why the government has imposed an age limit. I do not know whether that is the case, but it is a possibility and I think my assertion has as much evidence as the parliamentary secretary's assertion about the effect of ECT on children. In any case, as the parliamentary secretary very well knows, there has been major public concern about psychosurgery being used as a treatment for children in Western Australia. When, in earlier drafts of the current bill, the stipulation was proposed that 14 years of age should be the permissible age at which young people could be subjected to psychosurgery, there was a great public backlash. What did the government do? In the draft before us it has increased the age to 16. Of course, in the submission from the Commissioner for Children and Young People, who has a mandate to act and protect the interests of children, her view is that psychosurgery should take place only on an adult—so from the age of 18—and that children should not be subjected to psychosurgery.

The issue about informed consent is interesting, and I will mention it now even though it relates to the next clause. The parliamentary secretary has stated that psychosurgery will be a measure of last resort and that it will not be commonly used. Although that may be true, as we know there are certain doctors who always see surgery as a good option. In my time as a lawyer when I worked on workers' compensation matters, I would receive two reports on the same client, and I could not believe there were often two different medical reports. I am not talking about only one report representing the insurer and the other the worker, because they are always just standard precedents; I am talking about the fact that some doctors have a natural tendency to consider surgery as an option.

Ms S.F. McGURK: Madam Acting Speaker, I am interested in what the member for Armadale is saying.

Dr A.D. BUTI: I thank the member for Fremantle.

As was mentioned in the letter from N. McLaren of Northern Psychiatric Services in Queensland during the debate the other night on ECT, he found during his time in Western Australia that some psychiatrists considered ECT basically as a matter of course or as a standard procedure, while others did not, and some did not perform it at all. If psychosurgery is a measure of last resort, the 16-year-old must be in pretty bad shape. They must be in pretty bad condition because, as the parliamentary secretary said, psychosurgery will be a measure of last resort, and probably even more so on a 16-year-old; however, they will be in a position to have to give informed consent. It is interesting that a 16-year-old who is believed to be in such a condition as to warrant psychosurgery is thought to be in a condition to give informed consent. In any case, I believe the view of informed consent that runs throughout this bill is a false informed consent because the doctor or the psychiatrist does not have to disclose financial and other matters that could form a conflict of interest and would be important in any informed consent scenario. We have had a four or five-hour debate on ECT, yet psychosurgery is much more drastic. The parliamentary secretary will say it is lifesaving, and it may be lifesaving, but it is drastic. It is invasive surgery on the brain. The Commissioner for Children and Young People recommended that psychosurgery should not be performed on anyone under the age of 18. The government has moved from its position of a minimum age of 14 and increased it to 16, which shows me that it was not confident in its position in the first place and that the age was moved under public pressure. The opposition has not moved on this issue. We have not moved on

psychosurgery, members for Bateman and Joondalup; we have been consistent in our position that it should not be performed on people under the age of 18. Once again, the parliamentary secretary will say it could be lifesaving. We are looking at a two-year period between the ages of 16 and 18. The parliamentary secretary says psychosurgery will not be performed very often, that it is potentially lifesaving and the patient has to give informed consent, but they must be in a pretty bad state if they need psychosurgery as a 16-year-old. There is nothing but danger here. Also, deep-brain stimulation, which has not been approved in the USA, is being permitted on a 16-year-old, and at the moment the Victorian trials on it have not been completed. This is incredibly drastic; this is an incredible scenario. Parliament will vote very shortly on an amendment we will move that psychosurgery should not be performed on a person under 18 years of age.

Mr P. Papalia: Did you move the amendment?

Dr A.D. BUTI: I will in a minute; I thank the member for Warnbro very much.

I move —

Page 153, lines 17 and 18 — To delete "child under 16 years of age" and substitute —

person under 18 years of age

In moving this amendment we are making it clear that we on this side of the house want the public of Western Australia to know that we stand by the children's commissioner and all the people from whom the government has heard, leading it to change the age limit from 14 to 16. We stand by the people in the medical and psychiatric profession who have concerns about psychosurgery, especially young people.

Mr P. PAPALIA: I would like to have heard more from the member for Armadale, but I want to lend my weight in support of his argument. The truth is that there is no evidence supporting enabling 16-year-olds in Western Australia to be subject to psychosurgery for the purpose of treating mental illness. The jury is out on adults. Around the country psychosurgery is not underway anywhere except in Victoria, where experiments are being done on, I assume, adults. It is not allowed in the United States. Members know my concerns about the children who will be most vulnerable to being experimented upon if we were to pass this legislation as it stands. They will be children in state care and/or under detention at Banksia Hill Detention Centre or any future detention facility. In my view, the informed consent will be virtually automatic. No amount of safeguards will prevent the potential for them to be subjected to this, whether or not they really want it. It will never be known whether they really want it or whether the people affected are capable of giving informed consent. The person who determines whether they need it will be the person treating them. Their advice will far outweigh the views of the young individual concerned or they could sway the young individual concerned to comply, hence giving informed consent. It becomes a real experiment. It becomes an experiment on people who are subjected to this, much like guinea pigs. It becomes our way of getting someone's name on a research paper.

I thank the parliamentary secretary for providing statistics on juveniles in detention currently being treated for mental illness. I am sceptical of the total figure of 13 out of the 163 out there. This is no criticism of the parliamentary secretary, but I suggest that a lot juveniles being treated for attention deficit hyperactivity disorder, for example, are not on that list. ADHD is a mental illness, and it is embarrassing that they are being treated in the way that I assume they are being treated. It was very difficult to extract that information, and I do not think that 13 tops out the entire list of mentally ill juveniles at Banksia Hill Detention Centre. Nevertheless, even if that is the number, the parliamentary secretary has indicated that nine of those juveniles are on antidepressant medication, and 11—including another couple—are also on antipsychotics; so I assume nine of them are on both antidepressant and antipsychotic medication because there are 13 in total and those two numbers have been given to me, which indicates a significant number of children.

Let us face it, we have heard from the Premier and the Minister for Corrective Services that a lot of these individuals are suffering from post-traumatic stress syndrome and they have all manner of psychological damage from the life that they have endured, in some cases from birth. There is comorbidity and all manner of challenges associated with analysing and treating these individuals, and I think that they are the ones for whom I know the parliamentary secretary is saying that there are safeguards in place but whom we should be considering the most when discussing this matter. When we are discussing whether it is constrained to adults, it is these people we need to think about—people behind closed doors, behind the wire, not in a transparent open situation, and, in all likelihood, who do not have family members and loved ones advocating on their behalf. They are entirely dependent on the whim of the clinician who is treating them.

Ms S.F. McGURK: I am interested in what the member for Warnbro is saying.

Mr P. PAPALIA: I am not willing to sign over responsibility for this sort of treatment to a treating clinician. I concede that I am not a professional in this field, but, as the member for Cannington referred, we have evidence

in Western Australia of this profession engaging in what can only be described as suspicious and unprofessional conduct when Western Australia was leading the world for prescriptions of ADHD treatment drugs for children, in 2003. WA led the world. In that year, the former Labor government imposed a responsibility on clinicians to notify at prescription. What did we see between 2003 and 2008? We saw a halving of prescription rates. WA experienced a growth in the population throughout that time. There were 50 000 people a year coming to Western Australia and children were being born. The drop in prescriptions was not due to a drop in the population. It was due to a little bit of light being shone on the profession. This is the same profession that the parliamentary secretary is arguing we should trust inherently and explicitly with preserving the rights and wellbeing of children when it comes to experimenting with psychosurgery, deep-brain stimulation. I am sorry, I am not convinced. It is no reflection on the many professional psychiatrists and other clinicians involved in this sort of thing, it is just that I am sceptical, and I have to be, because I am operating on behalf of the people who do not get the chance to be sceptical. If we do not speak up in here and do not question the legislation that comes in without overwhelming evidence to suggest that it is a good thing and it is going to impact on children 16 years of age, whether or not you like it, in such a way that it undeniably could inflict on them irreversible damage as a consequence of having surgery on their brains, and if we do not act in a conservative fashion at that time, we will live to regret it. I hope we do not, but I feel that we could, particularly in relation to those people who do not have family members advocating for them, who do not have loved ones who care for them and who do not have people outside of the immediate staff and clinicians that they encounter in detention standing up for them and their rights. It is time to be conservative. It is one thing if someone who is 16 years old and voluntarily, with the support of their loved ones, considers that there is a need for this, and it is their only choice and opportunity, but what we are doing here is enabling the treatment of any 16-year-old who is deemed to be suitable.

Ms A.R. Mitchell: No.

Mr P. PAPALIA: Yes, that is what is going to happen. I know that there are measures, such as those held by the board, and that there will be oversight, but that is what we will be allowing. It is one thing to say that this applies to someone who has a loving family surrounding them, caring for their wellbeing, advocating on their behalf and best interests at all times. But it is another thing completely when it comes to a juvenile detainee, who has acted in a horrible fashion, possibly committed incredible crimes, does not have anyone caring about them, does not have a family around them and does not have anyone who sees their best interests as their prime motivator. That is not a reflection on the people at Banksia Hill, it is simply the truth. They are not the loved ones and the family of these people—and it is pretty hard to love some of them. They are the ones we have to consider. I am not convinced. It is not adequate to say that this may be beneficial. We need to consider all the positive and negative consequences and outcomes in the worst possible scenario, and how does it hurt making it for 18-year-olds and not 16-year-olds?

Ms A.R. MITCHELL: I will try to cover the number of matters raised by the member for Warnbro in my response. Firstly, I will provide a snapshot of what is available in the other states, because we have talked about what is in the current act and what is proposed in this bill. In South Australia the age is 16. In Queensland, Victoria and Tasmania there is no age limit at all. In New South Wales, it is not allowed but there has been—I do not like to use the word—a backlash to have that changed. The Northern Territory is the other place that does not allow it at this stage. In the recent bill in Victoria there is no age limit; there is no age limit in the current act and it continues to have no age limit. Even though we have said that Victoria is the only place that is doing studies and things like that, it has been recognised that Victoria has been the centre for psychosurgery in Australia for over 30 years. It is not something that they are doing experiments on at the moment; it is a recognised research area.

As we discussed during the ECT clause—and the member for Warnbro is right—we had to come up with an age that was considered acceptable to all parties. As I have said before, community concerns were taken into consideration. There were a huge number of submissions. There was a great deal of consultation. We went through that process again. Once again, we were trying to find a balance between community concerns and what the medical clinicians wanted. As the member for Warnbro would understand, the Faculty of Child and Adolescent Psychiatrists and the Royal Australian and New Zealand College of Psychiatrists wanted to continue with no age limit. However, we felt that we should listen to community concerns as well. That is why the 16 years of age provision has come in. That is why the safeguards have been put in place so that we do not end up with rogue people doing things. The member for Warnbro's concern for people in care is always recognised, but we are talking about people. Sitting next to me is Dr Patchett. He said that when people are at this level, they are pleading for this treatment. We do not understand that, but he has experienced it. They plead for treatment. We have taken into consideration the child and adolescent psychiatrists' point of view, the community's view and once again, we have come up with an age that we believe is appropriate for this form of surgery because of the things that we are going through.

I will check that I have covered everything. I mention the safeguards again because they do support and protect people in detention. The safeguards require the Mental Health Tribunal's approval. The tribunal will include a lawyer, two psychiatrists, a neurosurgeon and a community member. Those people are serious people and there is the community involvement so that there is a balanced perspective. The treatment cannot be provided without informed consent. Those safeguards are real but, at the same time, we are providing an opportunity for people who really want this treatment to have this treatment here in Western Australia.

Dr A.D. BUTI: Parliamentary secretary, in the consultation process, were Indigenous groups consulted?

Ms A.R. MITCHELL: Yes, they were.

Dr A.D. BUTI: Can the parliamentary secretary elaborate more on who was consulted and any concerns that were expressed?

The ACTING SPEAKER (Mr I.M. Britza): The parliamentary secretary can answer from her chair.

Dr A.D. BUTI: I have more to say; she can answer from her chair.

Ms A.R. MITCHELL: I will do that. Yes, member, we have two specific areas. A large Aboriginal community control organisation did a consultation and reported to the Mental Health Commission. There was also a clinical and cultural reference group of which the state Specialist Aboriginal Mental Health Service was a part throughout the process of consultation.

Dr A.D. BUTI: Thank you, but the other part of my question was whether any concerns were expressed by the Indigenous groups.

Ms A.R. Mitchell: No, there were not.

Dr A.D. BUTI: There were no concerns? Things have changed since I was a lawyer at the Aboriginal Legal Service because, as I stated the other night, when the 1996 bill was being debated or about to be debated in that Parliament, Indigenous groups had major concerns. It is interesting that the parliamentary secretary went through the various state jurisdictions and mentioned that New South Wales and the Northern Territory do not allow psychosurgery. As the parliamentary secretary very well knows, the Northern Territory has probably the largest proportional Indigenous population in Australia. I wonder whether part of the reason it is prohibited in the Northern Territory is because of Indigenous people's concerns. This is not unlike the member for Warnbro's articulation of the concerns that those in detention and those who are most vulnerable may be the ones who will more than likely be subjected to psychosurgery. There is an assumption that Indigenous people also will have major fears about psychosurgery because often the most vulnerable people end up being the major subjects in these extreme forms of treatment.

The parliamentary secretary mentioned that the Royal Australian and New Zealand College of Psychiatrists does not believe there should be an age limit. In some respects that is not surprising because most professional bodies prefer to have no prohibition on the way they practice. It is not surprising that the psychiatry profession would prefer to not have any regulation on psychosurgery so that it can leave it up to its own professional decisional capacity. Of course, many psychiatrists are opposed to performing psychosurgery on 16-year-olds or kids. Maybe the body as a whole is not, and this is not surprising. That does not just go for psychiatry; it goes for a lot of professional bodies. As a whole, professional bodies like to have as few regulations imposed on them as possible. One might say that the psychiatric association or society does not want an age limit but many psychiatrists do want an age limit and do not want it performed on persons aged less than 18 years.

Ms S.F. McGURK: I am interested in hearing more of what the member for Armadale has to say.

Dr A.D. BUTI: Thank you very much. As we have already stated, at present there is no age limit; the government then brought in an age limit of 14 years. As the member for Warnbro was just discussing with me, that age was then moved up to 16 because of political pressure. There is no other reason; the government moved to 16 because of political pressure. If those opposite honestly believe that this treatment is necessary for children, why is it not 14? If it is so necessary that we enact legislation to allow psychosurgery for adolescents, why would they not allow it at 14? Why does it then increase to 16 years? It has increased to 16 because of political pressure. It is political pressure with no medical basis to support the decision. If there was a strong medical basis for allowing psychosurgery in adolescents, why not allow it at 14 years of age? This is an incredibly invasive form of medicine. The government is allowing psychosurgery on adolescents, on 16-year-olds who are not permitted to drive—they can get a learner's permit but they cannot drive—and not allowed to vote, but the government believes they have the capacity to make informed decisions about this form of medicine. Their mind would have to be in such a state and their illness quite severe for the government to think that psychosurgery should be allowed, yet it thinks they are of a capacity to consent to this form of surgery. We strongly stand by our conviction—psychosurgery should not be performed on anyone but adults. We have concerns about deep-

brain stimulation but that is now by and by because we put an argument under clause 205. If the government is going to allow psychosurgery and deep-brain stimulation, please do not allow it on adolescents. That is why we moved our amendment.

Mr P. PAPALIA: I assume the parliamentary secretary is not going to get up and respond. In that case, no doubt our amendment will come to the vote very shortly, so I will reiterate the point that I think would be the universal view on our side of the chamber, that I do not believe the government has provided adequate evidence to suggest that it is necessary to allow deep-brain stimulation and psychosurgery on 16-year-olds. The concerns I have aired have been echoed by the member for Armadale. It is a fact that the people who have been most subjected to this type of experimental treatment through the ages have been the most vulnerable people; that is, people who do not have the capacity to oppose it being imposed on them. Historically, the people who used to inhabit our mental health asylums were frequently subjected to experimental treatment. That treatment would now be deemed to be quite morbid, invasive and brutal. The parliamentary secretary even referred to it in a dismissive fashion when she said that the bill will not allow that, but that is how it is seen through our eyes. At the time, as the member for Armadale indicated, that was seen as cutting-edge treatment. No doubt arguments were conveyed in places such as this on behalf of patients who desperately wanted the best treatment of the day—lobotomies. But the people who were subjected to them were overwhelmingly the people who were not necessarily in a place to determine whether they should have been subjected to them or were not in a place where they could oppose it being imposed on them.

The danger here will be similar. If we pass legislation that enables some people to willingly and appropriately make the decision, with informed consent, to have this treatment given to them, there will be other people who notionally tick the box of informed consent but who will be in a place from which they will not really be capable of doing that. They will be subjected to a balance of power in which they will be well and truly outweighed. They will be well and truly at the mercy of other people who hold all the power and all the decision-making weight over their lives. I am never willing to concede that a tribunal should make decisions about people's lives in this type of situation—that is, when there are questions about irreversibility associated with psychosurgery. It cannot be denied that any surgery has potential for failure and any surgery has potential for irreversible consequences. This is not without risk.

When we impose this type of surgery on people who do not have the power to make that decision, regardless of what the bill says, I think it is wrong. Be it on the government's head. Sadly, I wish we had the numbers to defeat this clause. I do not think that much thought has been put into this by the Minister for Mental Health. I understand that introducing this bill and dealing with it has been a significant job. The minister deserves to be commended for that, and has been, but that does not excuse going along for the ride over some pretty difficult questions, of which this is one. This is the most controversial for me, as I think it would probably be for most people in WA society. The only reason the government rolled back from no age limit to 16 years is there was extensive public disquiet over the matter. A lot of people found the concept quite abhorrent and made their arguments and cases known to the government. The government rolled back and said, "We had better throw out some sort of limit so we do not look like we're monsters. We're not doing this to babies; let's just do it to 16-year-olds." But there is no real justification for that being a correct threshold; therefore, it is wrong. It would not hurt to make it 18 years, but we are obviously going to be defeated. I will sit down and we will let the parliamentary secretary get on with what she is going to do.

Dr A.D. BUTI: If there is a 16-year-old child who is subjected to a guardianship order—in other words, they have a guardian—I assume that under the guardianship legislation, the guardian can make a decision to allow psychosurgery; or, if they cannot allow psychosurgery, can they prevent psychosurgery if the 16-year-old wants psychosurgery? In other words, can the guardian veto the wishes of the 16-year-old?

Ms A.R. MITCHELL: I have been informed that a guardian cannot permit psychosurgery; that is, the 16-year-old must have capacity—and consent therefore is by the child and then approval by the tribunal.

Dr A.D. BUTI: The child must have "capacity"—where is that in the legislation? I do not see it anywhere in the next clause, which talks about informed consent. It is not necessarily the same thing as capacity.

Ms A.R. MITCHELL: I refer the member to clause 14 of the bill, "Capacity of child to make decisions". The tribunal must be satisfied that clause 14 has been met by the child. Clause 208(2) also brings that in—that the patient gives informed consent.

Dr A.D. BUTI: That is not the same thing as capacity, but anyway. Clause 14 does not actually state what the parliamentary secretary says. It states —

> **14. Capacity of child to make decisions**

(1) For the purposes of this Act, a child is presumed not to have the capacity to make a decision about a matter relating to himself or herself unless the child is shown to have that capacity.

(2) For the purposes of this Act, if a child does not have the capacity to make a decision about a matter relating to himself or herself, the child's parent or guardian may make the decision on the child's behalf.

In clause 208, which we have not got to yet, how does informed consent equate to capacity? Clause 14 that the parliamentary secretary kindly referred me to states that if a child does not have capacity, the guardian is given permission to make the decision on the child's behalf. I revert to my question: where in clause 207, or as we will get on to clause 208, is it stated that the guardian is prohibited from making the decision for psychosurgery on behalf of the child?

Ms A.R. MITCHELL: Clause 208 says that the patient gives informed consent.

Dr A.D. BUTI: Can the parliamentary secretary please tell me what "informed consent" means?

Ms A.R. Mitchell: It is a subsequent clause.

Dr A.D. BUTI: If the parliamentary secretary will not answer, I will try again because this is an incredibly important issue. Surely we do not want the situation, do we, in which the guardian could consent to psychosurgery on a 16-year-old? The parliamentary secretary may be right, but I will ask again. The parliamentary secretary has got me going on informed consent, and I am annoyed that she keeps arguing the fraudulent decision she has on informed consent. We cannot have informed consent if everything is not disclosed to the person making the decision. The parliamentary secretary should not come back with a medical and a legal definition of consent—informed consent is informed consent. We have had cases in law, and the member for Butler will quite readily recall these, in which it is not considered there has been informed consent if financial pressure is put on a person. There has been a series of cases described as sexually transmitted debt. That means that the spouse or partner has been pressured into acting as a guarantor to a loan taken out by the husband or partner and the courts have ruled that that is not legal consent because of the pressure that has been imposed through the relationship et cetera. Case law states that if a person does not have all the information on a financial matter, there is not informed consent. The parliamentary secretary is basing her capacity argument on informed consent. Informed consent may equate to capacity, but informed consent in this bill is fraudulent because it does not provide that the psychiatrist has to disclose financial interests. This was included in previous drafts of this bill. We could have a scenario in which a 16-year-old who is in dire straits and not thinking very clearly and would not know what psychosurgery was—in fact, most adults would not know—being advised by the psychiatrist that psychosurgery is a possible treatment. It would be very rare that many 16-year-olds would go to a psychiatrist and say, "Please, please, give me psychosurgery!" That would be strange and very rare. The psychiatrist will be advising that 16-year-old what psychosurgery is and that it is a form of treatment. At the same time, under this bill, there will be no prohibition against a psychiatrist who will gain a financial interest over and above their normal fees from providing that advice and giving a 16-year-old that information. If capacity does equal informed consent, we have to include the provision that was contained in the 2011 bill that stated that the psychiatrist has to disclose financial interest.

I cannot believe this clause. This is one of the rare professions in which financial interest is not mandated to be disclosed. The Minister for Planning will be interested in this. When I sat on the board of the Armadale Redevelopment Authority, we started each meeting answering the question: do you have anything to disclose? Some of the things we disclosed were insubstantial! I can tell the parliamentary secretary one thing: if there was any financial interest, the information was provided up-front. The parliamentary secretary is saying it is okay for a psychiatrist not to disclose a financial interest over and above their normal fees. She says that will not affect informed consent and that informed consent equates to capacity. It probably would, if it were properly informed consent. I do not understand how the parliamentary secretary can say that informed consent equals capacity, when informed consent in this bill is fraudulent.

Ms S.F. McGURK: I am interested in what the member has to say.

Dr A.D. BUTI: I do not think I need to say any more.

Division

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

Ayes (18)

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

Noes (33)

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

Pairs

Mr B.S. Wyatt	Ms W.M. Duncan
Ms R. Saffioti	Mr T.R. Buswell
Ms L.L. Baker	Mr D.T. Redman

Amendment thus negatived.

Clause put and passed.

Clause 208: Psychosurgery on adult or child over 16 years old —

Dr A.D. BUTI: I will not move my amendment to clause 208 because of the result of the vote on clause 207, but I will briefly talk on this clause. I will not belabour the point with the parliamentary secretary, and maybe we will talk about it more over a cup of coffee. Informed consent is an incredibly serious issue and the definition in the bill is very flawed because the bill does not require financial disclosure to be mandated.

Mr P. PAPALIA: I add comments to the member for Armadale's observations on informed consent. As I indicated earlier, this is a profession in Western Australia with form. One can only speculate as to the motivation for the massive overprescription of ADHD drugs to children prior to the requirement for compulsory disclosure that came into force in 2003, but I suspect that making money may have been part of this for some people. The suggestion that people should disclose financial benefits that they stand to make from any form of treatment as a matter of course as part of an informed consent process is quite reasonable. I agree with the member for Armadale on that. It is disappointing that the government does not see the potential for the distortion of any process through not having to disclose financial interests. Having not provided any reasonable argument against it, I can only assume that it is yet another component of this bill on which the government will refuse to consider any change, purely because it does not want to be seen to accept amendments. That was the case with the clause on the age limit, which we have just passed. That is the only reason; there is no justification for 16 as opposed to any other age limit, other than perhaps 18, because that is when someone becomes an adult. The only reason I can see for the government refusing to accept our amendment was that it has come to the conclusion that it will not accept any amendments, will not listen to the debate and will just stonewall it and refuse to waver or budge. That is disappointing. The result will be legislation that is not as good as it could have been, and that is a sad thing.

Clause put and passed.

Clauses 209 to 223 put and passed.

Clause 224: Report to Chief Psychiatrist and Mentally Impaired Accused Review Board —

Dr A.D. BUTI: I move —

> Page 164, after line 6, to insert —
>
> (ba) the Chief Mental Health Advocate; and

This clause is about seclusion. The definition of "seclusion" is provided in clause 212, which states —

> Seclusion is the confinement of a person who is being provided with treatment or care at an authorised hospital by leaving the person at any time of the day or night alone in a room or area from which it is not within the person's control to leave.

That is quite a significant restriction on someone's freedom and rights. As we know from clause 10, the objects of the bill, this government is very keen to not restrict people's rights and freedoms to any greater degree than is

necessary. Clause 224 is about reporting to the Chief Psychiatrist and the Mentally Impaired Accused Review Board and states —

> (1) This section applies whenever a person is released from seclusion …

So a person has been secluded and has then been released. It then states —

> (2) The treating psychiatrist or, if the person does not have a treating psychiatrist, the person in charge of the authorised hospital where the person was secluded must, as soon as practicable, give the documents specified in subsection (3) —

Which talks about the copy of the seclusion order —

> … to —
>
> (a) the Chief Psychiatrist; and
>
> (b) if the person is a mentally impaired accused—the Mentally Impaired Accused Review Board.

Once again, the Chief Mental Health Advocate has been omitted. It is really strange that the Chief Mental Health Advocate seems to be absent throughout this bill. Surely, the Chief Mental Health Advocate is incredibly important to the whole process if we are trying to ensure that the rights and freedoms of patients are upheld. Why would the Chief Mental Health Advocate not be told that a patient is no longer in a seclusion situation? Why would the Chief Psychiatrist be told? The Chief Psychiatrist is told because they are interested in the treatment of the patient and what phase of treatment they are in. The Mentally Impaired Accused Review Board is told for obvious reasons. Why not also tell the Chief Mental Health Advocate, who has a particular interest in the treatment process of the patient?

Ms A.R. MITCHELL: I guess the response is very similar to what we have said over time about the Chief Mental Health Advocate. That role is important. It is an advocacy role rather than a medical role. The member is right that the Chief Psychiatrist is the key person to get that information, because they are also responsible for driving improvement in that practice, particularly in relation to seclusion. At the same time, that information must be reported by the Chief Psychiatrist in his annual report. That means that there will also be much greater public scrutiny of the use of seclusion in mental health practice. To require that the information be reported to the Chief Mental Health Advocate really, once again, would mean extra administrative work without necessarily providing a clear benefit to patients. The Chief Mental Health Advocate can always be contacted and can access the medical records. We do not believe that it is necessary to make it a requirement at this time, given the advocacy role.

Dr A.D. BUTI: We keep coming back to this increased administrative load. It would be possible to probably email or fax the copy. I am not sure how that is such an onerous task. I do not think that that would be an onerous task. The parliamentary secretary said that the Chief Psychiatrist needs to put this information into an annual report and that that is then open to review by the public. That is fine, but what about the individual patients? It is irrelevant to individual patients if something is put in an annual report that might come six, seven, eight or nine months later. The Chief Mental Health Advocate is there to advocate on behalf of the patient. They therefore need knowledge of all parts of the treatment process. Maybe they would be celebrating that the seclusion order has come to an end. The government might actually be decreasing the load on the Chief Mental Health Advocate by sending them a copy of the expiry of the seclusion order, because maybe that would then be one person for whom they would no longer need to be so vigilant about supervising. If they know that a patient's seclusion has come to an end, they may be able to spend more time in advocating for someone else who is under seclusion. This administrative order is just a matter of pressing a button. It is not that onerous. At the same time as the report goes to the Chief Psychiatrist and the Mentally Impaired Accused Review Board it should go to the Chief Mental Health Advocate. It may not be able to go by email or fax because of confidentiality issues, but it might go by registered post. That is one more envelope and one more stamp; surely, that is not that onerous. The onerous task that it may be, but which it is not, surely is a small price to pay to ensure that the Chief Mental Health Advocate is kept abreast of all parts of the treatment process for someone for whom they are advocating. It is a very simple amendment that would enable a copy to be sent to the Chief Mental Health Advocate.

Ms A.R. MITCHELL: We believe that there are ways that the Chief Mental Health Advocate or their representative will be informed of the situation. We believe that that is available to them now. All we are saying is that we do not believe it should be a requirement.

Dr A.D. BUTI: Basically, the parliamentary secretary is saying that the Chief Mental Health Advocate should not have the same status or their role is not as important as the roles of the Chief Psychiatrist or the Mentally Impaired Accused Review Board. Yes, in some respects the Chief Mental Health Advocate's role is probably not

as important as the Chief Psychiatrist's role, but then again, the Chief Psychiatrist is not the treating psychiatrist; they are the administrator or overseer. Why does the overseer, the administrator, have a higher status in the treatment and safeguard of an individual patient than the Chief Mental Health Advocate, who is there to support and protect the rights and freedom of the patient?

Ms A.R. MITCHELL: I think I have responded to that. I think the member recognises that the role of the Chief Psychiatrist is quite different from that of the Chief Mental Health Advocate, and that is why the Chief Psychiatrist is required to comply with certain administrative functions and responsibilities in this area.

Ms M.M. QUIRK: Can the parliamentary secretary understand the point that the member for Armadale has very clearly made about accountability and scrutiny? The idea of something being recorded in a report that comes out only annually does not allow for scrutiny at a meaningful time that links to the treatment being given. It is too long after the event. That is what I think the member for Armadale is trying to convey to the parliamentary secretary. The parliamentary secretary is saying that this might be administratively onerous for the Chief Mental Health Advocate, but that raises more concerns for me because it seems that limited resources will be given to that position. The fact that the government is trying to constrain the level of scrutiny or the nature of his role suggests to me that the resources given to the Chief Mental Health Advocate will be restricted, which, of course, very much subverts the scheme of the legislation.

Ms A.R. MITCHELL: We understand what the member for Armadale is saying. I think the administrative burden to which I referred is more on the clinicians through their work rather than on the Chief Mental Health Advocate. I reaffirm that advocates have access to medical records. Patients, their carers and other people involved can certainly be in touch with the Chief Mental Health Advocate or their representative. As I said, we recognise the situation and it is important, but we do not believe it needs to be a requirement.

Mr P. PAPALIA: The parliamentary secretary has intimated a couple of times now that the Chief Mental Health Advocate will have access to the mental health records of patients in these cases. How will cases come to the attention of the Chief Mental Health Advocate? It will not be automatic because we are not putting it in the legislation. How does the parliamentary secretary perceive that cases will come to the attention of the Chief Mental Health Advocate?

Ms A.R. MITCHELL: The advocates' role will be similar to the role of the Council of Official Visitors. Therefore, they can visit authorised hospitals—it could be daily, if not very regularly—and they can read files and listen to any complaints that patients may have. That service will still be available under a slightly different name.

Mr P. PAPALIA: I understand what the parliamentary secretary just said. Is the assumption that by happenstance the advocate will arrive at the hospital on the day that the person is being released and ask to see their records because they are being released? We have been told that the legislation will not make it necessary for the treating clinician to notify the advocate, but the advocate can access the records if they happen to be visiting the location where the person was secluded. What if they do not? They would not find out about it until the annual report, which goes back to the member for Girrawheen's point that it is a bit late to advocate for someone on a date later than the incident for which they might want advocacy.

Ms A.R. MITCHELL: One of the first things that I would expect the Chief Mental Health Advocate or the other advocates to do when visiting a hospital on a regular basis—it could be daily—is review all the files of the people who are in there. I would be horrified if they were waiting to read what was in the Chief Psychiatrist's annual report. There is an expectation about how these people work, and I am sure they do work that way. I have every confidence that they work that way. Consumers and the carers can also make contact with advocates.

Mr P. Papalia: Is the parliamentary secretary assuming that it is a normal practice—I am not familiar with it—that when an advocate goes to a facility, they review all the files?

Ms A.R. MITCHELL: Certainly, they would review the files of the people with whom they are involved.

Mr P. Papalia: All the people who have been secluded.

Ms A.R. MITCHELL: If they were given any reason to review files, I would expect them to do so.

Dr A.D. BUTI: I have a couple of points. Should we not be trying to make the job easier for the Chief Mental Health Advocate? It would make the job easier for the Chief Mental Health Advocate if they were notified of a certain significant event that has happened to one of the patients for whom they advocate. The parliamentary secretary always wants to make the job easier for the Chief Psychiatrist—she keeps telling us that we do not want to put any more administrative burden on them—but she does not mind putting greater administrative burden on the Chief Mental Health Advocate. The parliamentary secretary says that advocates have to go to

hospitals and review every file, which she hopes they are doing, but it would be easier if advocates were alerted to any significant change in the treatment pattern of a patient.

I went to a talk last year by an official visitor and things are not all rosy out there in hospital land. Many official visitors have come up against many hurdles in the hospital system when they have tried to make contact with their patients. Interestingly, this official visitor also stated that many of the patients are scared to seek contact with the official visitor because they have been told that it may affect their ability to be granted leave from the hospital. The parliamentary secretary may refer to the official visitors scheme and that the Chief Mental Health Advocate will, basically, replace the official visitors scheme, or be the same person, but it ain't all rosy out there in hospital land. We should be trying to reduce the chance that one of these significant events is not brought to the attention of the Chief Mental Health Advocate. All it would take is a copy of the release of the seclusion order to be sent to the Chief Mental Health Advocate, whether by registered post or through secure email. If it is being done by the Chief Psychiatrist and being sent to the Mentally Impaired Accused Review Board, it should also be able to be sent to the Chief Mental Health Advocate.

Ms A.R. MITCHELL: I appreciate what the member is coming to now, but I suggest that we wait until part 20 of the bill, which covers the role of the mental health advocacy area in much more detail. It would be best to deal with it then and stick to this clause for now. I know that the member will not agree, but we believe that is the best way to go.

Amendment put and negatived.

Debate interrupted, pursuant to standing orders.

[Continued on page 1722.]