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

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

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

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

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

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

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

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

(i) with the least possible restriction of their freedom; and

(ii) with the least possible interference with their rights; and

(iii) with respect for their dignity;

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

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

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

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

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

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

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

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

> Under the Act it can be seen section 26(1)(b)(c) provides a required criterion to make someone involuntary to be that, *the person has refused or, due to the nature of the mental illness, is unable to consent to the treatment.*
>
> In recognition of the issues this raised and raised in submissions on the 2012 Bill, the Bill changes this refusal criterion for involuntary detention and treatment at cl.25(1)(c)(ii) and for a community treatment order at cl.25(2)(c)(ii) to, *the person has unreasonably refused treatment*.

The submission of the Mental Health Law Centre further reads —

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

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

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

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

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

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

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

[Member's time extended.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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