LEGISLATIVE COUNCIL

Thursday 19 February 2009

The PRESIDENT (Hon. R.K. Sneath) took the chair at 14:18 and read prayers.

ANSWERS TO QUESTIONS

The PRESIDENT: I direct that the following written answer be distributed and printed in *Hansard*.

PUBLIC SCHOOLS

170 The Hon. D.G.E. HOOD (24 September 2008). Can the Minister for Education advise:

1. What has been the incidence rate of reports of assault or serious threat to safety of teachers, principals and school services officers, for the last five reporting years?

2. To what extent or trend, statistically or anecdotally, has the use of firearms (real or imitation) featured in these incidents?

3. What has been the cost in time spent off work, or in weekly and lump sum payments from WorkCover, as a consequence of these incidents?

4. How much has the state government spent, or intends to spend, on addressing this issue in South Australian public schools?

The Hon. G.E. GAGO (Minister for State/Local Government Relations, Minister for the Status of Women, Minister for Consumer Affairs, Minister for Government Enterprises, Minister Assisting the Minister for Transport, Infrastructure and Energy): The Minister for Education has provided the following information:

1. Department of Education and Children's Services' (DECS) has provided the following advice:

A summary of the DECS critical incidents records reported by schools, which have indicated threatened and actual assault or serious threats to the safety of teachers, principals and school services officers, is summarised as follows:

Reports of threatened and actual assault or serious threats to safety of teachers, principals and school services officers

Year	Incidence rate reported to DECS expressed as a percentage of all teachers, principals and school services officers	Actual number of incidents reported to DECS that indicated threatened and actual assault or serious threats to the safety of teachers, principals and school services officers
2003	0.08%	16
2004	0.19%	40
2005	0.42%	91
2006	0.29%	62
2007	0.62%	136

In recent times, DECS and SA Police have actively encouraged schools to report all incidents, no matter how minor.

As a result, there has been an overall increase in the number of incidents reported by schools to DECS, corresponding with an increase in this particular category.

The government has strategies and initiatives in place to address violence in schools and their communities, including:

A Coalition to Decrease Bullying, Harassment and Violence in South Australian schools which takes a lead role on providing the government with advice on these issues.

Schools liaise closely with local police and immediately call for assistance if an incident occurs that threatens staff or student safety.

Earlier this year, DECS and SA Police took a road show across the State to provide principals with updated support materials and expert advice on maintaining school safety.

Intruder regulations introduced in 2004 give police and principals the power to refuse entry, evict and ban people who behave in a violent, offensive or threatening manner.

Schools will use suspension and exclusion measures where required. In extreme cases, students can be sent to learning centres.

All government schools are required to have a behaviour code and anti-bullying policy. These polices are negotiated through each school's governing council.

Teachers on yard duty have been issued with mobile phones so police can be called in the event of a schoolyard incident.

School Care staff provide ongoing advice to schools about safety and security.

2. There has been no use of real firearms featuring in the reported incidents above and only one (1) involving the use of an imitation firearm.

3. Information relating to the cost in time spent off work or in weekly and lump sum payments from WorkCover as a consequence of the incidents is not available. DECS receives separate notification for all incidents that may result in Workers Compensation claims.

4. In addition to the strategies outlined in Question 1, the State Government provides funding for a wide range of preventative programs that support the management of this issue within schools. Examples include:

$10 million over four years for a five-part student behaviour management program. This program includes a training package 'Your Classroom: Safe, Orderly and Productive', with training for 2000 classroom teachers (initially targeting teachers in their first five years). There is also funding for schools to bring in experts when the issues are beyond the expertise of school and district education officers.

Annual funding totalling $3 million last year that support programs for students who demonstrate behavioural, social and emotional difficulties. This support ranges from short-term modified educational programs in learning centres to intensive long-term support plans and implementation for students with extreme behavioural, social and emotional difficulties.

$800,000 per year for the Challenging Behaviours program. This program provides salary support to schools so students who demonstrate behavioural difficulties can be supported according to their individual needs. Schools use the funding in a range of ways, for example, one-on-one support to teach anger management and development of social skills or staff training in supporting students with complex needs.

$6 million over five years to provide security fencing at up to 35 State schools. Schools experiencing issues with intruders and those at greatest risk of after-hours arson and vandal attacks are being targeted.

Security guards are provided on a needs basis to prevent or minimise the threat of violence or serious threats to safety ($40,000 per annum).

The Hon. D.W. Ridgway: There are only 1,742 answers to go!

The PRESIDENT: I also direct the Leader of the Opposition to cease interjecting.

PAPERS

The following papers were laid on the table:

By the President—

Wattle Range Council—Report, 2007-08

By the Minister for Mineral Resources Development (Hon. P. Holloway)—

South Australian Film Corporation—Report, 2007-08

By the Minister for Correctional Services (Hon. C. Zollo)—

Correctional Services Advisory Council—Report, 2007-08

Death in Custody of Renald Lance Forsaith—Report on actions taken following the Coronial Inquiry
Rules under Acts—
Workers Rehabilitation and Compensation Act 1986—
Representation Costs
Tribunal Rules

By the Minister for State/Local Government Relations (Hon. G.E. Gago)—

Reports, 2007-08—
Country Health SA
Kingston Soldiers' Memorial Hospital Inc.
Teachers Registration Board of South Australia

SELECT COMMITTEE ON SA WATER

The Hon. M. PARNELL (14:19): I move:

That standing orders be so far suspended as to enable me to move a motion for the substitution of a member of the committee.

Motion carried.

The Hon. M. PARNELL: I move:

That the Hon. R.D. Lawson be substituted on the select committee in place of the Hon. C.V. Schaefer (resigned).

Motion carried.

WATER SECURITY

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (14:21): I table a copy of a ministerial statement relating to South Australia's water security made earlier today in another place by my colleague the Minister for Water Security.

QUESTION TIME

MINING SECTOR

The Hon. D.W. RIDGWAY (Leader of the Opposition) (14:23): I seek leave to make a brief explanation before asking the Minister for Mineral Resources Development a question about the takeover of South Australian mines by overseas companies.

Leave granted.

The Hon. D.W. RIDGWAY: It has been widely reported in the media that OZ Minerals has recommended that shareholders accept the $2.6 billion takeover of their company by Chinese company Minmetals. We have seen the minister in this place on a number of occasions talking about the wonderful work that has been happening at Prominent Hill—a wonderful mine in our north not far from Coober Pedy. In fact, I myself visited the mine, and I think it is a credit to the company that it has been able to develop a mine of that calibre and size as quickly as it has.

One of the things that really excited me with that mine was initially Oxiana's commitment to recruitment in South Australia, with a focus on recruiting South Australian people to work in the mine and also the focus they had on the indigenous employment program. I cannot recall exactly where the plane was flying in and out from, but it was bringing some young indigenous people from other parts of the state into the mine on a fly-in/fly-out basis to actually add real value to those communities. They also had a training program for the very big trucks that have been used up there and the minister, I think, was there for the launch of that training program.

The Hon. P. Holloway: I actually drove one!

The Hon. D.W. RIDGWAY: He interjects that he actually drove one. Now, that is a scary thought! If someone who has spent most of his life behind a desk can drive one, then it must be a very comprehensive training program.

The other component of Oxiana's commitment to the community was its wonderful commitment to Coober Pedy, and the investment it has made in the football oval, grassing it and having some irrigated turf put in, and the facilities for the local communities.

My question to the minister is: has he had any discussions with Minmetals or any other overseas companies in relation to making sure that the future owners of these mining assets in our state reinvest in our South Australian communities and that we do not see the profits disappear overseas and our South Australian communities be poorer for the experience?

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (14:25): I thank the honourable member for his question. I am grateful that he appreciates the efforts of this government in ensuring that mines such as Prominent Hill have been able to be brought into production so quickly.

The Hon. D.W. Ridgway interjecting:

The Hon. P. HOLLOWAY: No, of course not, you would not do that. It is important to recognise the great contribution that the mining industry has made to this state, thanks to the efforts of this government. In relation to the general question of foreign investment, the honourable member has already asked me a question about that, and I put my views on that on the record some time back.

As far as the takeover of OZ Minerals is concerned, it will be subject to a number of approvals, both from the Foreign Investment Review Board and then the Treasurer, and also the Defence Department, because Prominent Hill is within the Woomera protected area, so it will need those approvals. Some other parts of the OZ sale will also need approvals.

In relation to the takeover, I have had some discussions with OZ. I am informed that the company that is taking over, Minmetals, has stated that it is its intention to continue the operation as an Australian-based operation, so, essentially, it will be run as it is now, but as a subsidiary of its new owner.

The policies that have been run by the current management of the Prominent Hill mine are very good, and I trust that people such as Mick Wilkes and others up there who are responsible for running the Prominent Hill mine will continue in that role. That is certainly my expectation.

I have not had the opportunity yet to speak to Minmetals and, of course, that takeover will not be complete until, firstly, the approvals that I mentioned earlier are obtained and, secondly, the shareholders of the company approve that particular proposal. It would be my expectation—

The Hon. D.W. Ridgway: You haven't spoken to them.

The Hon. P. HOLLOWAY: I have spoken with them in the past. I met with that particular company in Beijing, I believe, several years ago, but I have not spoken with them since. As I said, until the takeover is complete, and there are still some months to go, it will have no influence on it.

Obviously, it will be the position of this government that we would expect that those very successful policies that have been introduced by OZ Minerals will continue under the new ownership. We will be meeting with the principals of that company at the appropriate time, if and when this takeover occurs, and do everything we can to ensure that that continues.

CORRECTIONAL SERVICES, BUDGET CUTS

The Hon. S.G. WADE (14:29): I seek leave to make a brief explanation before asking the Minister for Correctional Services a question regarding correctional services budget cuts.

Leave granted.

The Hon. S.G. WADE: On 15 February, *The Advertiser* published a story regarding Treasurer Foley's public sector budget cuts due to the worsening financial situation in South Australia. Included in the article was reference to an email from the chief executive of the Department for Correctional Services advising that DCS would be losing 30 FTEs over the next three years. Mr Severin's email stated:

> Correctional officers, professional officers and education instructors are exempted and no staff in these categories will be declared a redeployee or offered a TVSP.

However, Mr Severin did not exclude administrative staff located within the prisons. Concerns have been raised with the opposition that any reductions in administrative staff in prisons is likely to

place an increased administrative workload on correctional services officers—officers who are already trying to cope with record overcrowding. The minister admitted yesterday that prisons, such as Port Augusta Prison, are understaffed. My questions are:

1. Will the minister guarantee that administrative staff based in prisons will be exempted from the budget cuts?

2. If not, will the minister give an assurance that correctional services officers will not be required to take on an additional administrative workload as a result of the staff reductions?

Members interjecting:

The PRESIDENT: Order, the Hon. Mr Finnigan and the Hon. Mr Ridgway!

The Hon. CARMEL ZOLLO (Minister for Correctional Services, Minister for Road Safety, Minister for Gambling, Minister Assisting the Minister for Multicultural Affairs) (14:31): Clearly, the honourable member is referring to the mid-year budget review, information that was released last December, where the government outlined the decision to ask agency chief executives to reduce—

An honourable member interjecting:

The Hon. CARMEL ZOLLO: I think he has had a meeting with a particular group of people—their FTEs, but that would occur across several financial years. The Department for Correctional Services has 22 FTEs in 2009-10; an additional four FTEs in 2010-11; and a further four FTEs in 2011-12. That makes a total of 30 FTEs. That information has already been placed on the record, although I do not believe it was mentioned in *The Advertiser* article.

I need to emphasise that, in general, the frontline correctional officer, the professional officer and the educational instructor positions are exempt from this process, and no staff occupying frontline positions in these key categories will be declared redeployees or will be offered a targeted voluntary separation package.

As an interim measure, and to ensure appropriate consideration of the department's business strategy and workforce requirements, the Chief Executive circulated an email to all staff instructing that there be an immediate freeze on advertising in the notice of vacancies section in the external press, which information was reported in the newspaper.

As I have said, what is important here is that, in general, frontline correctional officers, professional officers and educational instructor positions are exempt from this process. As I have placed on the record on several occasions, the department undertook an aggressive recruitment campaign last year. We are continuing with that campaign to ensure that our prisons are well staffed and that our community is secure, and for the honourable member to suggest that anything else is the case is nonsense.

ONE AND ALL

The Hon. T.J. STEPHENS (14:34): I seek leave to make a brief explanation before asking the Leader of the Government a question about the *One and All*.

Leave granted.

The Hon. T.J. STEPHENS: Last week, I asked the Leader of the Government whether the $2 million paid to a business in Sydney to refurbish the *One and All* could have been spent here in South Australia.

Members interjecting:

The PRESIDENT: Order!

The Hon. T.J. STEPHENS: Mr President, throw the parrot out, please. She is a parrot; throw her out.

The PRESIDENT: Order! I think the Hon. Mr Stephens might be asking about the desalination plant.

The Hon. T.J. STEPHENS: The leader stated that he did not think there was the expertise in South Australia to repair timber vessels, even though the *One and All* was built here in Adelaide. On 4 February, the minister said:

Providing refurbishment for a very specialist vessel, a wooden sailing ship, is not exactly the sort of mainstream activity that we have here in this state. Certainly, we do provide many specialist activities and services in our state, and we do our best to support them, but refurbishing wooden sailing ships is not one of those mainstream activities.

The opposition—and, I know, the Premier—has been contacted by a number of people regarding this issue. I will read an email widely circulated among electorate offices and to *The Advertiser* as follows:

I refer to the statement by the government that the refit of the vessel *One and All* was carried out interstate because 'South Australia does not have the required skills'. That statement is the greatest piece of codswallop fostered on the electorate. It would seem that the members of the government would say anything but their prayers, and they would whistle them backwards. I was a ship surveyor in the ship survey section of the then department of marine and harbours and was appointed by the commonwealth department of shipping and transport as surveyor on the construction of this vessel when built by the South Australian firm of W.G. Porter & Sons. The firm R.T. Searles & Sons of South Australia has been in existence since 1910 and is more than capable of carrying out the refit of this vessel and, if necessary, building a replica. One would think the government would be more guarded in such statements in trying to cover their actions.

That email is from Mr Neil W. Cormack. I have mentioned his name because obviously he is not frightened to make his views known. Does the minister stand by his misleading comments that the *One and All* could not have been refurbished here in South Australia?

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (14:36): The honourable member is misrepresenting what I said in the answer. I said that fixing wooden vessels is not the sort of mainstream activity on which this state would base its future. I suggested that may have been one of the questions why—

The Hon. T.J. Stephens interjecting:

The Hon. P. HOLLOWAY: I repeat the comment I made in my answer. Is this really the best that the opposition can do? With all the issues around us, is a question about refurbishing a replica wooden sailing vessel really where it is all at in South Australia? Of all the issues facing us, is this really the big one? I will ask the honourable member whether the company he is referring to—

The Hon. T.J. Stephens: We ask the questions, and you are supposed to provide the answers.

The PRESIDENT: Order! The minister can answer the question any way he sees fit. If the minister has a question to help him further answer the question—

Members interjecting:

The PRESIDENT: I make the rulings on whether members are out of order, not you people sitting down there.

The Hon. P. HOLLOWAY: The honourable member in his question referred to a company that had been involved. The obvious question is: did that company put in a tender? If it did not tender, it is easy enough for someone to say they worked for a company 10 years ago and it made a boat. I do not know the conditions and the work that was required, and I do not know the process for selecting—

Members interjecting:

The Hon. P. HOLLOWAY: Talk down the industry! An industry repairing wooden boats in South Australia—come on! Of all the industries in this state, I do not think the industry that repairs wooden replica sailing ships is where the future of the state is at, and that was the only point I made in relation to the last question. If this is the best the opposition can do, we can rest assured that the government of this state is in very good hands. If that is the best issue, clearly all the other issues are well and truly being addressed adequately by this government.

The PRESIDENT: Game, set and match to the minister.

PLANNING APPROVALS

The Hon. B.V. FINNIGAN (14:39): I do not have a question about the long ship led recovery, but I direct my question to the Leader of the Government. Will the minister provide details of any changes to the planning approvals process that have made it easier for home renovators to improve their properties?

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (14:39): I thank the honourable member for his very important question, because this government is in the—

Members interjecting:

The Hon. P. HOLLOWAY: The big issues? I would have thought reducing red tape and saving many millions of dollars—

Members interjecting:

The PRESIDENT: Order! There is an old song, I think, *As Time Goes By*, and that is what is happening to members' question time.

The Hon. P. HOLLOWAY: It is an important question, because the changes that have been made to the planning approvals process to make it easier for home renovators will contribute significantly to the economy of this state as well as making things easier for its residents. That is what I think good government is all about. Home renovators in South Australia now face a lot less red tape when doing some work around their properties.

The new planning rules to remove many home improvements from the local council approval system came into force from 1 January. This, of course, makes a lot of basic home renovation work exempt from building and planning approvals, to save both time and money for South Australians. Home renovators should be aware that, from 1 January, items such as pergolas, sheds, shade sails and decks in most circumstances will no longer require prior approval from their local council. This expanded list of exempt developments delivers stage 1 of this government's sweeping planning reforms.

Further reforms will be rolled out throughout 2009, including a new residential development code that will dramatically reduce waiting times for planning and building approvals. Most building work in South Australia requires council assessment and approval. However, exempt development requires no prior development assessment or approval at all.

The list of exempt development was expanded to include minor residential development matters that are commonly undertaken by home owners to improve their property. This expanded list includes small sheds of less than 15 square metres floor area which meet certain conditions; pergolas which meet certain conditions, including not having a hard roof; decks which meet certain conditions such as not being more than 50 centimetres above the ground; small shade sails to 20 square metres and no more than three metres in height which meet certain other conditions; solar panels, with certain conditions relating to the weight and position; water tanks of less than 10 square metres which meet certain other conditions; roller doors within specific conditions; certain fences to 2.1 metres in height; and retaining walls to one metre in height with certain conditions.

A more efficient approval system should translate into substantial savings in time and money for South Australians. This government is committed to ensuring that South Australia is one of the most attractive places in the world in which to live, work and do business, and to achieve this we are embarking on the broadest range of urban development and planning initiatives seen in South Australia in decades. The complete list of exempt development and the conditions that apply appears in schedule 3 of the Development Regulations 2008. They can be found online through links on the website of the Department of Planning and Local Government.

Exempt development applies in relation to all types of dwellings, be they standard detached homes, semi-detached homes, townhouses or even apartments. However, it is important to note that, where strata or community titles exist—for example, many townhouses or group dwellings such as retirement villages—special approval relating to those titles may need to be obtained from the body corporate to undertake any development. This is a significant change, and it will be accompanied very shortly by the next round of planning reforms. They are all designed to do one thing: to make it easier and cheaper for South Australians to upgrade and own a home.

PLANNING APPROVALS

The Hon. D.W. RIDGWAY (Leader of the Opposition) (14:43): Sir, I have a supplementary question. With respect to the residential code that the minister spoke about, we saw version No. 11 during the debate on the bill. Can the minister assure us that there have been no changes to that residential code since the legislation was passed?

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (14:44): There will be some very minor technical arrangements (and I will be happy to let the honourable member know when they come in), which have come out of discussions. They are essentially the same as the version that was produced in this parliament. As I said, any amendments are technical, based on the advice that we have received. However, it certainly does not change the principle.

SKYCITY

The Hon. D.G.E. HOOD (14:44): I seek leave to make a brief explanation before asking the Minister for Gambling a question about SkyCity Adelaide Casino.

Leave granted.

The Hon. D.G.E. HOOD: Earlier this week the minister provided me with some surprising data regarding crime and Office of the Liquor and Gambling Commissioner breaches detected at SkyCity casino. There were some 477 thefts and other crimes in SkyCity between 2002 and 2007. Further, the number of breaches of procedures detected by the Office of the Liquor and Gambling Commissioner at SkyCity has tripled in the past three years from 47 in 2005 to 95 in 2006 and 151 in 2007. My questions are:

1. Will the minister explain the rapid and substantial increase in breaches of procedures and incidence of crime at SkyCity casino?

2. What will the minister do to reduce crime and serious breaches of procedures at the casino?

The Hon. CARMEL ZOLLO (Minister for Correctional Services, Minister for Road Safety, Minister for Gambling, Minister Assisting the Minister for Multicultural Affairs) (14:45): The honourable member may be aware that very shortly I will be introducing legislation into the parliament that will see increased compliance in all gaming venues, including the casino, and a different way of administering that compliance. It is my intention to have the legislation before the council, hopefully, in the next few weeks.

At the same time as I introduce the legislation, we will be providing a copy on the internet of the responses to the bill that was out for consultation. There were some 11 responses and they will be provided on the internet. It is my intention to make available a system that we hope will work to reduce the number of gaming machines in our state. It is my intention to have that legislation lie before the council; I am not certain of the time—I am still taking advice—whether it be a month or perhaps a few weeks more so that people can feed back information to us.

Clearly, as a government we are ensuring that we do see more responsible gambling in our state. I have talked on a number of occasions about the various initiatives that we have undertaken. The casino has the Host Responsibility scheme in terms of its problem gamblers, and we have Club Safe, as well, and Gaming Care. We have barring mechanisms. Again, I have placed on record that we have no fewer than six barring mechanisms in our state.

I have asked for an inquiry, which is being held at present, and 24 February will be an inquiry day where people can go forward independently and express their views as to whether we need to do things better in terms of the inquiry. Barring also includes family protection orders. A lot of initiatives have been introduced recently, including the new code of practice on 1 December, but there is more legislation to come before this parliament, on which I look forward to support and good debate.

SKYCITY

The Hon. J.M.A. LENSINK (14:48): I have a supplementary question. Will the minister advise how many random and out-of-hours visits are undertaken by the inspectorate each year?

The Hon. CARMEL ZOLLO (Minister for Correctional Services, Minister for Road Safety, Minister for Gambling, Minister Assisting the Minister for Multicultural Affairs) (14:48): I will have to bring that information back for the honourable member.

MINISTERIAL STAFF

The Hon. R.I. LUCAS (14:48): I seek leave to make a brief explanation before asking the minister representing the Premier a question about ministerial staff salaries.

Leave granted.

The Hon. R.I. LUCAS: Members will be aware that ministers in this government have almost 300 staff in their ministerial offices, many of whom are media advisers, spin doctors or staff employed under ministerial contract. According to the last public announcements, some of the salaries paid to these officers are as high, for example, as $165,000 for Mr Nick Alexandrides (who works for the Premier) and $147,000 for Ms Jillian Bottrall; and I think they were in the *Government Gazette* in July last year.

Information provided to the Liberal Party is that, just prior to Christmas, the Premier and the government made a decision to give all their media advisers, spin doctors and other ministerial advisers on contract a pay rise of 3.5 per cent, which was backdated to July last year. My questions are:

1. Why did the Premier keep secret his government's decision made just prior to Christmas to give these staff a 3.5 per cent pay rise and to backdate it to 1 July last year?

2. What was the exact date of the decision taken by the Premier and his government?

3. When did these staff get their last pay increase prior to that, what was the level of that increase and was that increase also backdated?

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (14:50): My understanding is that the previous increase the staff had would have been on the previous 1 July. It is my understanding that a 3.5 per cent increase was also given to senior public servants, and ministerial staff were given it at the same time.

The Hon. R.I. Lucas interjecting:

The Hon. P. HOLLOWAY: There is nothing secret about it. What is secret about it? I do not think there is anything particularly secret about it. Presumably, the flow-on would have gone to electoral and opposition staff; that is usually the way, and I have no problem with that. I would have thought a 3.5 per cent increase was relatively modest at a time when many others in the community such as medical practitioners—some of the medical staff in the Public Service—received a little bit more than that. I do not think there is anything mysterious about it, but I will refer the question to the Premier. In case there is anything I have not covered, I will give him the opportunity to respond, but I do not think there is anything particularly unusual or unique about that increase.

CORRECTIONAL SERVICES AWARDS

The Hon. R.P. WORTLEY (14:51): I seek leave to make a brief explanation before asking the Minister for Correctional Services a question regarding the recent 2009 Correctional Services awards ceremony.

Leave granted.

The Hon. R.P. WORTLEY: I understand that the Minister for Correctional Services attended a Department for Correctional Services awards ceremony on 9 February this year. It was held at the Adelaide Town Hall, and she presented awards recognising outstanding professionalism and conduct by the staff of the department. Will the minister, above all the interjections from the other side, provide some details of the individual awards presented?

The Hon. CARMEL ZOLLO (Minister for Correctional Services, Minister for Road Safety, Minister for Gambling, Minister Assisting the Minister for Multicultural Affairs) (14:52): I thank the honourable member for his very important question. I am sorry that those opposite are not interested in hard working public servants in this state. All they are interested in is whingeing and nothing more than that. It gave me great pleasure to attend the Correctional Services awards ceremony, and I congratulate all the award recipients on behalf of the government and also personally for their hard work and achievements.

I want to recognise the individual award recipients in this place. The Individual Commendation Award is presented to employees who show efficiency and diligence in their role through their commitment to leadership, innovation, knowledge and professionalism. Individual commendation awards were given to Mr Bernie Gelstone, Mr Neil Gillies, Mr Chris Johnson and Ms Anna Kemp. Bernie Gelstone, who is a manager at Mobilong Prison, has demonstrated outstanding leadership and organisational skills throughout his career in the department. Neil Gillies is a supervisor at the Adelaide Remand Centre with over 20 years experience in both community corrections and custodial services.

Chris Johnson is the Manager, Executive Services and is an exceptional example of commitment to high levels of excellence in quality service provision. Anna Kemp is a community corrections officer with outstanding commitment and dedication in her work in bettering the lives of women whilst in the Adelaide Women's Prison and increasing their opportunities to succeed in the community once released.

I also express sincere recognition to Lange Powell, who was the recipient of the Meritorious Service Medal. The Meritorious Service Medal is presented to employees for outstanding service above and beyond what is required in their paid employment and in leadership and management; initiative through enhancing and developing significant work practices, procedures and service delivery; distinguished service; and outstanding contribution to the corporate goals and mission of the department and stakeholders.

I suspect there would be quite a few members in this chamber who know of Lange Powell. Lange has been an outstanding state public servant for 28 years. Throughout his career he has made significant contributions to human services delivery in South Australia through his many roles and responsibilities. Lange worked in both country and metropolitan areas and has a rich and diverse background across many areas, including social welfare, dealing with ageing citizens, housing, social justice, Aboriginal people and, for the past 10 years, in correctional services.

Lange was the director of Community Corrections for nine years, and during this time he initiated and implemented many important reforms and service improvements. For 12 months prior to commencing a period of long service leave leading to retirement, Lange was the director of Custodial Services.

Lange's outstanding leadership qualities are firmly based on a sound set of human service principles, always seeking new and innovative solutions to improve outcomes for disadvantaged people in our community. He is known for his impressive ability to link services and his capacity to think outside the square. Lange also tirelessly contributes to organisations and services outside his workplace. He is honoured for his vision, leadership, dedication, commitment and achievements during his career—particularly with the Department for Correctional Services.

Other individual awards presented were Australia Day achievement medallions. The Australia Day Council recognises and celebrates the outstanding achievements and contributions of extraordinary Australians, and the Australia Day achievement medallions acknowledge dedicated public employees. They are presented to employees who have made a significant contribution to the work of their department during the past year or who have given outstanding service over a number of years. The names of the recipients of Australia Day achievement medallions are listed on the National Australia Day Council website and in the Commonwealth Public Service *Gazette*.

Australia Day achievement medallions were awarded to Kevin Baohm, John Peake and David Thompson. Kevin Baohm joined the Department for Correctional Services in 1982 and in 1995 was appointed general manager of the Adelaide Pre-release Centre, a position he still holds today. Kevin's commitment to the excellent correctional program that is Adelaide Pre-Release Centre is a credit to him. He is to be commended for his leadership, vision and dedication.

John Peake joined the South Australian Public Service in 1986 and joined the Department for Correctional Services in 2000. His role is now senior procurement officer. John is well respected by staff, peers and senior management for his sound knowledge and experience in the procurement function. David Thompson joined the Department for Correctional Services in 1985 and is currently regional manager for the northern country region. David has led initiatives in that region in regard to Aboriginal issues, and he is currently leading work in the remote area family violence program and cross-border legislation project.

I would like to sincerely congratulate all the award recipients on behalf of the government—and, I am sure, on behalf of all in this chamber. I would also like to personally thank them for their hard work and achievements.

ROYAL ADELAIDE HOSPITAL

The Hon. J.A. DARLEY (14:57): I seek leave to make a brief explanation before asking the Minister for State/Local Government Relations, representing the Minister for Health, a question regarding the Royal Adelaide Hospital.

Leave granted.

The Hon. J.A. DARLEY: A few years ago the Central Northern Adelaide Health Service—incorporating the Royal Adelaide Hospital, the Queen Elizabeth Hospital, Modbury Hospital, the Lyell McEwin and other health care services—was established following the Generational Health Review. As a result, the Royal Adelaide Hospital, along with other hospitals, was abolished as a legal entity.

Following yesterday's announcement by the Premier that the new hospital would retain the Royal Adelaide Hospital name, my question is: can the minister advise whether the Royal Adelaide Hospital will now be reinstated as a legal entity?

The Hon. G.E. GAGO (Minister for State/Local Government Relations, Minister for the Status of Women, Minister for Consumer Affairs, Minister for Government Enterprises, Minister Assisting the Minister for Transport, Infrastructure and Energy) (14:58): I thank the honourable member for his question. I will refer it to the Minister for Health in another place and bring back a response.

BARRIER HIGHWAY

The Hon. J.S.L. DAWKINS (14:59): I seek leave to make a brief explanation before asking the Minister for Road Safety questions about narrow bridges on the Barrier Highway.

Leave granted.

The Hon. J.S.L. DAWKINS: I have been contacted by constituents who regularly travel to the Broken Hill area via the Barrier Highway. For many years this highway incorporated a number of narrow bridges over creeks between Yunta and Cockburn. A number of these bridges have been upgraded in recent years; however, I am advised that two of them remain between Manna Hill and Olary, both crossing Cartwrights Creek. The bridges are not wide enough for both a car and truck to pass each other on them.

However, the only warning that drivers receive is a sign—and only one sign—with a road narrowing symbol. Given the large number of road trains using the Barrier Highway, particularly at night, my constituents are concerned about the dangerous nature of these bridges. Will the minister indicate when these dangerous bridges will be widened; and will the minister, as a matter of urgency, ensure that much more indicative signage is provided in the proximity of these bridges?

The Hon. CARMEL ZOLLO (Minister for Correctional Services, Minister for Road Safety, Minister for Gambling, Minister Assisting the Minister for Multicultural Affairs) (15:00): I thank the honourable member for his important question. The issues that he raises do not sit just with my responsibility but also with that of the Minister for Transport, Infrastructure and Energy. However, some of them do sit with my responsibility, in particular, in terms of signage. I will ask the department to investigate, and I will bring back a response for the honourable member in relation to all the issues that he has raised.

SERVICE SA

The Hon. I.K. HUNTER (15:01): I seek leave to make a brief explanation before asking the Minister for Government Enterprises a question about Service SA rural agents.

Leave granted.

The Hon. I.K. HUNTER: Service SA strives to provide South Australians with convenient options for accessing a comprehensive range of government services, products and information that are responsive to community needs. Importantly, Service SA takes its obligations to non-metropolitan dwelling South Australians very seriously. Will the minister advise what Service SA is doing in the Clare region?

The Hon. G.E. GAGO (Minister for State/Local Government Relations, Minister for the Status of Women, Minister for Consumer Affairs, Minister for Government Enterprises, Minister Assisting the Minister for Transport, Infrastructure and Energy) (15:01): I thank the honourable member for his most important question and his interest in these important policy areas. Access to state government services, including learner driver theory tests, will soon be enhanced in the Clare area with the introduction of a Service SA rural agent.

A recent agreement with Country North Community Services will see it roll out face-to-face services from its office within the Clare Town Hall from late next month. Country North Community Services is a valued and well-established local not-for-profit organisation which currently provides Carers Link, Disability Link, Respite Link services and also the Centrelink agency for the Mid North.

The friendly faces of Country North Community Services staff led by their well-known Chief Executive Officer, Steve Lowe, will add to Service SA's successful rural agent program currently servicing Keith, Peterborough, Port Broughton, Port MacDonnell, Streaky Bay, Wudinna and Yorketown.

Rural agents provide a consistent community presence, offering access to many state government services where it is not feasible to develop a full customer service centre. This means that Clare and district residents will no longer have to rely on family and friends driving them more than an hour or so to Gawler, Kadina or Port Pirie to sit their learner's test. The whole process can now be completed without having to leave Clare.

The select range of government services that will be provided by Country North Community Services will also include providing information to customers on government services, processing transactions and downloading a range of forms.

This will soon be available between 10.30am and 2.30pm on Monday to Friday with additional time allocated outside school hours for learner theory tests each Wednesday from 4pm to 5pm. Demand for the service has been driven by the local community. The government has listened, consulted and gauged the needs of the area, and we will continue to monitor demand to ensure that community needs are met.

The rural agent program has already proven a cost-effective service delivery solution meeting the needs of rural and remote communities, and I am confident that it will continue to do so in Clare. Service SA is a division of the Department for Transport, Energy and Infrastructure and is the single entry point to a wide range of government services through phone, face-to-face and online delivery channels.

OLYMPIC DAM

The Hon. M. PARNELL (15:04): I seek leave to make a brief explanation before asking the Minister for Mineral Resources Development a question about public consultation on the Olympic Dam expansion project EIS.

Leave granted.

The Hon. M. PARNELL: On Tuesday, in reply to my question on Point Lowly, the minister stated:

> There is currently an environmental impact statement (which is being printed as we speak) by BHP Billiton relating to its proposals for the Point Lowly area. I believe that will be released on 1 May and it will be the largest document ever printed in this state when it is prepared.

This morning on ABC Radio, the minister, in response to a question by Kieran Weir as to whether the EIS has been completed, stated:

> I believe that BHP will now be undertaking the process of printing it, and given the size of it and the need to proofread it that is why I believe that it will take most of the next two and a bit months to ensure the document is ready for release.

My questions over the past three years, and other members' questions, about the Olympic Dam expansion have generally been answered with the response, 'Wait for the EIS.' My questions of the minister are:

1. Given that this is the largest project in the state's history, set to become the largest open cut mine in the world and a project that has the potential to use, for example, half of the state's electricity, why are only 40 working days being provided for public consultation when other Planning SA organised consultation events are provided with a much longer period, such as the three months that was provided for comment on the Victoria Park grandstand proposal?

2. Why, if the minister knows that it will take the team at BHP Billiton most of the next two and a bit months just to proofread this massive document, does the minister think that it is acceptable for the South Australian public to have significantly less than two and a half months to find a copy, read and analyse it and then write a formal submission on the EIS?

3. Will the minister now extend the public consultation period for the Olympic Dam expansion EIS beyond eight weeks by either bringing the release date forward or by extending it afterwards and, if not, why not?

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (15:07): The statutory time for

public consultation in relation to major projects is six weeks. The government made the decision some time back to announce that it would be eight weeks, given that this is such a significant project.

The environmental impact statement has been in preparation for something like three years. It was back in February 2006 that the guidelines were first approved. As I said on the radio this morning in the interview the honourable member is referring to, I think it is about 55 pages for the first part of the draft guidelines and about 50 pages for the second part.

The PRESIDENT: As long as Mr Parnell's speech!

The Hon. P. HOLLOWAY: Yes; almost that long. The first part was to do with the issues that relate to the mineral lease area which, of course, is the mine at Olympic Dam, the processing plant expansion, the township of Roxby Downs and so on. The other issues that need to be addressed are power, water and transport.

As I pointed out on the radio this morning, the EIS statement will, we believe, satisfy the requirements of the commonwealth government and also of the Northern Territory government, because part of the issues addressed in it will be the possibility of any transport of material to Darwin. It will also, of course, look at other issues such as the desalination plant at Point Lowly. It was in that context that I made my comments earlier this week relating to the honourable member's question.

There has already been an extension of time. As I also pointed out in that interview this morning, those people who are interested in this issue I am sure will have been following these issues very closely. If someone is concerned about issues such as the impact of the desalination plant on Upper Spencer Gulf, there will be this huge document about the entire mine and all the associated issues. If they wish to look at that they will be able to find that chapter of it fairly quickly and make their comments.

I think we know what the Greens' view will be on this project. We know that they will find something wrong with it. I do not think you need a crystal ball to predict that they will be opposed to this particular expansion of Olympic Dam.

I believe there is sufficient time in the extension that the government has given for consideration of this project. In relation to the preparation of it, these major environmental impact statements are supplied to the government in the first instance to ensure that each of the issues that are set out in the guidelines for the EIS has been addressed—not to say that they have been addressed adequately but to say they have been addressed. It is at that point that the EIS then goes off to be printed and published, and that is the stage we are at now.

BHP has estimated that that is the time it will take. I suppose BHP has to let contracts, do the proof reading and everything else. That is the time BHP believes is required and, given the size of this document, I think that is reasonable. It is up to BHP as to when it releases the EIS, but the indication BHP has given the government is that it will be about 1 May.

In relation to the public consultation period, public meetings will likely be held not just in Roxby Downs and Adelaide but one would expect there will also be public consultations and meetings in Whyalla, Port Augusta and also in the Northern Territory. It will be a major exercise, but we believe there will be plenty of time for people to look at the document and make comments on the issues involved in this very significant project for the state.

As I also indicated in the radio interview this morning, you will always get people who ask for additional time. We often get submissions that come in a few days or even up to a week or two late, and it is always my practice and that of the department to accept those late submissions, provided they come within the assessment period but, of course, there has to be some cut-off date.

We believe that the eight-week period is reasonable and, when the EIS is released—which, hopefully, will be in early May—we would expect people to try to get their responses in within the eight-week period provided; but, of course, we will be reasonable in that regard if people are a day or two late. However, we believe that is adequate time.

I think the issues have been well canvassed. BHP Billiton had a number of public meetings during the preparation of the EIS, where BHP Billiton has discussed all the issues with, I think, all the communities that have concerns with particular parts of this project, whether they relate to the mine itself, the township of Roxby Downs, the desalination plant or transportation through the Northern Territory or elsewhere. I think people will be well briefed and will be able to make a

judgment in a short time as to whether or not, in their view, the EIS adequately addresses those issues.

Of course, once that period of consultation comes to an end, BHP will then be required to respond. The response document will then go to the government for a detailed assessment. So, it is a very long process, and we believe that the extended eight-week period should allow for adequate consultation on this project.

OLYMPIC DAM

The Hon. M. PARNELL (15:14): I have a supplementary question arising from the answer. If the minister has said that the document is already at the printers, is it not the case that the steps he has referred to in relation to proof reading, checking and the design are completed? If that is the case, why is it not possible for an online version to be made available now?

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (15:15): I am sure that, if that had happened, the Hon. Mark Parnell would be railing up in this parliament and contacting the media, telling us all how it was an incomplete document and how it had been rushed.

I am sure the Hon. Mark Parnell will want to ensure that, when the EIS is released by BHP, it is comprehensive. It is up to BHP to ensure that the document it releases (and I am sure it would not want criticism from Mr Parnell or others) has been adequately checked. It is a matter for BHP. All this great interest from Mr Parnell began from an aside I made in reply to a question he asked the other day about Point Lowly when I said that part of it would be addressed in the EIS process. The release of the document is essentially a matter for BHP Billiton. I hope I have been assisting the parliament in providing information as it is known to me as to how BHP intends to proceed.

Given the range of issues—it is not about just the mine or township issues in Roxby Downs but also about the water, power and transport issues and other matters—it is inevitably a huge document. That document has to be brought together. Before it has been signed off, the EIS must address all the points raised in the original requirement, but that is now subject to the open public process where people will put their views on the EIS, and then it will go for more detailed assessment by the government to ensure that all those terms of reference, which take up over 110 pages—those requirements are on the website and are publicly listed—are addressed.

OLYMPIC DAM

The Hon. C.V. SCHAEFER (15:18): By way of a supplementary question, given that the minister is well aware that the prawn and fishing industries intend to refer the EIS to an independent scientific assessment, and given that it has taken the government three years to prepare its scientific assessment, will he consider an extension for the fishing industry to seek an independent scientific opinion of the EIS with regard to the desal plant?

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (15:18): If the fishing industry has any concern it should be doing it now. It has had three years to try to get all the base data.

The PRESIDENT: There is something fishy about the supplementary question as I did not hear anything in the answer about fish or the desal plant.

The Hon. P. HOLLOWAY: It is important that I correct something that the honourable member said in her question when she implied that the government was undertaking the EIS. That is not the case: the EIS is being prepared by BHP Billiton. Through the independent Development Assessment Commission, the government has set the guidelines that the EIS has to comply with, and the 110 pages in the two volumes I referred to are just the list of guidelines or issues that the EIS is required to address.

The EIS has been prepared by BHP Billiton, which is responsible for printing it. It will release it and then must respond to submissions after the appropriate period, and it will then go for a more detailed assessment by government to ensure not just that the issues have been addressed (as that has already been looked at) but that all issues raised in the public consultation have been adequately addressed. In relation to the fishing industry, one would expect that it would be well aware of the basic issues involved with the requirements that have been in the guidelines for the EIS, and I would expect that it would be able to draft its response within that two-month period.

OLYMPIC DAM

The Hon. C.V. SCHAEFER (15:20): Sir, I have a further supplementary question. Can the minister explain to me how, as he has suggested, the industry can prepare itself to comment on an EIS that it has not seen?

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (15:20): The answer is that, if members of the industry are concerned about the impact that a desalination plant may have within Spencer Gulf, I think the basic parameters for that have been well defined as to what that project will do. Presumably, they will do their homework and will know exactly what they will be looking for, in terms of whether the EIS adequately addresses any increase in salinity, and so on. I assume they will have done their work to know what impact is tolerable and what is not. They will have to await the printing of the EIS, of course, but they will know exactly, one would think, what issues will need to be adequately addressed within that EIS, and that will be levels of salinity, diffusion, and so on.

OLYMPIC DAM

The Hon. D.W. RIDGWAY (Leader of the Opposition) (15:21): Sir, I have a supplementary question. The minister mentioned a whole range of issues in his answer to the question and, in particular, power.

The PRESIDENT: Order! There is no explanation when you are asking a supplementary question. I have let a couple of members get away with it, but they will not continue to do so. Ask your question.

The Hon. D.W. RIDGWAY: What discussions has the government had with BHP in relation to power requirements? It is my understanding that the EIS is likely to only talk about a powerline to Port Augusta—

The PRESIDENT: Order!

The Hon. D.W. RIDGWAY: —and not a power station at Roxby Downs.

The PRESIDENT: Order! The minister will ignore the comment.

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (15:22): It certainly is irrelevant, but I will answer the question anyway—otherwise, no doubt, the honourable member will try to misrepresent it. My role, if you like, at this stage is just in relation to the process that has been involved with the EIS and to ensure that it adequately addresses all the issues. I will not comment on what is in the EIS until it is published and made available, because I would just be speculating, as well. The honourable member may wish to read the guidelines which, as I said, have been available on the website since February 2006.

It is really a matter for BHP to determine how it proposes to address the power issues. It is up to BHP to put up a proposal. It will then be up to those assessing it when the report has come back and gone through all the public consultation process (the eight weeks). The government will then be in a position to see whether that adequately addresses it. However, at this stage, it is up to BHP Billiton to address those requirements as it sees fit.

ANSWERS TO QUESTIONS

SCHOOLS, TRUANCY

In reply to the **Hon. A. BRESSINGTON** (5 March 2008).

The Hon. G.E. GAGO (Minister for State/Local Government Relations, Minister for the Status of Women, Minister for Consumer Affairs, Minister for Government Enterprises, Minister Assisting the Minister for Transport, Infrastructure and Energy): The Minister for Education has provided the following information:

During the last five years there have been seven occasions when parents have been considered for prosecution.

Once the preliminary decision to prosecute is made by the Department of Education and Children's Services, the matter is then considered by the Crown Solicitor's Office. Of the seven matters referred to the Crown in the last five years, one has proceeded to a court appearance.

During those proceedings, the parents agreed to co-operate with an alternative process and the matter was withdrawn from the court.

The prosecution of parents is a final option and only in circumstances where the school's, DECS and other agencies' attempts to work with students and their parents/carers have failed.

Some of the avenues which are widely used by schools to re-engage students include:

Attendance officers across the state who work with chronic non-attenders and their families.

A new electronic data system, Indigenous Student Support System, which provides staff in each of the state's 18 district offices with a daily picture of attendance patterns. District staff, including Aboriginal education workers and attendance officers, are alerted when students repeatedly miss school, allowing immediate follow-up action to take place.

The school and district are the most effective means to re-engage with truants and their families to ensure attendance. Consequently, very few interventions subsequently require reporting to the department for consideration for prosecution as provided for by the Education Act 1972.

EDUCATION DEPARTMENT

In reply to the **Hon. R.L. BROKENSHIRE** (30 October 2008).

The Hon. G.E. GAGO (Minister for State/Local Government Relations, Minister for the Status of Women, Minister for Consumer Affairs, Minister for Government Enterprises, Minister Assisting the Minister for Transport, Infrastructure and Energy): The Minister for Education has provided the following information:

The Department of Education and Children's Services has advised that they are working with the young person and their family to develop an appropriate schooling solution for the child.

CHILDREN'S SCOOTERS

In reply to the **Hon. J.M.A. LENSINK** (13 November 2008).

The Hon. G.E. GAGO (Minister for State/Local Government Relations, Minister for the Status of Women, Minister for Consumer Affairs, Minister for Government Enterprises, Minister Assisting the Minister for Transport, Infrastructure and Energy): I am advised that:

1. OCBA has not received any complaints from consumers about the safety of electric scooters. It has been reported in the media that the scooters can be modified to increase the speed.

Many products can be potentially dangerous if not used correctly and sensibly. Parental Supervision is important to make sure that children are not using these items in a dangerous manner.

2. The Trade Standards Act 1979, that is administered by OCBA, provides for the regulation of the safety and quality of goods and services, but does not extend to how products may be used or misused.

Transport SA regulates the Road Traffic (Road Rules-Ancillary and Miscellaneous Provisions) Regulations 1999.

Advice received from the Vehicle Services Section of Transport SA indicates that the 'Razor' brand range of electric scooters would not be able to be ridden on any public road, whether in its original form or any potentially modified form. Their use would be restricted to private property only.

CRIMINAL INVESTIGATION (COVERT OPERATIONS) BILL

Adjourned debate on second reading.

(Continued from 18 February 2009. Page 1337.)

The Hon. R.D. LAWSON (15:24): I wish to make a brief contribution on the second reading of this bill, which has been some time in the making. It arises out of discussions that have been ongoing for a number of years in the Standing Committee of Attorneys-General and the Australian Police Ministers Council.

A joint working group, which was established by those bodies, produced a discussion paper in February 2003 and a final report in November that year. The report deals with the four general topics mentioned in the minister's second reading explanation. From my point of view, the two important issues in the bill relate to the subject of assumed identities and the witness protection scheme; and in respect of both subjects there is currently no South Australian legislation.

Dealing first with assumed identities, an assumed identity is, as the minister said, a false identity used by a law enforcement authority for a limited period for the purpose of criminal investigation or the gathering of criminal intelligence. The Wood Royal Commission into the New South Wales Police Service found that the lack of legislation in this particular area in that state led to uncertainty and a lack of accountability. There was no specific legislation and, in order to introduce some certainty, legislation was proposed.

It is noted that legislation of this kind has been passed in differing forms in other jurisdictions. The bill deals with a number of aspects, including the procedures for applying for an assumed identity authority, the grounds for issuing an authority for an assumed identity, the contents of that authority, the period for which the authority remains in force, the agencies or bodies from which false identity documents can be obtained and whether the issuing of those documents is mandatory or voluntary, the scope of protection from criminal liability, and the provision of civil indemnity for people using authorised false identities and the people who have issued them. Also, it provides for sanctions for the misuse of false identities and, importantly, for cross-border recognition of authorities, and the participation in this scheme of false identities of persons who are not law enforcement officers. It also contains miscellaneous provisions for record keeping, auditing and reporting.

It is appropriate, in my view, and in the view of members of the Liberal Party—as, indeed, it is the view of the government—that the regime relating to assumed identities ought to be laid down in statute so that, where it is appropriate to use an assumed identity, the person using the identity, the authorities authorising it, those who are encouraging the person to assume the identity and those who are asked to provide evidence in the form of certificates, and so on, know where they stand. It is entirely appropriate that the uncertainty that exists at the present time about these matters be resolved and be set out clearly.

I move to the second aspect of the bill, that is, witness protection. Once again, there is no legislation in South Australia regarding witness protection schemes. Everyone would accept that there are occasions when a witness giving evidence in court proceedings ought to have protected their true identity and information about their address and family, and so on.

It is a notorious fact that there will be cases where a witness may suffer in consequence of having given evidence in court that is contrary to the interests of a particular offender or accused person. The government is fond of pointing the finger at bikie gangs, and it is undoubtedly true if one reads the information about the activities of outlaw motorcycle gangs that there are cases where there is intimidation, threats and the like against witnesses. Indeed, in the outlaw motorcycle context, as indeed in the context of the Mafia, witnesses simply will not testify, for fear of repercussions. The advantage of having a legislative scheme for the protection of witnesses is that the witness will, one hopes, be prepared to come forward and testify if they can be assured that their anonymity will be preserved.

There is already legal authority that the identity of a witness can be concealed even in the absence of any statutory protection. Cases decided on common law principles have established this fact, including cases in our own state. The effect of those decisions, some of which are referred to in the minister's second reading explanation, is that there is a judicial discretion to allow undercover operatives to give evidence without revealing their true identity. However, when a matter is left to judicial discretion, the potential witness can only be advised as follows: 'Well, there is no certainty that your identity will be preserved and the information about you and your family will be preserved. We will be asking the court to do it and we are confident that the court will make an order and the judge will exercise the judicial discretion in favour of our application.'

In those circumstances one cannot be entirely sure, and a witness may well say, 'Well, if it is all left to judicial discretion, I'm not prepared to embark on the exercise, because the discretion might be exercised against me.' Accordingly, it is appropriate that this rule be placed in legislation so that the witness and the adviser can be assured by looking at the act itself that the advice is correct and the identity will be preserved.

The government suggests that legislation of this kind serves a number of public interests. First, it protects the personal safety of the witness, which of course is the primary objective, but also it means that the witness can continue to operate as a useful undercover officer; in other words, the witness's cover is not blown by giving evidence in a particular case but they can continue to operate. I think the government also makes the point, which I think is a good point, that concealing an undercover operative's true identity will have the effect of encouraging police officers and others to actually participate in undercover operations, because it will give them confidence that if necessary their safety and identity will be protected. So, by removing the uncertainty about the status of witnesses and officers who give evidence under a witness protection program, we should improve our system of criminal justice.

The legislation sets out a scheme for the obtaining of witness protection, and it provides that the Commissioner of Police (or, by delegation, a deputy commissioner) must be personally satisfied that disclosing the person's true identity will endanger them or someone else or will prejudice current or future investigation of a criminal offence. The decision-maker has to actually complete a formal certificate which outlines a wide range of information, including:

- the assumed name of the person;
- the period during which the operative was involved in the operation;
- the name of the agency;
- the date of the certificate;
- the grounds for giving the certificate;
- whether the operative has been found guilty of an offence and, if so, particulars of each instance;
- whether charges are pending or outstanding and, if so, particulars of each instance;
- whether a court has made adverse findings about the credibility of the operative, and the particulars of each such instance;
- whether the operative has made a false representation where the truth was required, and particulars of each instance; and
- anything else known which is relevant to the credibility of the operative.

This certificate will be made available not only to the court before whom the witness is appearing but will also be made available to the defence. Its effect is that the defence is restricted in its ability to cross-examine in relation to the credibility of the witness, as only the information in the certificate will be available. That raises a number of issues. For example, one of the matters that will be disclosed in the certificate is whether a court has made adverse findings about the credibility of the operative. It may well be that an operative has given evidence on one, or more than one, occasion previously in a jury trial and the evidence has simply not been accepted by the jury. There is no finding to that effect, of course; it is not as if it were a trial by judge alone, where the judge has to say, 'I don't accept the evidence of a particular witness.' In the case of a jury trial it may well be that the jury does not believe a word of what the officer has said on a prior occasion, but that cannot be recorded on a certificate.

Another matter to be disclosed is whether the operative has made a false representation when the truth was required, and particulars of each instance. I imagine that provision, whilst it sounds fair enough, is actually a dead letter. Clearly if the Commissioner, or a deputy commissioner, is aware of false representations being made where truth is required, they simply will not put forward that operative as a witness of truth.

There is also the general provision that the certificate must disclose anything else relevant to the credibility of the operative. However, it does not specifically say (as one would expect it to) whether, for example, the witness has been promised or offered some financial reward or other benefit—which is often a matter of great interest to defence counsel in attacking the credibility of witnesses.

So I ask the minister to indicate, in his second reading response, the considerations that went to the inclusion of matters such as whether a court has made adverse findings about the credibility of the operative, as well as in relation to the false representation provisions.

The Criminal Law Committee of the Law Society of South Australia, in a submission to the Attorney-General dated 12 November 2008, made a number of points in relation to this bill. I think it is truly deplorable that, when the shadow attorney-general in another place referred to the Criminal Law Committee of the Law Society, the Attorney—in parliament and on the record—described them as 'enemies of the people' and 'the usual suspects'.

These are disgraceful comments by the first law officer and reveal the shallow and unprincipled approach of this government to the criminal justice system. The Premier, always ably supported by the Attorney-General, is keen to paint the legal profession as scapegoats because they deem it in their political interests to do so.

My view is that the Law Society's comments are invariably helpful and thoughtful and worthy of consideration. One might not agree with them. It may be true that they generally take a civil libertarian approach to criminal justice matters, but they are legitimate opinions which ought to be expressed and, more importantly, ought to be heard.

For the Attorney-General to describe their authors as 'enemies of the people' and dismiss them as 'the usual suspects' is, as I say, absolutely deplorable. The letter from the Criminal Law Committee states:

> Dear Mr Attorney
>
> *Criminal Investigation(Covert Operations) Bill 2008*
>
> The Society's Criminal Law Committee has considered the above Bill. Accordingly, the Society provides the following comments.
>
> The Bill has a range of purposes. It provides for undercover operations and assumed identities of certain persons. The policy behind the Bill is worth while.

I interpose that I think that that is absolutely fair comment: the policy is worthwhile. The letter continues:

> However, there are a number of provisions to do with the protection of the identity of a witness that are of concern. These provisions in Part 4 represent a substantial departure from the common law position and therefore considerable care needs to be taken in the implementation of such legislative proposal. The explanatory remarks indicate that such a departure should only occur in exceptional circumstances. That policy has most recently been recognised by the House of Lords decision in R v Davis (2008) UKHL 36 delivered on 18 June 2008.

Of course, the House of Lords, sitting in its judicial capacity, is the highest court of appeal in the United Kingdom and a court to which it is always appropriate in Australian jurisprudence to have due regard. The Law Society's letter continues:

> Those fundamental principles are worth re-stating and include the following:
>
> - It is a long established principle of the common law that a defendant in a criminal trial should be confronted by his accusers so that he/she may cross-examine them and challenge their evidence. The principle originated in ancient Rome and has been recognised throughout history and even in cases where the problem of witness intimidation has been extreme.
> - That right is recognised in the United States as a constitutional right. It is as an essential and fundamental requirement of a fair trial.
> - It is an important right that has been recognised in New Zealand, Canada, Australia, South Africa and elsewhere.
> - The right to confront a witness is basic to any civilised nation of a fair trial.

The letter actually said 'nation' but I am sure that that is a typographical error—'notion' of a fair trial. It continues:

> - That right includes the right for an accused person to ascertain the true identity of a witness where questions of credibility are in issue.
> - Protective measures for witnesses are recognised, such as with a closed court, suppression orders and other current provisions in the Evidence Act for giving of evidence by closed circuit television or other ways that protect a witness.
> - It is not a new problem and hence demonstrates how such processes have historically been recognised as infringing fundamental rights.
> - Such protective measures were recognised by that House of Lords decision as hampering the conduct of the defence in a manner and to an extent which was unlawful and rendered the trial unfair.
>
> The question is whether the legislation goes too far or whether it achieves the correct balance. The trial process will require consideration of the witness identity protection certificate which is disclosed to the parties and

which is to include certain information. The nature and quality of that information may not be as sound and comprehensive as is required. The certificate seeks to identify matters that go to the credibility of the protected witness. However, those matters may not be sufficiently, accurately or comprehensively identified.

I interpose here the comment which I made earlier relating to the certificate and whether or not some inducements or other benefits might have been offered to the witness. The Law Society continues:

It is likely that there will be matters outside the contents of a certificate which may be discovered, disclosed or uncovered which goes to the credibility of the witness. Therefore, the breadth of the certificates should include any information as to whether the protected witness has been the subject of an allegation of the commission of an offence (as distinct from being convicted or found guilty of the same because an allegation may be sufficient to attack the witness's credibility). Section 33(1) should include reference to that type of information.

Section 33(1)(k) is unduly restricted to the information known to the person giving the certificate that may affect the protected witness's credibility. That provision should include any information that is known, comes to the attention of or has been reported to the law enforcement agency about the credibility of the witness.

Clearly, that is a valid point because the commissioner or deputy commissioner issuing the certificate may have no personal knowledge or understanding of the record or past history of the protected witness, that is, personal knowledge. The Law Society continues:

Furthermore, there are many other indicators of credibility issues which include behavioural matters, conduct, financial matters, other statements attributed to the protected witness which would ordinarily be the subject of cross-examination as to credibility.

The provision that directly effects the established concept of a fair trial in South Australia is in section 40 requiring that a party must seek the court's permission to ask questions of a protected witness that may lead to the disclosure of the operative's identity or where the operative lives and only if there is evidence that if accepted would substantially call into question the operative's credibility. The provisions of section 40(3) are unduly restrictive—

in the opinion of the Law Society—

Section 40 is not consonant with the other legislative provisions referred to in the explanatory notes to do with protecting the identity of certain witnesses.

Section 15XT of the Commonwealth Crimes Act 1914 and section 14 of the Law Enforcement and National Security (Assumed Identities) Act 1998 and section 25 of the Royal Commission (Police) Act 2002 (WA) do not erode the fundamental principle of a fair trial. In that legislation the protection of the identity of the witness is preserved by having a closed court and suppression orders.

I ask the minister to comment on whether the government agrees with that assertion or not and, if it does agree with the assertion of the Law Society, I ask why the model adopted in those jurisdictions was not adopted here.

The Law Society mentions the Queensland, Tasmanian and New South Wales legislation. I will not read all of those comments, other than to say that the Law Society believes that the New Zealand model is better than the provisions of section 40(3)(a) of this bill. The Law Society goes on to state:

It is to be noted that the statutory declaration to be provided by the witness for the purposes of providing the witness identity protection certificate is not to be disclosed in any proceedings other than proceedings for perjury in respect of falsity of the statutory declarations; disciplinary proceedings against the law enforcement officer; or investigations or enquiries into the conduct of a law enforcement officer.

The statutory declaration [so say the Law Society] should be produced in all proceedings. It does not serve the balancing exercise to exclude disclosure in court proceedings other than those referred to in section 31(4) as to do so erodes the concepts of a fair trial. If the statutory declaration should be disclosed for the purposes of the proceedings referred to in sub-section (4) then it should be capable of being disclosed in all types of court proceedings and in particular criminal proceedings. Given that the statutory declaration is the foundation for the content of the witness identity protection certificate then excluding the statutory declaration from the obligation of disclosure is incompatible. Furthermore, the statutory declaration ought to be disclosed because it contains relevant material as the primary evidence or the best evidence of the very issues of credibility to be potentially agitated at trial.

I ask the minister to indicate the government's response to that and other assertions in the letter that are critical of the bill. I believe that the parliament, as well as the Law Society, deserve an appropriate response to the matters raised by the society, rather than an abusive response simply describing the messengers as enemies of the people and the usual suspects.

I look forward to the minister's response. If it is intended to proceed with this matter through the committee stage today, before the minister has had an opportunity to be thoroughly briefed by officers on the appropriate response to the matters I have raised, I would appreciate, as I am sure the Law Society would appreciate, a formal response, by way of letter, to the matters raised.

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (15:53): I thank honourable members for their contribution to the debate. First, I will refer to the matters raised by the Hon. Mr Parnell. I do not know why the honourable member referred to the concept of 'criminal intelligence' which has found a place in a number of bills which have been brought before parliament. This bill does not employ the concept of 'criminal intelligence'.

The honourable member wanted to know what the government's response is to the issues raised by the Law Society about clause 33(1)(k) and clause 40(3)(a). The response is that clause 33 deals with a form of the witness identity protection certificate. The criticism of the Law Society is that clause 33(1)(k) should include any information that is known that comes to the attention of or has been reported to the law enforcement agency about the credibility of the witness. The government's answer is that it plainly does just that. Clause 33(1)(k) provides:

> If there is anything else known to the person giving the certificate that may be relevant to the local operative's credibility, particulars of the thing.

It is difficult to see how that could be broader. The Law Society does not suggest an alternative wording. In any event, the fact that any one or more particular matters are not listed in the certificate for any reason does not prevent defence counsel from asking the question. The only prohibition is in asking a question that will reveal the person's true identity, which is at it should be. There is no room for criticism here.

Clause 40 is a lengthy provision dealing with applications made to disclose a witness's identity. Clause 40(3) provides the criteria that the court should take into consideration. The Law Society criticism is merely that it thinks the criteria unduly restrictive. The government does not agree. The provision accords with the nationally agreed model enacted in Victoria, Tasmania and Queensland. Other jurisdictions give the court a statutory or common law discretion, without giving that discretion any structure at all. For example, the Law Society cites the New South Wales equivalent provisions. It simply says:

> In particular the court, tribunal, royal commission or other commission of inquiry—
>
> (a) may allow an officer in respect of whom an assumed identity approval is or was in force to appear before it under the assumed name or under a code name or code number.

There is no further guidance. By contrast, the proposed clause is far more open and transparent, and provides guidance on the exercise of the discretion. The government does not agree that the New Zealand formula is better and notes that the Law Society does not explain why it is thought to be better.

For the sake of completeness, I add that the Law Society made a third criticism of the bill. The application for a certificate from the chief officer is governed by clause 31 and must be verified in the first instance by statutory declaration by the operative himself or herself. The Law Society thinks that the statutory declaration that forms the basis of the certificate should be disclosed at trial. The government does not agree. The requirement for a formal statutory declaration was not in the nationally agreed model but was in the version enacted by Victoria. We agreed that it provided an additional safeguard in providing a basis for the appropriate prosecution of a person who gives false information as a basis for an application. That is its function. It is not part of its function to provide additional disclosure. Any relevant substantive content in the statutory declaration that does not risk disclosure of the identity of the operative will be in the certificate made public. To require the disclosure, the statutory declaration would render the whole process nugatory.

I turn now to the questions asked by the Hon. Mr Brokenshire. First, he asked whether we are the first state to enact the model provisions. The answer is no: Victoria, Queensland and Tasmania have enacted the full measures and parts of it are to be found in New South Wales and Western Australia. The commonwealth bill to the same effect lapsed at the last election and has not been introduced, but there are elements of the scheme in the commonwealth Crimes Act 1914. Secondly, the honourable member raised concerns about the retrospectivity provision in clause 5. I assure him that he should harbour no fears: clause 5 applies only to the approval of undercover operations. It is a re-enactment of precisely the same clause in the Criminal Law (Undercover Operations) Act 1995 and that has existed since 1995. There is no change here.

Thirdly, the honourable member wanted an indication of the number of approvals granted. This is the subject of an annual report tabled in both houses in about September of each year. The total number of approvals given for 2007-08 was 27, and the total number of renewals given for 2007-08 was 12. The classes of offence for which approvals were given were: offences against the

Controlled Substances Act, 17; deception, three; child pornography, one; murder, one; assault, blackmail and attempt to pervert the course of justice, one; soliciting murder, one; unlawful sexual intercourse and procuring, one; providing child sexual services, one; and, threatening harm, one.

Fourthly, the honourable member wanted to know whether the existing powers have been used against the prostitution industry. The data I have given shows that they have, albeit not many times. If the honourable member wants a briefing from the Commissioner of Police, I am sure something can be arranged.

The Hon. Mr Lawson also raised some issues. It is true that the certificate does not mention financial consideration, but that does not prevent defence counsel from asking and the court in the normal way requiring an answer. Like the rest of the legislation, these considerations are based faithfully on the carefully considered report of senior officers and police officers who reported to the Standing Committee of Attorneys-General and enacted in a number of Australian jurisdictions.

I also draw the attention of the honourable member to clause 31(5), which obliges the chief officer to undertake all reasonable inquiries to ensure that all required information is in the certificate. That includes anything else known to the local operative that may be relevant to his or her credibility. It is true that the House of Lords declined to extend the common law, but the law lords also said quite clearly that there was a serious problem to be addressed and that it was for parliament to address. Here, the parliament is addressing it.

I again thank honourable members for their contribution to this bill. If members wish to explore that matter further, perhaps we can do so during the committee stage. I commend the bill to the council.

Bill read a second time.

In committee.

Clause 1.

The Hon. R.D. LAWSON: The Law Society referred in the letter to the recent House of Lords case R v Davis, and in his second reading response the minister referred to the comments of their lordships. Can the minister outline to the committee the substance of that case, the nature of the issue and the context in which the comments to which he referred were made?

The Hon. P. HOLLOWAY: In the matter before the House of Lords, I am advised that they were considering whether there should be a more generous allowance for witness anonymity at common law, and the finding was that there should not. Lord Rodger said as follows:

> It is for the Government and Parliament to take notice if there are indeed areas of the country where intimidation of witnesses is rife and to decide what should be done to deal with the conditions which allow it to flourish. Tackling those conditions would be the best way of tackling the problem which lies behind this appeal. Any change in the law on the way that witnesses give their evidence to allow for those conditions would only be second best. But Parliament is the proper body both to decide whether such a change is now required, and, if so, to devise an appropriate system which still ensures a fair trial.

The Hon. R.D. LAWSON: Does the government propose to make any regulations pursuant to the regulation making power in this bill, and when is it envisaged that the legislation will come into operation? More specifically, is it intended to delay for any particular period the commencement of the operation of this bill? Is any other legislation or regulation required to be considered before it comes into operation?

The Hon. P. HOLLOWAY: I am advised that it is not proposed that there be regulations in relation to the commencement of the bill. I am advised that the government will take advice from the Commissioner of Police as to when he is ready for the bill to come into effect.

The Hon. R.D. LAWSON: Did the government consider whether or not arson or lighting bushfire offences ought to be included in the list of offences in respect of which this legislation operates?

The Hon. P. HOLLOWAY: Perhaps the honourable member could be more specific about which clauses he is referring to. The definition of serious criminal behaviour means behaviour involving the commission of an indictable offence, and other offences are listed. Arson and lighting bushfires are probably indictable offences.

Clause passed.

Clauses 2 to 32 passed.

Clause 33.

The Hon. S.G. WADE: I want to clarify the minister's response to the Hon. Mr Lawson's question in relation to financial inducements. I understood the point that the minister was making that counsel could ask about financial inducements, but I am not sure whether he was suggesting that paragraph (k) would mean that there was a duty on the law enforcement agency to reveal whether any financial inducements or similar had been given.

The Hon. P. HOLLOWAY: My advice is that clause 33(1)(k) would require that disclosure. I am advised to clarify an answer I gave in relation to an earlier question asked by the Hon. Mr Lawson. He asked about regulations. We will need regulations to declare corresponding law. Eventually we will need regulations for that purpose.

Clause passed.

Remaining clauses (34 to 48), schedule and title passed.

Bill reported without amendment.

Bill read a third time and passed.

ADMINISTRATION AND PROBATE (DISTRIBUTION ON INTESTACY) AMENDMENT BILL

Adjourned debate on second reading.

(Continued from 18 February 2009. Page 1343.)

The Hon. P. HOLLOWAY (Minister for Mineral Resources Development, Minister for Urban Development and Planning, Minister for Small Business) (16:10): I thank members for their cooperation in relation to this bill, and I particularly thank the Hon. Mr Lawson for his comments on it and indication of support. This bill would increase the statutory legacy to a spouse or domestic partner on intestacy.

The Hon. Mr Lawson asked how many grants of administration have been made annually in South Australia in recent years. I am advised that in 2006 there were 221 such grants in cases of intestacy as well as a further 68 grants of administration with a will annexed. In 2007 there were 195 grants in cases of intestacy as well as 76 grants with a will annexed. In 2008 there were 203 grants as well as a further 86 grants with a will annexed.

Grants of probate substantially outnumbered grants of administration over the same period, with 4,357 in 2006, 4,672 in 2007 and 4,554 in 2008. Nonetheless, there are roughly 200 South Australians per year whose spouses or domestic partners could potentially benefit from this amendment. Again, I thank the honourable member for his expression of support for the bill.

Bill read a second time.

EQUAL OPPORTUNITY (MISCELLANEOUS) AMENDMENT BILL

Adjourned debate on second reading.

(Continued from 18 February 2009. Page 1341.)

The Hon. M. PARNELL (16:14): The Greens will be supporting this bill, and we note that this package of amendments has been a long time coming. We also supported the previous bill, and we are somewhat disappointed that it has been watered down. Nevertheless, most of the correspondence I have had from credible representative organisations has urged me to support the bill regardless of its shortcomings, so that is what I intend to do

I will refer to some of the correspondence that I have received shortly. However, at the outset I would like to say that when this bill first came before the parliament I received a lot of pro forma correspondence, much of which showed a remarkable degree of bigotry and intolerance. Other correspondence was more reasonable but was clearly the product of a campaign of misinformation about the intent and scope of these laws.

People wrote to me firmly believing that the whole concept of free speech was being thrown out the window and that people would be sent to gaol for the most minor breaches of political correctness. Clearly, that was an incorrect understanding of the bill, and it is also wrong to ascribe those qualities to the current bill.

We do have to draw a line to demark the boundary between free speech and anti-vilification. Generally we are a tolerant society and are prepared to put up with a broader range of opinions than those in many other countries. In some countries Holocaust denial is a crime; and, while most of us in Australia would still be appalled at such views, we would generally accept the right of people to be ignorant, ill informed and divisive. However, we draw the line against more blatant forms of discrimination.

Yet it is the anti-discrimination provisions of this bill that have attracted the most attention. To paraphrase one of the common, standard-form letters that I have received recently, 'Dear Greens, please allow my school to discriminate against homosexuals and keep the fact of our discrimination a secret.' My response to those letters has been to write back along these lines:

> I appreciate that there have been some changes since the bill was first introduced to parliament in 2006, and one such change has been to allow religious schools to continue to discriminate against hiring teachers on the basis of their sexual orientation. The bill provides that schools who choose to implement policies that discriminate in such a way are required to make such policies publicly available. Whilst I do not support discrimination, I believe that where it is allowed it should be transparent.

That is my position. I would prefer that discrimination on the grounds of sexual orientation was made unlawful; however, I know that that position does not have majority support, so it is a second-rate option to at least require that such discrimination be open and transparent. If that means that people hold feelings of disappointment, contempt or even anger against these schools, then so be it. If this parliament is prepared to grant a dispensation from the general rule against discrimination, then the least we can do is ensure that such discrimination is open and transparent.

The case against allowing discrimination is weakest for bodies that put up their hand for public funding, and that includes all the schools who are likely to take advantage of the exemption. The minister made that point in slightly different words when introducing the bill. One submission I received to which I would like to briefly refer is from the Youth Affairs Council of South Australia. It had to consider whether to lend its support to a sub-optimal bill or whether it should hold out for more reforms. The president of the Youth Affairs Council of South Australia said:

> Whilst YACSA remains concerned that the proposed legislation will not cover same-sex attracted teachers working within religious schools, we broadly support the passage of the bill as proposed. In particular, we strongly endorse changes that prohibit discrimination by all schools against students, and prospective students, on the basis of their sexuality. The bill as proposed can be improved; however it is essential that the changes it does contain be passed promptly and without further amendment.
>
> Same-sex attracted young people can face isolation, fear of bullying and depression as they come to grips with their identity. They are more likely to experience difficulties at school, homelessness, higher rates of drug and alcohol use, mental health issues, family conflict and are at significant risk of self-harming or suicidal behaviours. For those living in rural, regional and outer metropolitan areas, these issues are exacerbated.
>
> These young people do not need the additional fear of being expelled on the basis of their sexuality and any moves that contribute towards changing this situation for young people are welcome.

Notwithstanding our general support for this legislation, there are still some areas of discrimination that, in my view, have not been adequately addressed, and I will come to those shortly.

One issue that I did want to comment on followed the contribution of the Hon. Ian Hunter where he pointed out that, in drawing the line between lawful and unlawful discrimination, one test that can be applied is whether or not the matter being discriminated against is within the control of the person.

He made the point, and I agree with this, that we should not be sucked into thinking that a person's sexual orientation is purely a matter of choice. That is how people are, and that puts those people in the same category as men or women who do not have a choice. That is how they were born. I do believe that that is one of the tests for where to draw the line in relation to lawful and unlawful discrimination.

One of the missing issues for me is the question of discrimination on the grounds of place of residence. I know that this is a difficult issue. I think most of us would be appalled if someone were not able to get a job because of some prejudice about where they live. Certainly some areas of South Australia have a higher crime rate than others, but that does not mean, obviously, that all those who live in those areas are criminals. So, why would we allow discrimination on that ground?

On the other hand, it is also reasonable for an employer to try to give preference to local workers, and that might mean discriminating indirectly against someone on the basis of where they do not live. I would like further explanation from the minister as to why the government has chosen not to address this issue, because it is a deviation from the original bill.

The second area where I think there are still some problems is in relation to discrimination on the grounds of a person's occupation or employment or their previous occupation or employment. One person who is involved in giving advice to young workers put it to me that there is a large number of people who at some stage in their lives engage in the sex industry—students, in particular. Whilst it might not be a lifelong vocation, it might be something in which, at a stage in their life, they find themselves involved willingly or even unwillingly, perhaps to pay the bills.

Under the current legislation, it would still be lawful to discriminate on the basis of someone's past employment so, if we take a most extreme example, you could have a 90 year old rejected from a nursing home because of something that that person might have been involved in during the war years. That is stretching it a long way but, at the end of the day, if we are going to allow discrimination on the basis of current or past employment, that is the type of outcome. It is more likely to be in relation to more recent events or current employment than that but, nevertheless, that is the consequence of these types of laws that do not address all forms of improper discrimination.

One group that is happy with the current changes is those who represent carers, because they were neglected from the earlier version of the bill. I will refer briefly to some of the comments from Janet Wallent and Rosemary Warmington, the President and CEO respectively of Carers SA, as follows:

> We are therefore pleased to see that this Bill makes it unlawful to discriminate on the ground of caring responsibilities including indirect discrimination such as setting unreasonable requirements that are too difficult for a Carer to meet.
>
> We also note and acknowledge that the Bill provides protections at a state level for people with disabilities, mental illness, learning disabilities or illnesses such as HIV and Hepatitis C.
>
> We believe that this Bill is a useful complement to the SA Carers Recognition Act 2005 and the associated SA Carers Policy 2006.
>
> Carers SA has previously expressed disappointment at the failure of earlier attempts at equal opportunity legislation and strongly encourages you to support this current bill, so that carers, among others, can receive the legislative protection they have been seeking for so long.
>
> Carers are amongst the most vulnerable of our society: they need all the support they can get.
>
> Changes in the culture of the workplace, for example, that enable a work/life balance, are required if carers are to thrive within a caring community.

So, that is an improvement on the previous legislation. One other issue that has been raised with me in correspondence has been the right of the commissioner, of his or her own volition, to investigate matters. This is a new power that I welcome. I think it is important because many people who are facing discrimination will choose not to bring an individual complaint for a variety of reasons. Perhaps the foremost of these reasons would be the fear of further discrimination, or even retribution.

In the area of housing, for example, a complaint on any grounds can very likely lead to homelessness, particularly since our residential tenancy laws provide for evictions with no reason. So, unless there is a mechanism for the commissioner to investigate and get involved, the chances are that these forms of discrimination will go unaddressed.

Overall, the Greens believe that this bill, whilst not perfect, has come a considerable way to addressing some of the injustices that exist in society. We think these reforms are better than no reform at all and accordingly we will be supporting the second reading of the bill.

Debate adjourned on motion of Hon. J.M. Gazzola.

NATIVE VEGETATION (MISCELLANEOUS) AMENDMENT BILL

Adjourned debate on second reading.

(Continued from 5 February 2009. Page 1209.)

The Hon. M. PARNELL (16:27): The Greens will be supporting the second reading of this bill, which contains a number of sensible reforms. The issue of native vegetation has been put on the national agenda by the Victorian fires. Clearly, people are focusing themselves on our relationship with the natural environment, and natural vegetation in particular.

In South Australia we have led the nation in the protection of native vegetation. It has got to the stage where, when I was working in conservation groups, interstate colleagues were very

jealous of the fact that we had broadacre clearance controls. They found it somewhat amazing that we would have debates and arguments over individual trees, rather than entire forests that are still under threat in many other states.

I think that on the whole our native vegetation laws are accepted and welcomed in the community. That is largely because we as a society have, over decades, cleared most of the vegetation in our settled areas. When you have, as on, say, Yorke Peninsula, less than 5 or 10 per cent of the vegetation left, the need to protect what remains becomes overwhelming.

This legislation is now about the detail of protecting native vegetation. Broadscale clearance has effectively been banned but, as with any regulatory regime, there are always exemptions and loopholes that need to be addressed. One area of the legislation which was very unclear, and which has now been clarified, is a fairly fundamental question that goes to the heart of this legislation, and that is: where does the act apply?

Generally, we know that the Native Vegetation Act applies outside the metropolitan area, but the act is worded in such a way that it applies to some parts of the metropolitan area, namely, areas that are to the east of the Hills Face Zone.

When those provisions were drafted, I imagine that it was assumed that the Hills Face Zone was a continuous and contiguous strip, where it was very easy to determine who was to the east of it. However, if I take the example of my local neighbourhood, if I were to draw a line due west from my house, I would not hit any part of the Hills Face Zone, but the people in the next street, if they were to draw a line due west of their properties, would hit the Hills Face Zone. So, I am not to the east of it but my neighbours are, which means that the act, in my interpretation, does not apply to me but does apply to my neighbours.

The government has clarified that situation by making it quite clear that the bush suburbs of the Mitcham Hills area in particular are covered by the Native Vegetation Act, and the act lists those suburbs, including Belair, Bellevue Heights, Blackwood, Coromandel Valley, Craigburn Farm, Eden Hills, Glenalta and Hawthorndene. The fact that it includes Belair, I guess, was brought to our attention in relation to the fires, with the recent *Sunday Mail* article referring to some of the dead-end streets in the bush suburbs which fire trucks would not even attempt to get down in the event of a fire. So, I think it is an important clarification. Ignorance is no excuse when it comes to breaking the law. If it is unclear where the law applies, it puts citizens at a distinct disadvantage.

I want to make just a few more comments about the relationship between native vegetation and fire, because it is so topical. When we are faced with the overwhelming tragedy of situations such as the Victorian fires, there is perhaps a natural reaction for people to see anything flammable, whether it be native vegetation or a poorly designed house, as a problem that has to be addressed. We could make Australia completely safe from bushfires by clearing everything, but no-one is calling for that. It is all about where we draw the line. It is all about where the firebreaks go and how wide they are, and it is about controlled burning regimes—and I put on the record now that the Greens support controlled burning regimes. All we have ever asked for is that they be done on an ecological basis, not random, unscientific and unplanned.

These are some of the debates we have to have. But, ultimately, the fact is that in South Australia, especially in the settled areas, we have cleared most of the vegetation. We were known as the mammal extinction capital of the world. An academic from Flinders University coined that phrase. More mammals became extinct in South Australia after settlement than anywhere else in the world, and that was largely a consequence of the patterns of settlement and, in particular, the vegetation clearance. So, we should never lose sight of the fact that in South Australia we are starting from a fairly low base in terms of the remaining vegetation and the need to protect it, and that is why I think the Native Vegetation Act is so important.

In relation to some of the other provisions of the bill that relate, for example, to what we might call offsets or environmental benefits, clearly, the regime that is being proposed is becoming more sophisticated as we follow the rules, in some ways, that were established under planning laws in relation to car parks—for example, if you are building a facility that is going to create vehicular traffic, the state expects you to provide car parking. Similarly, if you want to be able to clear native vegetation, the state expects that you will put something back in return. The debate that we can have is whether that replanted vegetation should be in the same area, the size it should be and questions like that. Most of the detail will eventually find its way into our law through the regulations but, nevertheless, the act does set out the regime. I will have more to say about that in committee, when we look at some of the changes in that area.

Getting back to the coverage by the legislation of the Mitcham Hills area, members may have received correspondence from a fairly new group, the Grey Box Community Group, based in Eden Hills and Blackwood. These people point out that the grey box, or eucalyptus microcarpa community, if not listed probably deserves to be listed as an endangered ecological community. Because of the increasing urbanisation of the Mount Lofty Ranges, the tree is increasingly under threat, and that is why it is important for those bush suburbs to be covered by the Native Vegetation Act, because that tree rarely gets to the size necessary to achieve significant tree status.

The Hon. P. Holloway interjecting:

The Hon. M. PARNELL: I am giving you credit for it, and I will declare an interest: I have attended meetings of the Grey Box Community Group, and I have grey box in my backyard. I know how important they are to wildlife and how hard they are to grow. With those brief words, I will have more to say when we get deep into committee on this bill, but for now the Greens are happy to support the second reading.

Debate adjourned on motion of Hon. I.K. Hunter.

ADMINISTRATION AND PROBATE (DISTRIBUTION ON INTESTACY) AMENDMENT BILL

Bill taken through committee without amendment.

Bill read a third time and passed.

STATUTES AMENDMENT (PROHIBITION OF HUMAN CLONING FOR REPRODUCTION AND REGULATION OF RESEARCH INVOLVING HUMAN EMBRYOS) BILL

Adjourned debate on second reading.

(Continued from 5 February 2009. Page 1209.)

The Hon. R.L. BROKENSHIRE (16:40): On the last occasion I was reading from a Reuters article of 12 October, and I will resume reading from that article. If honourable members or others wish to read my entire speech, my office is happy to assist. I want to talk about inserting genes, as follows:

> ...pluripotent stem cell such as the embryonic cells are difficult to make, requiring the use of an embryo or cloning technology. Many people also object to their use, and several countries, including the United States, limit funding for such experiments. In the past year, several teams of scientists have reported finding a handful of genes that can transform ordinary skin cells into iPS cells, which look and act like embryonic stem cells. To get these genes into the cells, they have had to use retroviruses, which integrate their own genetic material into the cells they infect. This can be dangerous and can cause tumours and perhaps other effects.
>
> Last month, US researchers did the same thing using a harmless virus called an adenovirus, but the method was not efficient. And last week, Shinya Yamanaka of Kyoto University in Japan, who discovered iPS cells in mice, used a loop of genetic material called a plasmid to reformat the cells. Huangfu tried treating the cells first with valproic acid. After she did this, it only took two of the four usual genes to reprogram the cells into iPS cells, she reported. This is good, because the other two genes usually needed can promote cancer. The Melton team used retroviruses to carry the two genes in but suggest they might not be necessary.
>
> 'These results support the possibility of reprogramming through purely chemical means, which would make therapeutic use of reprogrammed cells safer and more practical,' they wrote in their report. Huangfu said the valproic acid unravelled the chromatin—the physical structure of the chromosomes—making it possible to get in and alter the DNA more easily. 'We may need two types of chemicals, one to loosen the chromatin structure, and one to reprogram. We are looking for that reprogramming chemical, and it should be possible to find it eventually,' she said.

So, there is great hope here. It is hard to understand why South Australian scientists do not want a piece of this action. It is beyond belief that South Australian scientists are pushing for such dangerous and immoral practices to be considered by this chamber and this parliament when all this other work is so far advanced and takes all the ethical and moral debate out of it.

The development that I just described, which was announced last month across the world, has reduced the risk of using viral vectors as the catalyst to induce adult cells to become induced pluripotent stem cells, as attested by headlines in press around the world last month. Some examples are, 'Yamanaka's team creates cancer risk-free iPS cells', 'Scientists eliminate viral vector in stem cell reprogramming', and 'Reprogramming iPS cells without viruses'. Yamanaka himself explains his iPS discovery in a 20-minute video. If members are interested they could go to the Japanese website which was published in January 2008 and which is:

www.tv.janjan.jp/movie/edit/fccj/080109fccj_shinya_yamananakai_v_01.php

The video is a presentation he made at a press conference at the Foreign Correspondents Club of Japan. For the sake of the press he avoids, as much as he can, the scientific jargon; and his English is quite good so members would be able to understand his presentation. I can give members the link if they would like it.

He begins his presentation by explaining that embryonic stem cells have the following problems: first, immune system rejection because—and this is critical to remember—the embryonic stem cells are not derived from the patient's own cells. Clearly, as we have seen on many occasions when foreign cells are put into patients, there is a negative reaction with the immune system. Secondly, there is the ethical problem, which has been and will be debated at length in this council. Due to those two problems, and other problems that Yamanaka does not explain, there have been no clinical applications in any country—none.

He goes on to explain that, in order to solve both those problems, he and those in his research team 'would like to make, to generate, ES-like pluripotent stem cells directly from a patient's own cells, such as skin cells by reprogramming'. He uses the phrase ES for embryonic stem, so I will use that in this summary of his presentation. Skin cells, Yamanaka explains, have the same blueprint as the ES cells (embryonic stem cells) with about 40,000 genes the same.

His research for the first three to four years was to establish what were the transcription factors or, if you like, the triggers that took embryonic stem cells and made them into skin cells when an embryo normally gestates in the womb at the early or blastocyst stage. Once they found those, using a vehicle called a retrovirus they sought to trigger ordinary skin cells to become pluripotent; if you like, to revert back to behaving like the parent embryonic stem cells they once were—but with cells derived from the patient, not from a human embryo.

The retrovirus catalyst had issues which, as I have outlined, have now been ironed out. So, too, has the tumour issue that some in this debate have tried to wrongly claim puts paid to the iPS argument. At about the 10-minute mark of his presentation on the video I am describing, Professor Yamanaka puts that argument to rest. That was a problem at one stage, but he clearly states that it has been sorted out; so it is no longer a matter for consideration or debate.

The eventual human iPS cells that Yamanaka created, he explains, 'can proliferate very rapidly and they can maintain the same morphology for a long time'. In other words, behaving like embryonic stem cells. In fact, Yamanaka says that iPS cells are almost indistinguishable from ES cells.

Yamanaka goes on to explain, most excitingly, that human iPS cells can differentiate—that is, move from pluripotency into a specific type of cell, as would ES cells—into neural cells and those neural cells, his trials show, can express dopamine, which means that iPS cells can be used to treat Parkinson's Disease—an incredible breakthrough.

Yamanaka also explains that they can make heart cells which beat like heart cells, independent of the human body. He goes on to explain that human iPS cells can differentiate into many other types of cells, such as muscle, cartilage, gut, epidermal (skin) cells and, as I said, neural tissue. Yamanaka explains that the oncogene, or cancer-causing gene, that they identified early in this process, but, as I have explained, they flushed out that tissue within one month of the initial discovery.

The subsequent concerns about using the remaining retrovirus catalysts, as I explained three months ago, have been resolved, and now scientists believe that they can use chemicals to induce pluripotency without the concern that some people had with retrovirus-induced pluripotency.

You know, it is interesting to note how quickly after the November 2007 changing of the guard that the embryonic stem cell dependent community, that is, those who are wedded to that research because they have government funding to continue that research, reacted with hostility to iPS, saying it would cause tumours and cancer.

Within a month, Yamanaka and Thomson had sorted out those issues, so then the critics shifted to shaky ground, spreading fear that iPS relied on a retrovirus. Late last year that line of attack was also blocked. This is an exciting, rapid pace in the field of science, and Yamanaka and his other scientists need to be congratulated, in my opinion.

It scares the hell out of that embryonic stem cell community who are wedded to hundreds and thousands nation-wide in existing research funding, and it is unfortunate that the funding is actually taking place instead of the opportunities presented here that then take away the ethical concerns for so many of us in society.

Let us not cloud our vision on why scientists are pushing hard for this bill and continued embryonic stem cell research. I ask the minister to outline the funding base for existing embryonic stem cell research. Family First will want specific answers on what the funding base is. Where does the money come from? How much is there Australia-wide? What have been the receipts of funding in South Australia for that research, and what results has that produced? How dependent are BresaGen and Repromed on that funding?

I do not want to be brushed off and have those answers declined, as the government did on the Murray debate on a host of questions I had. I might add that I had a whole lot more for debate, but I ducked out at one point and suddenly the debate on the bill was rammed through at a pace I had never seen in my time in parliament. I walked back in and it was all over; it was absolutely phenomenal. I am here for this debate, and I am not going away until we have put all that funding on record. No flippant answers: this debate is too important to refer us to a report or say it is too hard to find that information.

Returning to the Yamanaka presentation, he concludes by outlining the expected future uses of iPS cells, which are in truth almost limitless. His first targets would be spinal cord injury; diabetes; Parkinson's disease, as I have already mentioned; and cardiac dysfunction. He jokes (perhaps he has been visiting in America for too long; the joke goes down poorly with a Japanese audience) that he also hopes iPS technology can treat baldness, an ailment which appears in its early stages on Yamanaka.

I want to highlight how Yamanaka's presentation concludes, because it illustrates why I believe honourable members should absolutely and categorically reject this bill in its entirety and in so doing cast a big yes vote for iPS research. Yamanaka lists three government sponsors of his work: the Japan Science and Technology Agency; the Ministry of Education, Culture, Sports, Science and Technology, and the National Institute of Biomedical Innovation. You see, where there is a will there is a way, and I congratulate Yamanaka for getting those government sponsors.

As you can imagine, Professor Yamanaka is popular, not only in Japan but also across the world. We approached him to discuss his research but unfortunately, due to workloads and schedules, he was not available. Let us talk about Yamanaka's research colleague, Professor James Thomson, from the University of Wisconsin. I think his story demonstrates how legislators can guide scientists towards the right outcomes. MSNBC profiled him in June 2005 with the opening statement, 'Seven years ago when James Thomson became the first scientist to isolate and culture human embryonic stem cells he knew he was stepping into a whirlwind of controversy.' In the MSNBC profile, Thomson was critical of the shackles that had been put on his embryonic stem cell research by the Bush administration. Yet even at that point in 2005, before the 2007 discovery and whilst Thomson was trying to exploit embryonic stem cells, MSNBC reports:

> Some of Thomson's other pronouncements might seem more surprising:
>
> - that supporters of stem cell research are over-estimating the prospects for transplantation cures;
> - that the current stem cell lines aren't well-suited for such applications anyway; and
> - that there's no need to resort to therapeutic cloning right now—or perhaps ever.

What did those ethical legislative shackles drive Thomson to do? He looked for ethical alternatives and, with Yamanaka in late 2007, we are thankful that he hit the jackpot.

There is no denying that this is an inspirational story of what happens when legislators have the fortitude to direct their scientists, not just give them funding but actually direct them. Thomson's shift into iPS is no less dramatic than Wilmut's, given his foundational role in getting embryonic stem cell research going at the end of the last millennium. That fact was not lost on *The New York Times* which, on 22 November 2007, wrote:

> If the stem cell wars are indeed nearly over, no-one will savour the peace more than James A. Thomson.

It is worth noting that this was written more than 12 months ago and, as I outlined when profiling the work of Professor Yamanaka, much improvement on the November 2007 prospect has occurred. The war is over; it is just that we have this redundant legislation we are asked to pass to approve of cloning, a legacy of a former scientific era. I do not understand why the minister, or the government, wants to put this legislation to the parliament on behalf of the people of South Australia. It makes no sense to me at all, nor to many others who continually email and contact us with the same concerns that Family First has with the legislation.

I also want to mention that iPS is moving not only to clinical trials but also to use in diagnostics. The Californian Institute for Regenerative Medicine is using iPS technology to produce a cell-based tool to diagnose long QT syndrome, a common cause of sudden heart death. Yamanaka explains, in the video presentation I mentioned earlier, that the iPS technology can already be used to work out why patients get sick, to screen medications to work out which will be most effective for patients, and to identify potential drug side effects.

I now turn to the adult stem cells part of this debate. Under this section I again want to mention my colleague the Hon. Dennis Hood. He went into this in more detail, but I will briefly mention a few points. Treatments have been developed using stem cells already available in the adult body, as follows:

- the adult central nervous system, long thought not to contain cells capable of dividing, in fact harbours stem cells. Such cells may help treat Alzheimer's and Parkinson's disease, and haematopoietic stem cells from bone marrow may one day provide transplants to replace blood and immune cells. This research is moving ahead at a great pace;
- umbilical cord blood stem cells have been successfully used in the treatment of diseases, including helping to obtain bone marrow matches for children suffering from leukaemia. In total, 85 diseases have been successfully treated using cord blood stem cells and there is the potential to treat more;
- investing in embryonic research diverts resources away from umbilical cord blood stem cell research and from adult stem cell research, and this is counter-productive.

It is bizarre to think that they are still allowing embryonic research. Indeed, as recently as 20 November, just a few months ago, we heard the internationally breaking news of a mother of two, Claudia Castillo, aged 30 and a TB sufferer, bed-ridden after her windpipe became blocked. On that day, on page 6, *The Advertiser* quoted a report from *The Daily Mail* in London, as follows:

> A mother of two has become the first person in the world to undergo an organ transplant using her own stem cells.

How exciting is that! No embryos involved, no cloning, no animal hybrids—just the mother's own stem cells. The report continues:

> The breakthrough is thanks to the pioneering work of British scientists, who are hailing a new dawn in transplant surgery which could revolutionise the lives of millions. The University of Bristol researchers are the first to use adult stem cells to grow an entire organ.

They actually used adult stem cells to grow a windpipe which has then been successfully implanted.

With the tragic circumstances in Victoria, and with the windpipe being highly susceptible to damage in intense fire situations, what a breakthrough this would be and a blessing for some of the burns victims. Scientists believe the technique could be extended now to organs such as the heart and the lungs and are confident that it will be the normal way of carrying out transplants in just two decades.

Having retraced the scientific developments, building upon what my colleague the Hon. Dennis Hood MLC outlined, I want to contrast the present debate with the climate change debate for a moment, which might, at first, seem odd to members. In the climate change debate, we are presented with compelling evidence about the science pointing a particular way.

On *60 Minutes* on the evening of Sunday 17 August 2008, the Prime Minister Kevin Rudd was challenged about the science by reporter Tara Brown, who asked, 'How certain are you that mankind is the cause behind global warming?' Prime Minister Kevin Rudd answered:

> Well, I just look at what the scientists say. There's a group of scientists called the International Panel on Climate Change—4,000 of them. Guys in white coats who run around and don't have a sense of humour. They just measure things. And what they say to us is it's happening and it's caused by human activity.

I make reference to this because, first of all, I have outlined today the pioneering work of Yamanaka and Thomson, their research teams and associates. Members have also received a letter from over 160 Australian doctors concerning this bill. As I understand it, Medicine with Morality wrote to every member of parliament about this bill—160 doctors absolutely opposed to the government's bill.

The Hon. Dennis Hood set out the dramatic turnarounds of the father of cloning, Professor Ian Wilmut, and others (including Thomson who I have spoken about earlier today) from cloning to

ethical stem cell research. Will members listen to the science? If that line of argument is good enough on climate change, it is good enough on the evaporated merits of human cloning, also.

I want to talk about the risk to women—a very important part of this debate, in my opinion. I want to revisit the risk to women of this cloning science. My colleague, the Hon. Dennis Hood, recounted a harrowing tale of the pain a woman experiences when induced ovulation goes wrong. Opposing cloning is a pro-woman gesture. I want to place on record my concern that supporting cloning puts women at risk.

We cannot be ignorant of that fact. As I said, my colleague, the Hon. Dennis Hood, said enough about that issue and I will not labour that point, but it is a very important point that must be considered. Precursor cells are from aborted girls. I want to highlight another critical point in this debate. It is not clear, and I invite the minister to make it crystal clear. The Prohibition of Human Cloning Act 2003 talks about precursor cells as a source for eggs from which embryos may be made by cloning or by fertilisation. To do cloning for somatic cell transfer, you need ova, but no country in the world that permits cloning has been able to get fresh eggs from women without paying them. My question is: where do you get the eggs?

One possibility to be allowed under this bill which has not received much attention, and this is tragic, is aborted girls; not those blobs of flesh that people say are aborted girls in the early weeks of gestation but aborted girls with developed ovaries. Here is how the argument develops: a precursor cell is a cell which could develop into a germ cell, that is, a sperm cell or an egg cell. Section 13 of the current Prohibition of Human Cloning Act bans the use of precursor cells from a human embryo or foetus to create a human embryo. So, there are two sources in the ban: human embryo and human foetus.

The act defines source 1, the human embryo, as something less than eight weeks after fertilisation. At eight weeks, we are informed, no ovaries or ova will have developed in the embryo. So, you are not going to be able to source ova from a human embryo.

That leaves source 2, the human foetus. Eggs from precursor cells for cloning, for somatic cell transfer, will have to come from aborted girls—aborted girls, I might add, at 16 weeks gestation or older. Now remember, under the Abortion Reporting Committee criteria, abortion after 20 weeks is a late-term abortion and babies are viable these days even within that second trimester. Is this true? I seek a guarantee from the minister, a guarantee at the very least of the nature of that which he made relating to country health, a guarantee that no ova from the ovaries of aborted girls, aborted girls of at least 16 weeks gestation, will ever be used for this research.

Mr President, honourable members, please, we must have an answer on this: where will the ova come from? I say to the minister: do not deny me an answer, do not deny the mothers of these children, because there is a corollary to that question. If the answer is yes to the truth about aborted girls, if precursor cells come from aborted girls' ovaries, then tell me this: will the mothers of those aborted girls know that this is what is going to happen? Will they be given informed consent to that exploitation occurring when they abort that child? This is very important. I am standing here for women and their dignity. I know that it is tough stuff in the debate but it has to be debated. There are very strong moral issues here.

How absolutely remarkable it is that scientists are asking us to harvest ova from aborted girls for cloning research, and yet in South Australian hospitals day in, day out we are disposing of umbilical cords and their blood, a rich source of stem cells with, so far, 85 treatments and growing.

I turn now to hybrids. I touch on this briefly because my colleague the Hon. Dennis Hood said much on the issue of hybrids. We are talking here about inseminating, in the immediate future if this bill passes, human sperm with animal eggs for sperm viability. The Hon. Dennis Hood quite rightly states that there are other better ethical ways to do this testing. However, the opportunity is there in this bill for animal sperm and human eggs—that is undeniable.

We have seen recent news in *The Advertiser* of 20 abnormalities, this year alone, nationwide in compliance with gene technology regulation. There is every risk that a rogue experiment could occur and I, for one, advocate that we must never let that be a possibility and we must ensure that this bill does not pass through parliament.

When we consider hybrids, we need to be informed that two kinds of hybrid are possible. One is true hybrids, which involves fertilising a human egg using animal sperm, or an animal egg using human sperm. Another type is cytoplasmic hybrids (cybrids) which are produced by cloning

(cell nuclear replacement) technology. However, all types of hybrid embryos are unethical and strike at the very heart of what it means to be human.

In the United Kingdom, from the same kind of spin doctors who tried to rebadge drought as dryness, we have seen pro-hybrid campaigners try to describe hybrids as 'human admixed embryos'. We must be alert to the spin and careful dodging of scientific reality that can happen in these debates.

I want to remind honourable members that, in the debate on this issue in 2003, not one member in either this or the other place raised any objection to the banning of animal hybrid experiments. We—I say 'we' because I was a member of the other place then—all agreed that it was appropriate to ban that type of experimentation and, for that matter, human cloning. Five years ago, no scientist came to us to say that they wanted to test sperm viability by making man cows. As a dairy farmer, I am as offended for the cows as I am by the people putting forward the concept.

In relation to the voting on the legislation, I note that in 2003 I voted for the Rau amendment, along with 25 of my colleagues from all sides of politics, as opposed to 18 who voted against the amendment. The member for Enfield's amendment provided that there would be a cut-off date for the use of so-called leftover IVF embryos for research. The bill at that time contained a clause providing that the date (the goal posts, if you like) could be shifted by COAG's own motion without reference to any parliament. It sounds like some of the stuff that we have dealt with in relation to the River Murray—it just keeps going on without any reference to the parliament. I note that that was a Howard government concept.

The amendment was simply to prevent COAG from shifting the goal posts without reference to the state parliaments. As I have said, the vote was 25 to 18. That is a very interesting outcome, because some of the current ministers, including the Minister for the River Murray, were sitting on my side of the chamber. In the context of the recent debate that we had on the River Murray handover and our concern about COAG dictating what we should do, I find that interesting—and it has already come home to roost with the objections from Premier Brumby in relation to the cap.

Perhaps more instructive is that the Premier voted against that amendment, and I commend him for that. As we did in the Murray debate, we have heard that, if we change anything, everything will fall over. That is the catch cry: if you change anything at all in this parliament that is put up by the government, everything will fall over.

In 2003, the member for Enfield used some colourful analogies. In essence, he claimed that the then health minister (the current minister's predecessor) was complaining that the sun would not come up in the morning if the bill was amended at all. Let us put paid to this nonsense that you cannot amend national COAG-agreed legislation. The parliament allows that, and that right should be protected, especially in cases like this where the basis of the bill is fundamentally flawed. I give notice that I have filed amendments to this bill, which I will outline at the committee stage.

If we have the courage, there is a niche market for South Australia. When this bill was previously before us prior to the proroguing of parliament, the prospect of South Australia becoming a niche market, a frontrunner in iPS science, was raised with members of the Adelaide University research group, who have promoted this bill. The science is clear. Why don't we move into the area? Why don't we arrest this alleged brain drain, which I do not think is occurring, by establishing research in iPS?

The science is viable, as I have pointed out in my speech. Everyone from Wilmut downwards through the cloning ranks has said that iPS is infinitely more viable than cloning. You do not need expensive new equipment; laboratories can perform this work right now. Surely, at a time when there is a crucial need in South Australia for the creation of jobs for the future and opportunities for new industry development, together with our great universities and the intellectual capacity of our young people and the scientists we already have here in South Australia, why do we not make South Australia the headquarters for iPS research?

There is much more I would like to put on the record, including recent and significant developments in the growing field of pluripotent stem cell research and also the findings that cloning simply no longer has merit. There is no merit to cloning. I am seeing stories showing that previous assumptions about cloning of animal hybrids are being refuted regularly. I encourage members to read their emails on this subject as I believe more will come their way. I have said

plenty on the subject and I will leave it to other members to update us on the science now occurring in early 2009. We are seeing reports virtually weekly.

In conclusion, all that is required is direction from our parliament in South Australia as the proportionally elected representatives of the people of South Australia. We can tell the scientists of South Australia that we have a preference—IPS. I have spoken to a lot of people and have had a lot of phone calls, letters and emails, and overwhelmingly, almost without exception, all of the representation and discussion I have had with South Australian people is that they want this bill disallowed. They do not want to see it passed and they support the opportunities we have now with skin cells and IPS.

It is up to us to tell the scientists that there is a new way forward, a better and exciting way that will allow a lot of health innovation opportunities for those people suffering so much at the moment not only in our state and nation but around the world. It could come from us by showing a lead here and encouraging our scientists and universities to focus on the future and not try to further develop science practices that are now obsolete. I am not an expert scientist—I acknowledge that—but I can read, be briefed and listen to what people have to say. I can weigh it up also with the parallel and most important consideration, namely, the moral values around this most important matter.

We have people here who are saying that we must not go down the track of genetically modified food. In fact, we have members inviting us to a briefing, which I will attend, but clearly is all one way with regard to making sure we do not allow genetically modified food and those engineering practices. We have a lot of people running around opposed to that. However, I suggest that that issue is nowhere near as serious morally or ethically as is this bill. This bill needs to be chucked out—it is obsolete.

I put this analogy to members: we have the health minister running around spending a lot of taxpayers' money promoting all the good values about the Marj and how we have to have a new hospital at a cost of $1.7 billion—

Members interjecting:

The Hon. R.L. BROKENSHIRE: Sorry; I forgot. My colleagues have corrected me—it changed yesterday and it will now remain the RAH. We have a health minister saying that we must have a greenfields site for the RAH, that we cannot continue with the existing RAH campus. I put on the public record, as it ties in with what we are debating now, that in London and other parts of the world they have tertiary, leading, research-orientated, world-class hospitals such as we have with the RAH, and do members know how old the campuses are? They are over 300 years old. They are beautiful, magnificent buildings. They have not knocked them down, because they were built to last 500 years.

In conclusion, I point out that the health minister is saying that this government must lead the way in modern practices, in scientific opportunities for the future, that we must be at the cutting edge, and that that is why we have to spend $1.7 billion that we do not have but have to borrow, because we have to dispense with the old campus because we want to lead Australia in modern health practices. That is what the Minister for Health is saying, yet on the other hand the same Minister for Health is asking us to support his bill that is ancient science. We have moved on past all that.

I do not understand it, and I ask minister Hill to tell the parliament what is going on here. If you are a leading edge minister and government, with the most proactive and creative health department in the southern hemisphere, and you are going to build this magnificent cutting edge campus for future generations to come, why would you bring in old-fashioned, scientific legislation that brings up so much in the area of debate with respect to moral values? The community do not want this bill to be passed. I cannot understand the government. Either you are for the future and right on the cutting edge with the sciences or you are in the past. I say to the health minister that he cannot have it both ways.

This is not a debate about whether South Australia becomes a scientific backwater. Any scientist who wants to argue that can debate it with me any day, because we are not here choosing against progress. It would be good to see just one genuine piece of evidence from those scientists who are already funded that shows me that what I have said today is wrong. We have put a lot of research into this area, and a lot of people have fed us the information, and I know that what we have been told about future opportunities with respect to iPS is true and correct.

We are making a choice between two sciences: one is unethical and the other is ethical; one has a future and the other is without a future; and one offers hope to patients with incurable diseases and the other offers false hope. We have a choice here for parliamentary democracy and common sense and for aligning with the science rather than the whims of bureaucracy. I urge honourable members to acknowledge the change in the wind, the fresh breeze of induced pluripotent stem cell research, rather than the stale stench of dead cloning science. I oppose this bill.

The Hon. I.K. HUNTER (17:22): The use of embryonic stem cells has been a controversial issue, mostly due to views about when life begins and the moral status of pre-embryos and embryos. Let me say at the outset that this is the nub of the debate for me. To my mind, life is about living as a productive and healthy member of our community, aspiring to achieve our full potential. That opportunity is what we need to be able to provide for those individuals in our community who are disabled by an accident or a disease that will not allow them to function optimally. Embryonic stem cell research may provide solutions for these individuals but, in order to achieve those solutions, we need research innovation, and that requires passing this legislation.

Today I will discuss why supporting this legislation is not a question of the science but instead is an issue about health and improving life quality and is, therefore, an ethical issue. I will discuss what embryonic stem cells are in reality and not what they have been perceived to be, and I will discuss why at this point in time they are more important than adult stem cells. I will also talk about their potential to improve the health and quality of life of many people in our community. In addition, I will remind the chamber that South Australia has been a leader in social policy and medical research throughout its short history, and I believe that it is time for us to move to the forefront again.

At this point I would like to summarise what the bill does, and I do not believe that I would be able to do that any better than the Minister for Health did in the other place. I will quickly repeat his words here. As the minister stated, the purpose of the legislation is:

- to streamline current processes for embryo research licensing and to strengthen oversight;
- to extend the scope to regulate the creation, development and use of all embryos, not just excess ART embryos, and to regulate the use of donated eggs;
- to alter the definition of an embryo to reflect the point at which fertilisation is complete;
- to extend the criteria for licences issued for research and training to include the use of the embryos not created by fertilisation;
- to permit a licence for research techniques such as somatic cell nuclear transfer and parthenogenesis;
- to clarify what constitutes proper consent by donors and an embryo that is unsuitable for implantation;
- to strengthen and extend consent provisions to include all donors whose genetic material is incorporated in the cells used; and
- to increase penalties for breaching prohibitions.

We also need to consider what will happen if we do not pass this legislation. Some in the other place say 'Not much', but I disagree.

Scientists are conservative by nature, and we need to allow them to proceed with certainty in the pursuit of their science. If we do not pass this legislation, we leave many of them in limbo. For example, researchers based in federally-funded centres that have some state funding may decide not to proceed with research for fear that they are unwittingly stepping outside what is permitted by law. Also, some researchers, who may be working in public hospitals and get NHMRC grants, may feel in a bit of a quandary, not knowing which laws apply to them. We cannot allow such uncertainty and ambiguity to exist.

We come to debate this matter, about which people on both sides of the issue feel extremely passionate, to bring the state legislation in line with the current federal legislation. This is an issue on which everyone has an opinion—an opinion which is usually deeply held. No-one seems to be ambivalent, and I expect this debate will reflect this passion—as it should.

I urge all members to support the passage of this legislation, no matter what their private views are, for the good of the many and for future generations. This legislation has the potential to improve life for millions of people. South Australia is a state that so often has been at the forefront of debates that were considered controversial at their time. We are the state of female suffrage, decriminalisation of homosexuality and Aboriginal Land Rights; and with the effluxion of time we wonder, looking back, what all the fuss was about when those debates were occurring.

We are the state that educated a young Howard Florey, before he went on to save millions of lives by working out how penicillin could be mass produced, and which nurtured the early studies of Lawrence Bragg, who went on to be a joint winner of a Nobel Prize in Physics in 1915 at the age of 25 for his work into the diffraction of x-rays by crystals. We have encouraged our youth to dream of the possibility of a better world and we have reaped the rewards of their living their dreams. We have enjoyed living in a progressive state where ideas and free inquiry have been able to flourish.

But on this issue we are not innovators: we are playing catch-up—not breaking new ground. We are the last state in the commonwealth to debate this legislation. Stem cell research, and embryonic stem cell research in particular, has so many possibilities to benefit human kind. Embryonic stem cells have the potential to change millions of lives for the better, as I will outline shortly.

Most of us are familiar with the arguments about why stem cells are so important as a research tool and why they may be a rich source of clinical treatments. It is worth summarising these features for the record. I want also to speak about the advances with iPSCs (induced pluripotent stem cells) and why they are not an excuse to abandon work with ESCs.

In order to do that properly I do need to summarise the science, albeit briefly. Before I go further, I will touch on Dolly the sheep—the spectre of whom some have evoked in this debate to argue against this legislation. Let us be very clear: cloning of an entire organism is not relevant to this debate. The cloning used in the process of creating Dolly was fundamentally different from embryonic stem cell research. Stem cell research relates to the use of cells that can be changed into another type of cell for the purpose of regeneration of tissue, but cloning such as that used in the Dolly instance was a replication of an entire organism. It involved taking a somatic cell nuclear transfer clone to term. Such action is not possible or permissible under this bill, and to evoke this argument is to confuse the debate; and it does not bring any clarity to our deliberations.

I return to the science. The human body is made up of about 210 types of cells, all of which do specific jobs in the body. Most cells are mature or adult and unable to differentiate into other kinds of cells. On the other hand, by their very nature, embryonic stem cells are pluripotent or totipotent and are able to evolve into any one of these particular types of body cells, unlike adult stem cells.

Research is currently being conducted around the world to discover the full abilities of embryonic stem cells, but we are really only scratching the surface. Much has been made of the possibilities for embryonic stem cells to treat, and perhaps cure, conditions such as Alzheimer's, Parkinson's Disease and spinal cord injuries. This, in part, has been due to some high profile individuals afflicted by these conditions and supporters who have pushed embryonic stem cell research into the limelight. Whilst embryonic stem cells show extraordinary possibilities in these areas, there are many other areas where life-changing and life-saving possibilities are currently being researched.

The Hon. Mr Hood has made some claims—and to my mind they were ill informed—about the lack of success in developing cures and treatments from embryonic stem cells. Really, he was very badly informed. Science, no matter how much we would wish it otherwise, is not in the business of overnight cures. Science is about the slow, deliberate, step by step build-up of knowledge, of checking and rechecking that knowledge and of slowly moving towards the use of that knowledge in real world applications, in this case, for medical treatment. To criticise science for that cautious deliberation is really a great disservice to the debate.

Let me go on to summarise just some of the areas where stem cell research is showing some promise. One of the many benefits of embryonic stem cell research is the ability for researchers to examine these cells to gain a better insight into some birth abnormalities and discover why it is that some cells become cancerous. By gaining further understanding of both of these things, scientists are better prepared to work towards prevention, therapy and, perhaps one day, cures.

Type 1 diabetes is typified by the destruction of islet cells, the cells responsible for the production of insulin. Novocell, a San Diego based research company, told a conference in Eury, France, in 2008 of its positive results in laboratory testing in mice in replacing islet cells. Simultaneous to Novocell's research, ES Cell International in Singapore and Geron of California are also working on their own research using embryonic stem cells to find a cure for Type 1 diabetes. Type 1 diabetes is one of the most serious and common chronic diseases in Australian children.

Organ donation in Australia and around the world does not occur in high enough numbers to provide all those in need with the organs that will save their lives. Pluripotent stem cells offer the possibility of a renewable source of replacement cells and tissues. Liver transplant is just one area where organ demand outstrips organ supply. A collaborative team of researchers based in Japan and the US National Institute of Health has had success in coaxing embryonic stem cells into liver-like cells, which may prove to be the answer for people suffering liver diseases like cirrhosis and hepatitis.

Another collaborative project, this one between California Stem Cell, the Amyotrophic Lateral Sclerosis Association and a small Belgian firm, is currently working with motor neuron cells searching for a cure for Lou Gehrig's disease, which is a progressive disease that causes the degeneration of motor neurons.

Further, there is hope that research utilising embryonic stem cells will find a cure for Sandhoffer disease, an illness which sees a toxic build-up of debris with the neurons and which eventually kills those neurons. Muscular dystrophy affects approximately 1,500 South Australians, and research into embryonic stem cells has shown that these pluripotent stem cells can be generated into new muscle cells to replace the diseased muscles in sufferers.

Advanced Cell Technology in Worcester, Massachusetts has been undertaking studies in rats on age-related macular degeneration. They have been able to persuade embryonic stem cells to grow into cells resembling retinal pigment epithelial cells, the cells that support the photoreceptors in the retina. The studies have shown that the cells have boosted the thickness of degraded retinas, increasing sight, a most promising result.

In August last year, that same company announced that it has used embryonic stem cells to create human blood cells and can control what type of blood is produced. The cells have been shown to operate just the same as other blood cells and would help avoid medical crises brought on by insufficient blood supplies. Embryonic stem cells have been used to generate alveolar type 2 cells, the cells that line the human lung. We are often reminded that heart disease is the leading cause of death among Australians, with one Australian dying every 10 minutes from some form of cardiovascular disease. Embryonic stem cells have been shown to produce the three main types of heart cells: cardiomyocytes, endothelial cells and vascular smooth muscle cells.

In addition to these conditions, embryonic stem cells have demonstrated potential in treating burns, strokes, osteoarthritis and rheumatoid arthritis. Add to this the potential for increased knowledge that this research could bring to IVF research, and I conclude that supporting this bill is the right thing to do.

Infertility is an issue that would have touched so many of us here today, either directly or through our support of family and friends. This proposed legislation will allow researchers to improve methods of infertility treatment through further research of parthenogenesis, a process by which human eggs are stimulated to divide and grow without fertilisation. This would allow scientists to trial new techniques and develop more successful fertilisation techniques into the future.

Standing here today, we can only begin to speculate about how bright the future might be. In the words of Albert Einstein:

> Imagination is more important than knowledge. For while knowledge defines what we currently know and understand, imagination points to all we might yet discover and create.

For all the possibilities of stem cell research that we currently know, who can tell what benefits may arise in the future from this form of research? After all, Florey's groundbreaking research work in mass producing penicillin would not have occurred without Fleming's serendipitous discovery of the antibiotic a decade before—so much for the arguments that embryonic stem cells (ESCs) do not have a promising future.

As I have stated, this is not a new debate. Around the world this issue has already been thrashed out many times over. The United Kingdom has some of the most liberal legislation in this regard, and it is no accident that it has been at the forefront of some of the most significant discoveries to date. I turn to the UK now to address another criticism raised by the Hon. Dennis Hood in his contribution.

In fact, it was in the UK that Professor Sir Martin Evans first identified and isolated embryonic stem cells back in 1981. It was in the UK, too, that the world's first stem cell bank was established. The United Kingdom parliament has amended its Human Fertilisation and Embryology Act to allow for the destruction of embryos for human embryonic stem cell harvest. Effective from July 2006, the United Kingdom National Stem Cell Network has been established to coordinate research.

Licensed researchers are able to undertake research using surplus IVF embryos and partake in therapeutic cloning. In 2008, permission was given for scientists to undertake research on human-animal hybrid embryos under extremely strict conditions. This is not contemplated in the bill presently before us. I repeat: this is not contemplated in the bill presently before us, despite some speakers seeming to imply that it is.

It concerns me when contributions in this place are so muddled that they may confuse the public. The Hon. Dennis Hood, for example, mentioned this issue a few times in his contribution and, once again, I think he gets things mixed up. He said, at one point, that 'some scientists want to use the eggs of other mammals such as rabbits, cows, sheep or monkeys', and he went on to talk about this technology being used in patients. Well, no, actually.

Scientists want to use animal eggs to test systems. Why waste hard-to-get human eggs on testing? There is no question of creating human-animal hybrids for clinical use in patients; the ethical guidelines do not allow it, not even in the UK. The Hon. Mr Hood goes on to say in his speech that this bill is solely about—and this is the important point—'extending research into new and unknown realms which allow for the mixing of human and animal genetic material'. Yes, it does, but not for any outlandish purpose. It is clearly limited in the legislation to just one purpose—the testing of the viability of sperm, not for research, making into stem cells, patient use or any other purpose.

Like many of my honourable colleagues, I, too, have received a few letters and emails about this bill suggesting that I vote against it, often on the grounds that it is against God's will. Most correspondents do not identify the particular god or religion they are relying on for this authoritative statement, so I thought I would quickly canvass a summary of the religious position generally. Not all religions have the same point of view. While I appreciate that people personally hold deep religious conviction, it seems that some religious people and some religions have no objections to embryonic stem cell research.

Religious beliefs are not universal and even within various religions there exists a multiplicity of views. I do not hold myself up to be a religious scholar by any stretch. So, when I turned to what I consider to be a well-researched book on the subject, I found that the different world religions offer wildly different points of view, reinforcing my belief that we need to look outside of religion for guidance on these issues.

As I understand it, the Roman Catholic faith and Eastern Orthodox versions of Christianity believe that human life begins at the time of conception and any destruction of this life is comparable to murder. Buddhism and Hinduism both place the beginning of life at conception but, in both religions, the embryonic stem cell debate has yet to register as far as I can determine. Fundamentalist Protestants tend to believe that life begins at conception whilst more moderate Protestant denominations do not believe that an embryo has the same moral status as a foetus or a human.

Most academics note that neither conservative nor orthodox Judaism view life beginning at conception, thus most scholars seem to believe that Jewish bioethics support embryonic stem cell research. The general consensus in Islam is that embryos are not human and personhood does not occur until the fourth month. Generally, Islamic scholars have used the teachings of the Koran and other sources of Islamic law to demonstrate support for embryonic stem cell research.

However, even within these faiths we find great dissent. For any who believe that the soul enters the body upon conception, the matter of twinning remains unresolved. In the early period after conception the zygote may split into two to create twins. This issue becomes particularly thorny for those who claim that life begins at conception. One can be split into two or even four

zygotes, all of which have the potential to develop into humans. These zygotes can then be brought back together in this early period, and the one zygote that became four zygotes can become just one again, all with no cells being created or destroyed.

For those who believe that life begins at conception, that that is the point where 'humanness', or souls, enter the equation, then this surely provides a logical quagmire. One can be divided into four, so does one soul split four ways or are new souls created? If these four can then be brought back to one, a process whereby no material is damaged or destroyed, what, hypothetically, happens to the excess souls? This is a philosophical mind-twister that is, quite frankly, beyond me.

With so much dissent within and between religions, we cannot say that there is universal religious opposition to this legislation. As religious scholars debate this issue amongst themselves, and continue to debate it, the people of South Australia have come to a pretty clear consensus on the issue. Polls have suggested that 82 per cent of South Australians support this legislation (I refer to a Roy Morgan research poll of 2006).

While there is dissent within and between religions in regard to this research, it is worth remembering the similarities that exist between the world's religions that are happily embraced by those of us who share an ethical framework not dependent upon a supernatural being—namely, the desire to help those in need and to alleviate suffering where we can. Whether or not we approach these issues from a religious position, it is worth remembering our commonality, our desire to act in the best interests of humankind, to protect the vulnerable, the sick and the suffering and to do what we can to alleviate that suffering. So, if there is no common religious position upon which we can rely, we are forced to fall back on the best scientific information available to us which, as I hope I have outlined, demonstrates that we must continue to explore the possibilities of embryonic stem cell research for the potential alleviation of illness and suffering.

Around the world, legislators are grappling with the ethics surrounding stem cell research, and the issue before us today is an ethical debate. Although the specifics of the science will, as with all science, continue to be explored and argued by its practitioners, the fact is that stem cells offer possibilities for humankind that were once confined to the realm of fantasy. We are standing on the precipice of medical history.

Members of both houses of this parliament have been petitioned by community members advocating that the discovery of induced pluripotent stem cells signals the end for the need of embryonic stem cell research. There may be members of the council who believe that the discovery of iPSCs renders this debate unnecessary, but I urge caution before honourable members grasp at this straw. Anyone who tries to confuse the debate by claiming that it is certain that induced stem cells can do what we are already certain that embryonic stem cells can do is indulging in wishful thinking.

I appreciate that this is a very complex area and I realise, given the complex nature of the debate, that some people may be confused about what is actually being debated here. But to argue that induced stem cells currently provide equal possibilities as embryonic stem cells is just wrong. Those who clutch at such an argument want the benefits of research into stem cells without the moral quandary that embryonic stem cells present to them. I understand that desire, of course I do; however, it is just not borne out by the science as it stands today.

Let me turn to induced pluripotent stem cells. iPS cells were discovered almost simultaneously by a team at the Genome Centre in Wisconsin in the United States and a team at the University of Kyoto in Japan. The discovery of induced stem cells is very exciting indeed and needs much further exploration. iPSCs offer interesting possibilities for the future, and who knows what that might hold. I quote from the influential science journal *Nature*:

> Flexible cells from non-embryonic sources do offer exciting possibilities: perhaps adult human cells can be reprogrammed and cells from testis and amniotic fluid can be coaxed into an array of functioning tissues. If such cells can be derived from individual patients with diseases, these non-embryonic sources could be of great value. But this value is more likely to be unleashed if they are studied alongside embryonic stem cells rather than in their place.

Shinya Yamanaka, who headed the University of Kyoto team, has himself stated that at this point in time—although I will admit that recent events of the past few weeks have caught up with us—he is not sure of the possibility of the use of iPSCs.

In an interview with the *New Scientist*, Yamanaka outlined both the possibilities and the limitations of the discovery, as follows:

> Theoretically scientists should now be able to make patient-specific iPS cells quite easily but at the moment we have to use retroviruses to carry the foreign material into cells, which could generate tumours. This is the same problem we had with gene therapy, so we wouldn't use this on patients yet. At this stage, iPS cells should be used only for testing new drugs, until we find ways of making changes without using retrovirus.

Of course, as we heard from the previous speaker, Yamanaka now feels that he has cracked that issue, but he goes on to say:

> We also need a more detailed comparison between iPS cells and embryonic stem cells in terms of what they do. If it is proved that iPS cells are as good as or better than embryonic stem cells, I think they can replace them. I do want to avoid the use of embryos if possible. Ultimately I think that patients' lives are more important than embryos.

This is a man who has developed this new realm of investigation in science, and he says 'but ultimately I think that patients' lives are more important than embryos'.

The key point really in what he is saying is that these two systems must be researched side by side. We must not throw one away but, rather, keep both systems in place so that we can learn more about both of them. At this point we do not know what we may lose by discounting a particular avenue of research. We must allow scientists to make the decisions about such research, knowing that they do so with regard to stringent ethical guidelines which we can determine.

So, with the ins and outs of the science left to be debated by experts, the ethical debate remains, and it is the ethical debate that we must confront. I respect those members who have deeply-held views about the morality of experimenting on embryonic stem cells. I disagree with them, certainly, but I can see how they come to hold such views.

The ethics surrounding this legislation are complex and are not taken lightly by any of us. However, for the reasons that I have outlined, I believe that we are ethically required to pass this legislation. We have a duty as a society to try to alleviate the suffering of others. To my mind, this means the suffering of other human beings and, to me, the term 'human being' does not extend to the cells created shortly after fertilisation.

Despite what opponents wish to argue, this is not a permissive piece of legislation. It is in fact very prescriptive, placing tight and careful controls around research. The legislation provides that no research can be conducted past the 14-day mark, and that is not an arbitrary date. On day 15, the primitive streak begins to form.

Prior to that, the mass of cells has no nervous system, no heart, no ability to think, feel, fear or love. It is a ball of cells that, given a very specific set of circumstances, may indeed form into a human but which, in nature, of course, very often does not. The set of circumstances required for that to happen is incredibly rigid and, for the cells in a Petri dish in a laboratory, there is no potential at all for those cells to form into a human being.

It is worth remembering that the chance of a blastocyst becoming a human when fertilisation happens in utero is also not high. Four in every five embryos conceived naturally are lost. Furthermore, the progesterone-only mini-pill—the preferred contraceptive of some women—does not suppress release of the egg as do other forms of the contraceptive pill. Instead, this particular pill inhibits fertilised eggs from implanting in a woman's womb.

In nature, the majority of fertilised eggs do not go on to become humans, and to see every zygote or blastocyst as having the full moral status of a human being does not, to my mind, make sense. If all were given the same status as humans, I am not sure, for a start, how we would address the issue of naturally wasted blastocysts. Of course we do not, and those who argue the humanness of the fertilised ovum conveniently turn a blind eye to this inconvenient fact. That is not to say that I am denying that a blastocyst—or a pre-embryo, if you like—is bereft of moral status. On the contrary, I believe that it does have a moral status and it should be treated with a level of respect that befits that status.

However, the moral status of the pre-embryo is not absolute. In fact, it is particularly fluid. Take, for example, two common examples which are in many ways the same but, by virtue of a particular set of circumstances, each instance is considered very differently, resulting in the different moral status of the pre-embryo involved.

In one example, a couple who are not trying to get pregnant do fall pregnant but, after conception, the fertilised egg miscarries. The couple may not even know what has happened and do not grieve. The other instance is a couple trying desperately to conceive. They also manage to

conceive naturally but, soon after conception, they miscarry. One case is a tragedy; one case is not. In one case, a potential life is grieved for and, in the other, it is not; it is not even known about.

On either side of the debate, I do not think that the reactions of the two couples I have described would be viewed as anything other than normal. Because of the very specific set of circumstances in each case, the pre-embryo is given very different moral status.

The other argument often conjured up is the 'slippery slope' argument, one which is very emotive and is used to stir up images reminiscent of Huxley's *Brave New World*. It is also completely nonsensical. This argument centres around the idea that, if we allow this legislation (or something like it) through this parliament, we will suddenly lose control of scientists. We will face a world where ethics cease to matter, as out-of-control researchers experiment in more diabolical scenarios. I have just one question: why? Why would passing this legislation suddenly suggest that all controls that parliaments have enjoyed over societies would suddenly disappear?

As I have stated, this is a very tightly prescribed piece of legislation which clearly states what is and what is not allowed. As parliamentarians, we will continue to monitor what happens and respond as it does happen.

By its very nature, scientific research is about exploring the unknown. If we already knew the results, it would not be research at all. I understand that looking into the unknown can be challenging but, for progress to occur, we cannot shy away from exploration. Risk is inherent in all that we do but, by acknowledging those risks—as this legislation does—we are able to manage them.

Before I finish, I wish to remind members that this legislation is not addressing conditions in which an egg has been fertilised by sperm. Quite plainly, this legislation deals with something quite different—a research embryo created through the manipulation of egg cells in a Petri dish, with no involvement of sperm. Are we suggesting that this could have the same moral status as a fertilised embryo resulting from the joining of an egg and a sperm? On reflection, I think probably not.

Dr Lawrence Goldstein, Professor of Cellular and Molecular Medicine at the University of California, put it quite plainly:

> The embryos in question are simple clusters or balls of cells that have been generated within a dish in a lab, have never been in a woman's body, and are thus not pregnancies or foetuses. Such embryos are at a developmental stage before any organs such as the heart or nervous system have yet formed and are capable of being frozen or thawed—not typical attributes of 'people' as most of us define them.

And I agree with that summary. Because I accept this analysis of the pre-embryo, because I believe we have an ethical duty to pursue medical research that may lead to treatments and, hopefully, cures for so many debilitating diseases and conditions that currently affect so many people, and because I believe the stringent ethical guidelines mandated in this legislation provide appropriate respect for pre-embryos, I will be supporting this bill. I commend this legislation to the chamber and will celebrate its passage through this council.

Debate adjourned on motion of Hon. J.S.L. Dawkins.

MENTAL HEALTH BILL

Received from the House of Assembly and read a first time.

The Hon. G.E. GAGO (Minister for State/Local Government Relations, Minister for the Status of Women, Minister for Consumer Affairs, Minister for Government Enterprises, Minister Assisting the Minister for Transport, Infrastructure and Energy) (17:55): I move:

> That this bill be now read a second time.

I seek leave to have the second reading explanation inserted in *Hansard* without my reading it.

Leave granted.

> A world class mental health system depends on an effective legislative framework to ensure that society can fulfil its obligation to care for individuals with serious mental illness. There is an expectation in the community, and an obligation on the part of government, that where a person is unable to make an informed decision about their own mental health and welfare, and they are vulnerable or pose a risk to others, intervention can take place to ensure they obtain the assessment, treatment and care that is necessary.
>
> The *Mental Health Bill 2008* is designed to replace the *Mental Health Act 1993* and provide a contemporary framework for the provision of services to people with serious mental illness who are either unwilling or unable to consent to their own treatment.

To ensure that our mental health legislation is based on up to date knowledge and research and contemporary standards, a thorough review of the *Mental Health Act 1993* and related legislation was undertaken. This review commenced in August 2004 and was chaired by Mr Ian Bidmeade, Legal Policy Consultant and Solicitor.

The terms of reference for the review focussed on the extent to which South Australia's legislation provided a framework for the management of mental health issues for individuals in a manner consistent with contemporary standards.

The report of the committee's findings, 'Paving the Way-Review of Mental Health Legislation in South Australia April 2005' (the Report) was released for public comment by the Department of Health at the end of May 2005.

The Report was distributed to approximately 500 stakeholders and the recommendations received significant support.

The Report proposed a number of changes to modernise the legislation and improve responses to people with mental illness. These included:

- the need for a clearer articulation of the rights of people using mental health services and carers;
- greater emphasis on community care, not just hospital or institutional care;
- recognition of the particular circumstances of children;
- acknowledging the unique cultural perspective of Aboriginal and Torres Strait Islander people.

A majority of the changes recommended in the Report were supported by the Government and in December 2006 Cabinet approved the drafting of a Bill for a new mental health Act. The Report recommended the establishment of a Mental Health Tribunal to hear appeals currently heard by the Guardianship Board and the Administrative and Disciplinary Division of the District Court. The Government does not believe the establishment of a Mental Health Tribunal is necessary. Some of the issues regarding the hearing of appeals can be remedied through amendment of the *Guardianship and Administration Act 1993* which the Government is progressing.

In October 2007 a draft *Mental Health Bill* was released for public comment. Fifty-five written submissions were received through to late December 2007. This process resulted in further refinements to the Bill.

The Government would like to thank publicly all of the individuals and organisations who participated in this process, and who have taken the time to formally submit a response to the review, or participate in subsequent consultation. Their input has been of immense value in developing this Bill. I am confident that the comprehensive consultation process has ensured the Government has been able to address key concerns, and their efforts will result in legislation which is clear in its focus while retaining a degree of flexibility.

I would also like to acknowledge the significant contribution former mental health advocate and review and reference group committee member, the late Trevor Parry, made to ensuring mental health legislation and services have become more effectively focussed on the people who use our services. Trevor was passionate about ensuring a balance between any new provisions for early intervention with additional safeguards and supports for people who become subject to involuntary treatment, and this Bill achieves that balance.

The *Mental Health Bill 2008* incorporates provisions which bring South Australia into line with contemporary approaches to the management of serious mental health issues and includes innovations designed to assist people to obtain assistance in a manner which aims to minimise the extent to which their freedom is curtailed and to protect their rights.

The long title for the Bill states that it is a Bill for 'An Act to make provision for the treatment, care and rehabilitation of persons with serious mental illness…'. This Bill is primarily about the use of powers to treat people with serious mental illness against their will and provides for the checks, balances and protections necessary for the transparent and accountable exercise of these powers. The objects of the Bill were refined following consultation and include to ensure that people with serious mental illness retain their freedom, rights, dignity and self-respect as far as is consistent with their protection, the protection of the public and the proper delivery of mental health services designed to bring about their recovery as far as is possible.

Most people with a mental illness are never subject to an order which requires them to have treatment. They are treated by their general practitioner, psychologist or possibly a psychiatrist, willingly seeking and obtaining treatment. The Bill which is before you today is designed to provide a framework for providing care and treatment, while protecting the rights of the small minority of people who are unwilling to accept treatment even though they may be placing their own safety or the safety of others in jeopardy. Research indicates that one in five or twenty percent of Australian adults will be affected by mental illness at some time in their life. Three percent will be seriously affected. It is primarily the three percent of the population who suffer from a major mental illness which seriously affects them that this Bill is concerned with.

The *Mental Health Bill 2008* contains a set of principles which are designed to provide guidance to all persons and bodies involved in the administration of the Act. The following principles are included in the Bill:

mental health services should be designed to bring about the best therapeutic outcomes for patients, and, as far as possible, their recovery and participation in community life;

the services should be provided on a voluntary basis as far as possible, and otherwise in the least restrictive way and in the least restrictive environment that is consistent with their efficacy and public safety,

and at places as near as practicable to where the patients, or their families or other carers or supporters, reside;

the services should—

- be governed by comprehensive treatment plans that are developed in a multi-disciplinary framework in consultation with the patients (including children) and their family or other carers or supporters; and
- take into account the different developmental stages of children and young persons and the needs of the aged; and
- take into account the different cultural backgrounds of patients; and
- in the case of patients of Aboriginal or Torres Strait Islander descent, take into account the patients' traditional beliefs and practices and, when practicable and appropriate, involve collaboration with health workers and traditional healers from their communities;
- there should be regular medical examination of every patient's mental and physical health and regular medical review of any order applying to the patient;
- children and young persons should be cared for and treated separately from other patients as necessary to enable the care and treatment to be tailored to their different developmental stages;
- the rights, welfare and safety of the children and other dependants of patients should always be considered and protected as far as possible;
- medication should be used only for therapeutic purposes or safety reasons and not as a punishment or for the convenience of others;
- mechanical body restraints and seclusion should be used only as a last resort for safety reasons and not as a punishment or for the convenience of others;
- patients (together with their family or other carers or supporters) should be provided with comprehensive information about their illnesses, any orders that apply to them, their legal rights, the treatments and other services that are to be provided or offered to them and what alternatives are available;
- information should be provided in a way that ensures as far as practicable that it can be understood by those to whom it is provided.

I will now go on to discuss the key provisions of the Bill.

The *Mental Health Bill 2008* recognises the role of carers to ensure they can provide the best possible care and support to a person with a mental illness. The Bill includes a definition of a carer and refers to carers in the guiding principles as a category of people to whom information about the illness, any orders that apply, legal rights and the treatment and other services available to the person being cared for is to be given. The provisions regarding confidentiality and disclosure of information enable information to be disclosed to a carer, relative or friend of the person subject to an order if the disclosure is reasonably required for the treatment, care or rehabilitation of the person, and there is no reason to believe that the disclosure would be contrary to the person's best interests. If a person is subject to a Community Treatment Order or a Detention and Treatment Order, information reasonably required for their treatment, care or rehabilitation may be shared, despite their opposition to this. These provisions overcome the barriers identified by the Bidmeade review regarding the sharing of information. Carers, professionals and some of the people who use the services who were consulted as part of the Bidmeade review all expressed concern that information necessary for the appropriate care and treatment of a person was not able to be shared. The *Mental Health Bill 2008* clarifies that information can be shared with the consent of the person concerned, or with a carer, relative or friend as described.

The *Mental Health Act 1993* has been identified as lacking a sufficient focus on the rights of individuals using mental health services. The Bill, in contrast, articulates a number of rights for both voluntary and involuntary patients, as well as their carers, which are not included in the *Mental Health Act 1993*. These include:

- Providing a copy of orders and a statement of rights to a guardian, medical agent, relative, carer or friend of the patient nominated by the patient for the purpose, as well as to the patient;
- Providing for the use of interpreters where available and appropriate;
- Entitling the patient to have another person's support;
- Entitling the patient to communicate with people outside of the treatment centre;
- Enabling information reasonably required for the treatment, care or rehabilitation of the person to be shared with a relative, carer or friend of the patient, where such disclosure is not contrary to the person's best interest;
- The right to a comprehensive treatment and care plan and to input into the plan for patients and their carers or other persons providing support to them.

In recognition of the different and broader concept of mental health in Aboriginal and Torres Strait Islander and Torres Strait Islander culture, the Bill establishes as a principle that services should take into account the

patient's traditional beliefs and practices, and when practicable and appropriate, services should involve collaboration with Aboriginal and Torres Strait Islander health workers and traditional healers. The definition of relative used in the Bill recognises traditional Aboriginal and Torres Strait Islander kinship rules for determining who is a relative.

The Bill enables the Minister to determine that a specified place will be a Limited Treatment Centre for the purposes of the Act. This provision will enable some country hospitals which are suitably equipped, to be declared Limited Treatment Centres. This will enable them to detain and treat a person, if they meet the criteria for the order, for up to 7 days on a level 1 Detention and Treatment Order, rather than having to transport the person to Adelaide. During the 7 day period the illness may resolve itself. These provisions will be of benefit to all South Australians who live in country areas and, in particular, to Aboriginal and Torres Strait Islander people.

If further detention and treatment is deemed necessary, the person should be transferred to an Approved Treatment Centre. Currently the metropolitan public hospitals and 2 private hospitals are approved treatment centres and it is not anticipated that this will change in the immediate future.

The *Mental Health Act 1993* does not contain provisions especially directed at children. The *Mental Health Bill 2008* includes express provision about the application of the Act to children and includes a number of provisions designed to protect children's interests. These include principles that children and young people would be cared for and treated separately from other patients to enable the care to be tailored to their developmental stages and that the rights, safety and welfare of children and other dependants of patients should always be considered and protected as far as possible. The latter principle is designed to ensure that the needs of children and young people are considered and responded to when either or both of their parents have a serious mental illness. While it is not appropriate to include specific provisions for how the children of patients should be treated in the Bill, this principle will provide guidance to mental health and other staff dealing with children in specific circumstances. It is proposed that the Department of Health undertake a review of the current practices regarding the children of patients to ensure that their needs are being adequately addressed.

The Bill provides additional protections and safeguards for children under 18 but recognises that a child of 16 may consent to their own treatment, in line with the *Consent to Medical Treatment and Palliative Care Act 1995.* The long term orders on which a child may be placed, an infrequent occurrence, are shorter than those for adults and require more frequent review. These provisions are designed to provide greater protection for children.

The Bidmeade review recommended that provisions for electro-convulsive therapy (ECT) should be separate from the provisions for the other, much less commonly used treatments, the use of which is regulated by mental health legislation. This has been done. The Bill includes a requirement that consent, either by or on behalf of the patient, or by the Board, can only be given for a maximum of 12 episodes of ECT in a maximum period of 3 months. The use of ECT without consent is allowed in an emergency, however the psychiatrist administering the treatment in these circumstances must advise the Chief Psychiatrist of their actions within one working day. This requirement will enable the provision of emergency ECT to be monitored.

The term psychosurgery in the current Act has been changed to neurosurgery in the Bill. Psychosurgery is more tightly controlled than ECT and is currently unable to be performed if the patient cannot consent in writing. In practice, this part of the Act has never been used in South Australia. The Bill retains the requirement that neurosurgery has to be authorised by the person who will carry it out and 2 psychiatrists (at least one of whom is a senior psychiatrist), and the patient has to give written consent. If the patient is unable to consent, the Guardianship Board can do so. These provisions retain significant protection for patients but recognise that someone who may benefit from neurosurgery for mental illness is often unable to consent. Enabling the Guardianship Board to consent is designed to assist patients who may benefit from this treatment to obtain it.

The criteria for compulsory intervention for the purpose of mental health care and treatment are a critical component of any mental health legislation as they determine when an individual's wishes can be overridden, and assessment and treatment provided compulsorily. The criteria for detention under the current Act are that:

- the person has a mental illness that requires immediate treatment; and
- such treatment is available in an approved treatment centre; and
- the person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety or for the protection of other persons.

The concept of 'health and safety' has proved problematic in practice, often setting the threshold for intervention too high to include people who are obviously deteriorating but have not yet reached the point where both their health and safety are compromised. The criteria included in the Bill for the issue of a Community Treatment Order or Detention and Treatment Order have been developed after giving close consideration to the review's recommendation, the United Nations Principles for the Protection of Persons with Mental Illness, the Model Mental Health Legislation agreed to by the Australian Health Ministers' Council and submissions received during the consultation period. The criteria for both forms of order require decisions that:

- the person has a mental illness; and
- because of the mental illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
- there is no less restrictive means than the particular form of order in question for ensuring appropriate treatment of the person's mental illness.

The intent of the criteria for intervention in the *Mental Health Bill 2008* is to ensure that a person who needs a specialist psychiatric assessment will receive one. The intent is to broaden the basis for obtaining an order. In line with the recommendations of the 'Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau' (Palmer Report), initial orders for both detention and community treatment can be made where it 'appears' to the medical practitioner or authorised health professional that the person has a mental illness. This is a lower threshold than in the current Act where even a medical practitioner who makes a first order, not only a psychiatrist who confirms an order, has to be satisfied the person has a mental illness.

This set of criteria is also intended to address the problems identified by Australian researchers of mental health law. According to their research, mental health laws which place the emphasis on involuntary intervention only when persons are assessed as dangerous to themselves or others result in poorer outcomes for these people. They convincingly argue that placing the emphasis on the dangerousness of the person often results in the period of time between the first onset of the mental illness, usually psychosis including schizophrenia, and the time at which the illness is diagnosed and treated, being longer than necessary. This delay in receiving treatment can lead to a poorer prognosis for the patient and potentially homicide.

Recent data from both New South Wales and the United Kingdom show that the risk of a patient committing homicide during their first psychotic episode is in the order of one in 500 new cases. In contrast, the annual risk of homicide by patients who have received treatment is only about one in 10000 per year. The researchers note that the lethal assault was usually preceded by frightening delusional beliefs and most of the victims were family members or close associates. Only 15 per cent of victims were strangers.

It would be remiss of me not to point out that most people with a mental illness are not violent and that patients with psychosis are not generally violent once they have been treated and can be safely managed in the community. However it is now clear that untreated psychosis in particular can lead to violence and that mental health law in general, and the criteria for involuntary intervention in particular, can reduce this risk. The greatest risk of potential harm for people with mental illness arises from the potential for suicide if they are not treated. The suicide rate for people with a mental illness is up to one in 10 compared to an average of one in 100 for the whole population. The criteria in the Bill place the emphasis on the person's need for treatment with the aim of ensuring that patients who need an assessment and treatment will fall within the new legislative scheme. Enabling people to obtain an early assessment, and treatment if required, is designed to reduce the risk of both suicide and homicide arising from untreated illness.

Part 9 of the Bill enables 'authorised officers' to transport a person who appears to have a mental illness. This is in line with a 2006 Australian Labor Party election promise that mental health staff would be given the powers to do their jobs and police would be used where there was a danger involved.

Authorised officers are defined by the Bill as mental health clinicians, ambulance officers, and specific staff of the Royal Flying Doctor Service. Within this part of the Bill 'authorised officers' and police officers have broadly similar powers. The differences in powers are that some authorised officers, that is, specific ambulance and Royal Flying Doctor Service staff, will be legally able to chemically restrain a person under the provisions of the *Controlled Substances Act 1984*, while a police officer, unlike an authorised officer, will be able to break into premises under certain circumstances. These provisions are not new provisions, merely a clearer articulation of existing powers.

Currently, the Mental Health Emergency Services Memorandum of Understanding between the Department of Health, South Australian Ambulance Services, the South Australian Police and the Royal Flying Doctor Service signed in June 2006 provides a framework and specific guidance to staff transporting people with a mental illness. The Bill refers to the Memorandum of Understanding and states that authorised officers, police officers and other persons engaged in the administration of this measure should endeavour to comply with it. It is planned that the Memorandum of Understanding will be updated prior to the new Act coming into force. Practices, driven by the Memorandum of Understanding, are already consistent with the intentions of the Bill and have resulted in the safe transportation of people with mental illness. Police are no longer involved in inter-hospital transfers. The current *Mental Health Act 1993* lacks clarity regarding the power of various professionals to transport a person with a mental illness. The Bill and the Memorandum of Understanding clarify that in the main, responsibility for transporting people with a mental illness rests with health staff, however when there is a danger, assessed in line with agreed methods of risk assessment, then the police will be there to assist.

Recent reforms of mental health legislation in other Australian States and Territories have emphasised the 'treatment plan' as crucial to proper treatment, incorporating the involvement of both community services and hospitals as appropriate. The Bidmeade review argues that the treatment plan is the cornerstone of compulsory orders for treatment in the community or involuntary inpatient treatment, with the plans being individualised, multidisciplinary and comprehensive, not just focussing on medication.

Consistent with a focus on recovery from mental illness, treatment plans provide the means for clearly articulating the purpose of compulsory mental health orders and how treatment and care will be undertaken. The treatment plan, referred to as a treatment and care plan in the Bill to reflect the multidisciplinary nature of these plans, will specify the elements which are compulsory, for example, medication, and those which are voluntary, for example, counselling. While a treatment plan is a desirable component of a contemporary approach to the treatment of mental illness, the *Mental Health Bill 2008* does not allow the absence of a treatment plan as grounds for an appeal against an order. This is to encourage a comprehensive approach to treatment and care plans rather than a minimalist or token approach simply to be able to demonstrate compliance with a legislative requirement.

Organisations representing the interests of patients and their carers have welcomed the requirement for treatment and care plans in the Bill and their involvement in the development of such plans. Since the requirement for treatment plans was prescribed in legislation in Victoria, reportedly all patients have treatment plans and, there has been a significant increase in constructive dialogue and interaction between service providers and service users.

The most significant change in the provision of mental health services in the last century has been the development of care in the community. Facilitated by the development of new drugs to treat psychosis, including schizophrenia, and other major mental illnesses, care in the community has enabled the majority of people with a serious mental illness to remain in the community rather than being detained. This minimises the extent to which a person's freedom is limited while ensuring access to appropriate treatment.

The current Act enables only the Guardianship Board to make a Community Treatment Order. It is entirely appropriate for the Guardianship Board to continue to make longer term orders for community treatment or detention and treatment and it is pointed out that the Guardianship Board's role in making Community Treatment Orders on receipt of an application remains unchanged. It is expected that in most cases Community Treatment Orders will result from applications made to the Guardianship Board.

However, currently, Community Treatment Orders are generally made only after a person has deteriorated to the point where they have been hospitalised. The general trend in mental health legislation nationally is for orders similar to Community Treatment Orders to be available as a first treatment option if appropriate for a particular person at a particular time. This is also consistent with the principle, contained in the Bill that services are to be provided in the least restrictive environment and the least restrictive way that is consistent with their efficacy and public safety.

To prevent the present situation whereby a patient is often admitted as an inpatient, prior to a Community Treatment Order being made, the *Mental Health Bill 2008* enables medical practitioners or a few highly skilled and trained authorised health professionals to be able to make a level 1 Community Treatment Order for up to 28 days to facilitate early access to care and treatment if appropriate. The order must be confirmed by a psychiatrist or authorised medical practitioner within 24 hours or as soon as practicable.

The process used for the Board's review of a level 1 Community Treatment Order will, in fact, be similar to a Board hearing that is currently set up on receipt of an application by the Board for the Board's consideration of whether a Community Treatment Order should be made as only the Board can make a level 2 Community Treatment Order for up to 12 months.

Community Treatment Orders enable early intervention to occur with the aim of reducing the severity and impact of the mental illness. A level 1 order will be able to be made relatively quickly rather than taking up to 14 days for a hearing of the Guardianship Board as is the case at present. The current Act is also somewhat contradictory in enabling a person to be detained for up to 3 days by a medical practitioner, subject to confirmation of the order, but requiring the authority of the Guardianship Board for them to be treated in the community.

The criteria for both Community Treatment Orders and Detention and Treatment Orders contain common elements and the requirement that the order is the least restrictive means of ensuring appropriate treatment of the person's illness will mean that in appropriate cases a Community Treatment Order is made. This provision aligns with national and international approaches to managing serious mental illness.

The Chief Psychiatrist has a responsibility to ensure that a mental health clinician is responsible for monitoring compliance with the order which is aimed at preventing people falling through the cracks if they move to another area or even interstate. Rather than focussing narrowly on medication and medical treatment like the current Act, it is contemplated that a broader range of services will be included in a treatment and care plan under a Community Treatment Order.

In contrast to the other States and Territories, with the exception of Tasmania, the *Mental Health Act 1993* only allows a medical practitioner to make an order for detention and treatment. The Bill enables 'authorised health professionals' as well as medical practitioners to make both Community Treatment Orders and Detention and Treatment Orders. It is planned that 'authorised health professionals' will be a few individuals with advanced skills, knowledge and training in mental health. There will also be a code of practice to ensure that authorised health professionals appropriately discharge their responsibilities.

Currently, the power to confirm an order is restricted to a psychiatrist. The *Mental Health Bill 2008* enables psychiatrists and 'authorised medical practitioners' to confirm an order. An authorised medical practitioner will be a person who has undertaken several years of psychiatric training at a reputable training institution and has considerable psychiatric experience. These people will be selected by the Minister, on the advice of the Chief Psychiatrist.

The Bill, unlike the current Act, makes it clear that audio-visual conferencing can be used as the basis for making, confirming, extending, reviewing and revoking orders. This will reduce the need for people from remote areas to be transported to Adelaide for an assessment if they can be appropriately and safely examined via audio-visual conferencing.

The timeframes for involuntary treatment, particularly detention and treatment in the *Mental Health Bill 2008* have been adjusted to more accurately correspond with the actual patterns of many mental illnesses and reflect a number of safeguards including specialist psychiatric and Board reviews. In contrast to the current Act all orders will expire at 2pm on a business day rather than at midnight.

The particular needs of children are addressed by provisions for shorter orders and more frequent reviews.

Patients can appeal at any time against any order and legal representation for appeals will continue to be provided. A range of people may make an application to the Board for a variation or revocation of a long term Community Treatment Order or a Detention and Treatment Order, both of which are made by the Board.

The *Mental Health Bill 2008* provides additional safeguards for people in receipt of mental health services. The position of Chief Psychiatrist will replace the existing position of a Chief Advisor in Psychiatry. The Chief

Psychiatrist will have the authority to monitor and review the performance of mental health services with a focus on promoting continuous improvement and issue standards to apply in the treatment of patients.

The current Act is silent regarding the issue of how interstate orders apply in South Australia and how South Australian orders apply interstate and the current regulations deal only with transfer to and from the Northern Territory. The Bill deals with these matters in a comprehensive fashion. A Ministerial Agreement will be negotiated with the other States and Territories, on an individual basis. These agreements will provide greater clarity for all parties regarding the inter-state management of people on mental health orders.

Concerns were raised during consultation about the potential for patients not yet subject to an order for detention or treatment to be transferred long distances interstate for mental health examination and it was suggested that a requirement to transfer patients to the nearest facility should be imposed. It would, of course, be problematic to impose hard and fast rules given the need to consider multiple means of transport and routes and the many factors that properly affect a decision on the most appropriate facility for a person in need of mental health care in the particular circumstances.

The Bill includes a guiding principle that 'services should be provided...' at places as near as practicable to where the patients, or their families or other carers or supporters reside' and it is the intention that these new provisions should reduce the distances that people have to travel for a mental health examination.

The Bill also requires that, in circumstances where action is being taken in accordance with a Ministerial Agreement, the action may only be taken if it is in the best interests of the patient or person concerned. Prudent administration will require records to be kept of the basis on which the action is taken. A decision to transfer a patient interstate will be made by the Chief Psychiatrist and an appeal against this decision may be made to the Guardianship Board by the patient or a range of other people.

The *Mental Health Bill 2008* provides reforms which will complement the Government's recently announced $107.9 million mental health reform package to implement the Social Inclusion Board's recommendations. This reform package comprised funding for:

- 90 intermediate care beds;
- 73 supported accommodation places;
- 6 new community mental health centres;
- the employment of 8 new mental health nurse practitioners in the country;
- the establishment of a priority access service for about 800 people with chronic and complex needs, including those with drug and alcohol problems, a history of homelessness or who may be involved in the criminal justice system;
- the provision of non clinical community based support services by non-government organisations; and
- the establishment of an early intervention service for young people experiencing their first episode of psychosis.

The Social Inclusion Board also made recommendations about how care should be delivered in the future. The centre piece of their reforms was the stepped model of care which contains the following graduating steps:

- support across the community, including community mental health centres and care and support provided by non-government organisations
- 24-hour supported accommodation;
- community recovery centres;
- intermediate care beds;
- acute care beds; and
- secure care beds.

The Bill recognises the provision of care in the community to assist people leaving acute mental health facilities or to provide a place for early intervention. As a subset of the new stepped care system, the Government has already commenced the process of establishing community recovery centres and opened the first 20 bed centre at Mile End in June 2007. The second, the Trevor Parry Centre, was opened in January 2008 and the third facility at Playford opened in June 2008.

As a further commitment to mental health reform, the Government released the Glenside Concept Master Plan in September 2007 which outlined the development of the Glenside Campus into a new world-class 129 bed hospital for mental illness and substance abuse called: 'SA Specialist Health Services' that will comprise:

- 40 secure rehabilitation beds;
- 6 mother and infant acute beds;
- 23 rural and remote acute beds;
- 20 acute adult beds;

- 10 psychiatric intensive care beds;
- 30 drug and alcohol acute beds.

In anticipation of the Bill's provisions for early access to care and treatment, a new Mental Health Triage Service commenced operation in December 2007, providing for a single entry point and emergency response across Adelaide in partnership with SA Ambulance Service.

The broad definition of mental illness has been retained in the Mental Health Bill in response to the Coroner's concerns that people should not be denied access to services, including short term intervention in a crisis, on the basis of diagnosis. The Government's capital works program is replacing old and outmoded facilities with new inpatient mainstream facilities such as the Margaret Tobin Centre at the Flinders Medical Centre, the Repatriation General Hospital Aged Care Centre, a new 50 bed facility at Lyell McEwin Health Service which is due for completion in late 2009 and a new 40 bed secure forensic mental health centre at Mobilong.

The Bill acknowledges traditional healers and recognises the cultural values and practices of Aboriginal people and the Government is working in partnership with Aboriginal Health Services to improve service access for Aboriginal people.

The importance of partnership cannot be over-emphasised. For example, it is partnership that underpinned the RAISE Wellbeing Program in Port Augusta between Pika Wiya Health Service and the local specialist mental health service that won a Margaret Tobin Award in 2006.

The Child and Adolescent Mental Health Service has commenced a visiting service to the APY Lands. The visiting team is comprised of a psychiatrist and a social worker. A number of services are provided on the Lands through the Nganampa Health Council and there are 2 Anangu men working in the APY Lands Men's Health Program which provides cultural and social, emotional wellbeing support for men at risk of mental health issues.

Housing resources for Aboriginal people with a mental illness who are homeless or at risk of becoming so are located in Adelaide, Port Augusta, Ceduna, Port Pirie, Port Lincoln, Whyalla, Berri, Murray Bridge, Mount Gambier and Coober Pedy.

The Australian Government is providing capital funding for a substance misuse facility for the APY Lands and the SA Government will provide recurrent funding to run the facility. A mobile drug and alcohol outreach service is currently operating on the APY Lands.

In line with the Bill's provisions for care in the community and in partnering with non-government organisations, the State Government is undertaking a training initiative for the non-government mental health sector to support the development of its workforce and build up its capacity to deliver high quality services. The Government has also provided funding to NGOs to enhance their governance arrangements as well as for the development of quality standards. These initiatives form part of a broader capacity building program to improve services to people with mental illness.

The Bill recognises the role of informal, unpaid, family carers as partners with service providers in providing care and treatment for people with mental illness. In line with the *Carers Recognition Act 2005*, carers have choices and the Bill provides for the appropriate sharing of information with carers who care for a person with a mental illness who is subject to an order.

The Government values the important role that carers play and provides support funding for mental health carer respite and other support programs. A number of carer organisations receive funding from the Government.

The Australian Government is also rolling out a number of programs through the Council of Australian Governments National Action Plan on Mental Health 2006-2011. With the inclusion of the recent reforms and infrastructure initiatives, including the Glenside redevelopment, in the 2008-09 State Budget, the amount committed as part of the Council of Australian Governments National Action Plan on Mental Health 2006-11 is now $344 million. It should also be noted that a number of Australian Government funded services arising from the National Action Plan are now being provided in South Australia. Some of these service programs include Personal Helpers and Mentors, Support for Day to Day Living and Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule.

Most of the $107.9 million for the Social Inclusion Board Report initiatives, is over four years (2007-08 to 2010-11). An allocation of $600,000—of the $18.2 million—for intermediate care, will be spent in the fifth year (2011-12) and $13.84 million of the $25.92 million for the community mental health centres will be spent over years five and six, that is, until 2012-13.

The *Mental Health Bill 2008* and the service initiatives I have described will provide a modernised legislative framework and integrated service system to ensure that society can fulfil its obligation to care for individuals with serious mental illness.

I commend the Bill to Members.

Explanation of Clauses

Part 1—Preliminary

1—Short title

2—Commencement

These clauses are formal.

3—Interpretation

This clause sets out the terms that are defined for the purposes of the measure.

The Board is the Guardianship Board established under the *Guardianship and Administration Act 1993*.

Mental illness is given a general definition—any illness or disorder of the mind. Schedule 1 sets out conduct that will not on its own be taken to indicate mental illness.

Prescribed psychiatric treatment is defined as ECT or neurosurgery for mental illness or any other treatment declared by the regulations to be prescribed psychiatric treatment.

4—Application of Act to children

This clause provides that the measure applies to children in the same way as to persons of full age, subject to the following:

- in the case of a child under 16 years of age, a right conferred on a person may be exercised by a parent of guardian of the child on behalf of the child;
- an obligation to give a document to a person is, if the person is a child under 16 years of age, to be treated as an obligation to give the document to a parent or guardian of the child, and operates to the exclusion of any further obligation to send or give the document to a guardian, medical agent, relative, carer or friend.

5—Medical examinations by audio-visual conferencing

This clause makes provision for medical examinations to be conducted by audio-visual conferencing if it is not practicable in the circumstances for the medical practitioner or authorised health professional to carry out an examination of the person in the person's physical presence.

Part 2—Objects and guiding principles

6—Objects

The objects of the measure are—

- to ensure that persons with serious mental illness—
- receive a comprehensive range of services of the highest standard for their treatment, care and rehabilitation with the goal of bringing about their recovery as far as is possible; and
- retain their freedom, rights, dignity and self-respect as far as is consistent with their protection, the protection of the public and the proper delivery of the services; and
- for that purpose, to confer appropriately limited powers to make orders for community treatment, or detention and treatment, of such persons where required.

7—Guiding principles

The Minister, the Board, the Chief Psychiatrist, health professionals and other persons and bodies involved in the administration of the measure are to be guided by specified principles in the performance of their functions.

These are as follows:

- mental health services should be designed to bring about the best therapeutic outcomes for patients, and, as far as possible, their recovery and participation in community life;
- the services should be provided on a voluntary basis as far as possible, and otherwise in the least restrictive way and in the least restrictive environment that is consistent with their efficacy and public safety, and at places as near as practicable to where the patients, or their families or other carers or supporters, reside;
- the services should—
- be governed by comprehensive treatment and care plans that are developed in a multi-disciplinary framework in consultation with the patients (including children) and their family or other carers or supporters; and
- take into account the different developmental stages of children and young persons and the needs of the aged; and
- take into account the different cultural backgrounds of patients; and
- in the case of patients of Aboriginal or Torres Strait Islander descent, take into account the patients' traditional beliefs and practices and, when practicable and appropriate, involve collaboration with health workers and traditional healers from their communities;
- there should be regular medical examination of every patient's mental and physical health and regular medical review of any order applying to the patient;
- children and young persons should be cared for and treated separately from other patients as necessary to enable the care and treatment to be tailored to their different developmental stages;

- the rights, welfare and safety of the children and other dependants of patients should always be considered and protected as far as possible;
- medication should be used only for therapeutic purposes or safety reasons and not as a punishment or for the convenience of others;
- mechanical body restraints and seclusion should be used only as a last resort for safety reasons and not as a punishment or for the convenience of others;
- patients (together with their family or other carers or supporters) should be provided with comprehensive information about their illnesses, any orders that apply to them, their legal rights, the treatments and other services that are to be provided or offered to them and what alternatives are available;
- information should be provided in a way that ensures as far as practicable that it can be understood by those to whom it is provided.

Part 3—Voluntary patients

8—Voluntary patients

This clause provides that a person may be admitted as a voluntary patient in a treatment centre at his or her own request and that such a person may leave the centre at any time unless a detention and treatment order then applies to the person.

9—Voluntary patients to be given statement of rights

This clause provides that the Director of a treatment centre must ensure that a voluntary patient in the centre is given a written statement of rights informing the patient of his or her legal rights and containing any other information prescribed by the regulations.

The clause ensures that various measures are taken in circumstances where a patient is unable to read or otherwise comprehend the statement and that the director must cause a copy of the statement of rights to be sent or given to a guardian, medical agent, relative, carer or friend of the patient as soon as practicable.

Part 4—Orders for treatment of persons with mental illness

Division 1—Level 1 community treatment orders

10—Level 1 community treatment orders

This clause provides that a medical practitioner or authorised health professional may make an order for the treatment of a person (a *level 1 community treatment order)* if it appears to the medical practitioner or authorised health professional, after examining the person, that—

- the person has a mental illness; and
- because of the mental illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
- there are facilities and services available for appropriate treatment of the illness; and
- there is no less restrictive means than a community treatment order of ensuring appropriate treatment of the person's illness.

A level 1 community treatment order, unless earlier revoked, expires at a time fixed in the order which must be 2pm on a business day not later than 28 days after the day on which it is made.

Subclause (4) provides that if a level 1 community treatment order is made by a person other than a psychiatrist or authorised medical practitioner, the following provisions apply:

- a psychiatrist or authorised medical practitioner must examine the patient within 24 hours;
- if it is not practicable to examine the patient within that period, a psychiatrist or authorised medical practitioner must examine the patient as soon as practicable thereafter;
- after completing the examination, the psychiatrist or authorised medical practitioner may confirm the level 1 community treatment order if satisfied that the grounds referred to above exist for the making of a level 1 community treatment order, but otherwise must revoke the order.

A level 1 community treatment order may be varied or revoked at any time by a psychiatrist or authorised medical practitioner who has examined a patient to whom the order applies.

Confirmation, variation or revocation of a level 1 community treatment order must be effected by written notice in the form approved by the Minister.

11—Board and Chief Psychiatrist to be notified of level 1 orders or their variation or revocation

This clause provides that a psychiatrist or authorised medical practitioner making, confirming, varying or revoking a level 1 community treatment order must ensure that the Board and the Chief Psychiatrist are each sent or given, within 1 business day, a written notice in the form approved by the Minister.

Receipt of the notice provided must be acknowledged in writing by the Registrar of the Board and the Chief Psychiatrist respectively within 1 business day.

12—Copies of level 1 orders, notices and statements of rights to be given to patients etc

A medical practitioner or authorised health professional making a level 1 community treatment order must ensure that the patient is given, as soon as practicable, a copy of the order.

A medical practitioner or authorised health professional making a level 1 community treatment order must ensure that the patient is given a written statement of rights informing the patient of his or her legal rights and containing any other information prescribed by the regulations.

The clause ensures that various measures are taken in circumstances where a patient is unable to read or otherwise comprehend the statement and that the medical practitioner or authorised health professional must cause a copy of the statement of rights to be sent or given to a guardian, medical agent, relative, carer or friend of the patient as soon as practicable.

Subclause (5) provides that if a level 1 community treatment order is varied or revoked, the psychiatrist or authorised medical practitioner varying or revoking the order must—

- ensure that the patient is given, as soon as practicable, a copy of the notice of variation or revocation of the order; and
- cause a copy of the notice of variation or revocation to be sent or given to a guardian, medical agent, relative, carer or friend of the patient as soon as practicable.

13—Treatment of patients to whom level 1 orders apply

A patient to whom a level 1 community treatment order applies may be given treatment for his or her mental illness of a kind authorised by a psychiatrist or authorised medical practitioner who has examined the patient. Such authorisation is not required if a medical practitioner considers that—

- the nature of the patient's mental illness is such that the treatment is urgently needed for the patient's well-being; and
- in the circumstances it is not practicable to obtain that authorisation.

Treatment may be given under this clause despite the absence or refusal of consent to the treatment.

This clause does not apply to prescribed psychiatric treatment (as defined by clause 3), or to prescribed treatment within the meaning of the *Guardianship and Administration Act 1993*.

14—Chief Psychiatrist to ensure monitoring of compliance with level 1 orders

This clause provides that the Chief Psychiatrist must, after receiving notice of the making of a level 1 community treatment order, ensure that there is a mental health clinician who has ongoing responsibility for monitoring and reporting to the Chief Psychiatrist on the patient's compliance with the order.

15—Board to review level 1 orders

This clause requires that the Board review a level 1 community treatment order as soon as practicable after receiving notice of the order and before the order expires and enables the Board to conduct a review in any manner it considers appropriate.

The Board must, on a review of a level 1 community treatment order, revoke the order unless satisfied that grounds exist for a level 2 community treatment order to be made.

Division 2—Level 2 community treatment orders

16—Level 2 community treatment orders

This clause provides that the Board may make an order for a level 2 community treatment order if satisfied as to the matters set out as the grounds for a level 1 community treatment order.

Subclause (2) provides that a level 2 community treatment order may be made in respect of a person—

- on an application to the Board for the Board's decision as to whether it should make a community treatment order in respect of the person (whether or not a level 1 community treatment order has been made in respect of the person); or
- on a review by the Board of a level 1 community treatment order that applies to the person; or
- on an application to the Board for the revocation of a level 3 detention and treatment order that applies to the person.

Subclause (3) specifies the persons who may make an application to the Board for the Board's decision as to whether it should make a community treatment order in respect of a person. The persons specified for the purpose of subclause (3) may also make an application for a variation or revocation of a level 2 community treatment order.

Subclause (6) provides that the Board may, on application, by order, vary or revoke a level 2 community treatment order at any time.

17—Chief Psychiatrist to be notified of level 2 orders or their variation or revocation

The Registrar of the Board is required to ensure that the Chief Psychiatrist is notified, within 1 business day, of the making, variation or revocation of a level 2 community treatment order by the Board.

18—Treatment of patients to whom level 2 orders apply

Under this clause, a patient to whom a level 2 community treatment order applies may be given treatment for his or her mental illness of a kind authorised by a psychiatrist or authorised medical practitioner who has examined the patient.

Authorisation is not required for treatment if a medical practitioner considers that—

- the nature of the patient's mental illness is such that the treatment is urgently needed for the patient's well-being; and
- in the circumstances it is not practicable to obtain that authorisation.

Treatment may be given under this clause despite the absence or refusal of consent to the treatment.

This clause does not apply to prescribed psychiatric treatment (as defined by clause 3), or to prescribed treatment within the meaning of the *Guardianship and Administration Act 1993*.

19—Chief Psychiatrist to ensure monitoring of compliance with level 2 orders

Under this clause, the Chief Psychiatrist must ensure that for each patient to whom a level 2 community treatment order applies there is a mental health clinician who has ongoing responsibility for monitoring and reporting to the Chief Psychiatrist on the patient's compliance with the order.

Part 5—Orders for detention and treatment of persons with mental illness

Division 1—Non-compliance with community treatment orders and making of detention and treatment orders

20—Non-compliance with community treatment orders and making of detention and treatment orders

This clause provides that a person's refusal or failure to comply with a community treatment order is a relevant consideration in deciding whether a detention and treatment order should be made in respect of the person under this Part.

However, nothing in the measure is to prevent the making of a detention and treatment order under this Part in respect of a person without a prior community treatment order having been made in respect of the person if a detention and treatment order is required in the particular circumstances.

Division 2—Level 1 detention and treatment orders

21—Level 1 detention and treatment orders

This clause provides that a medical practitioner or authorised health professional may make an order for the treatment of a person (a *level 1 detention and treatment order)* if it appears to the medical practitioner or authorised health professional, after examining the person, that—

- the person has a mental illness; and
- because of the mental illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
- there is no less restrictive means than a detention and treatment order of ensuring appropriate treatment for the person's illness.

The clause also sets out the form in which the order must be made.

A level 1 detention and treatment order, unless earlier revoked, expires at a time fixed in the order which must be 2pm on a business day not later than 7 days after the day on which it is made.

On the making of a level 1 detention and treatment order, the following provisions apply:

- the patient must be examined by a psychiatrist or authorised medical practitioner, who must, if the order was made by a psychiatrist or authorised medical practitioner, be a different psychiatrist or authorised medical practitioner;
- the examination must occur within 24 hours of the making of the order;
- if it is not practicable for the examination to occur within that period, it must occur as soon as practicable thereafter;
- after completion of the examination, the psychiatrist or authorised medical practitioner may confirm the level 1 detention and treatment order if satisfied that the grounds referred to above exist for the making of a level 1 detention and treatment order, but otherwise must revoke the order.

A medical practitioner or authorised health professional may form an opinion about a person under subclause (1) or (4) based on his or her own observations and any other available evidence that he or she considers reliable and relevant (which may include evidence about matters occurring outside the State).

A psychiatrist or authorised medical practitioner who has examined a patient to whom a level 1 detention and treatment order applies may revoke the order at any time.

Confirmation or revocation of a level 1 detention and treatment order must be effected by written notice in the form approved by the Minister.

22—Board and Chief Psychiatrist to be notified of level 1 orders or their revocation

This clause provides that a psychiatrist or authorised medical practitioner making, confirming, or revoking a level 1 detention and treatment order must ensure that the Board and the Chief Psychiatrist are each sent or given, within 1 business day, a written notice in the form approved by the Minister.

Receipt of the notice must be acknowledged in writing by the Registrar of the Board and the Chief Psychiatrist respectively within 1 business day.

23—Copies of level 1 orders, notices and statements of rights to be given to patients etc

A medical practitioner or authorised health professional making a level 1 detention and treatment order must ensure that the patient is given, as soon as practicable, a copy of the order.

A medical practitioner or authorised health professional making a level 1 detention and treatment order must ensure that the patient is given a written statement of rights informing the patient of his or her legal rights and containing any other information prescribed by the regulations.

The clause ensures that various measures are taken in circumstances where a patient is unable to read or otherwise comprehend the statement and that the director of a treatment centre in which a patient is first detained under a level 1 detention and treatment order must cause a copy of the order and statement of rights to be sent or given to a guardian, medical agent, relative, carer or friend of the patient as soon as practicable.

Subclause (5) provides that if a level 1 detention and treatment order is revoked, the director of the treatment centre in which the patient is detained must—

- ensure that the patient is given, as soon as practicable, a copy of the notice of revocation of the order; and
- cause a copy of the notice of revocation to be sent or given to a guardian, medical agent, relative, carer or friend of the patient as soon as practicable.

24—Treatment of patients to whom level 1 orders apply

A patient to whom a level 1 detention and treatment order applies may be given treatment for his or her mental illness or any other illness of a kind authorised by a psychiatrist or authorised medical practitioner who has examined the patient.

Subclause (2) provides that the treatment may be given despite the absence or refusal of consent to the treatment.

This clause does not apply to prescribed psychiatric treatment (as defined by clause 3), or to prescribed treatment within the meaning of the *Guardianship and Administration Act 1993*. The administration of prescribed psychiatric treatment (as defined by clause 3) is governed by Part 7 of the measure.

If a medical practitioner authorises treatment of a patient to whom a level 1 detention and treatment order applies that is treatment of a kind prescribed by the regulations, the medical practitioner must ensure that the Chief Psychiatrist is sent or given, within 1 business day, a written notice in the form approved by the Minister.

Division 3—Level 2 detention and treatment orders

25—Level 2 detention and treatment orders

This clause provides that if a level 1 detention and treatment order has been made or confirmed by a psychiatrist or authorised medical practitioner under Division 2, a psychiatrist or authorised medical practitioner may, after further examination of the patient carried out before the order expires, make a further order for the detention and treatment of the patient (a *level 2 detention and treatment order)*.

A psychiatrist or authorised medical practitioner may make a level 2 detention and treatment order if satisfied as to the matters set out as the grounds for a level 1 detention and treatment order.

Subclause (3) provides that a psychiatrist or authorised medical practitioner may form an opinion about a person based on his or her own observations and any other available evidence that he or she considers reliable and relevant (which may include evidence about matters occurring outside the State).

The clause also sets out the form in which the order must be made.

A level 2 detention and treatment order, unless earlier revoked, expires at a time fixed in the order which must be 2pm on a business day not later than 42 days after the day on which it is made.

A psychiatrist or authorised medical practitioner who has examined a patient to whom a level 2 detention and treatment order applies may revoke the order at any time.

Revocation of a level 2 detention and treatment order must be effected by written notice in the form approved by the Minister.

26—Notices and reports relating to level 2 orders

This clause provides that a psychiatrist or authorised medical practitioner making or revoking a level 2 detention and treatment order must ensure that the Board and the Chief Psychiatrist are each sent or given, within 1 business day, a written notice in the form approved by the Minister.

Receipt of the notice must be acknowledged in writing by the Registrar of the Board and the Chief Psychiatrist respectively within 1 business day.

Subclause (4) provides that a psychiatrist or authorised medical practitioner making a level 2 detention and treatment order must, as soon as practicable, provide the director of the approved treatment centre in which the patient is or is to be detained under the order with a written report of the results of his or her examination of the patient and of the reasons for making the order.

On receiving a report under subclause (4), the director must forward a copy of the report to the Board.

27—Copies of level 2 orders and notices to be given to patients etc

A psychiatrist or authorised medical practitioner making a level 2 detention and treatment order must ensure that the patient is given, as soon as practicable, a copy of the order.

A psychiatrist or authorised medical practitioner making a level 2 detention and treatment order must ensure that the patient is given a written statement of rights informing the patient of his or her legal rights and containing any other information prescribed by the regulations.

The clause ensures that various measures are taken in circumstances where a patient is unable to read or otherwise comprehend the statement and that the director of a treatment centre in which a patient is first detained under a level 2 detention and treatment order must cause a copy of the order and statement of rights to be sent or given to a guardian, medical agent, relative, carer or friend of the patient as soon as practicable.

Subclause (5) provides that if a level 2 detention and treatment order is revoked, the director of the treatment centre in which the patient is detained must—

- ensure that the patient is given, as soon as practicable, a copy of the notice of revocation of the order; and
- cause a copy of the notice of revocation to be sent or given to a guardian, medical agent, relative, carer or friend of the patient as soon as practicable.

28—Treatment of patients to whom level 2 orders apply

A patient to whom a level 2 detention and treatment order applies may be given treatment for his or her mental illness or any other illness of a kind authorised by a medical practitioner who has examined the patient.

Subclause (2) provides that the treatment may be given despite the absence or refusal of consent to the treatment.

This clause does not apply to prescribed psychiatric treatment (as defined by clause 3), or to prescribed treatment within the meaning of the *Guardianship and Administration Act 1993*. The administration of prescribed psychiatric treatment (as defined by clause 3) is governed by Part 7 of the measure.

If a medical practitioner authorises treatment of a patient to whom a level 2 detention and treatment order applies that is treatment of a kind prescribed by the regulations, the medical practitioner must ensure that the Chief Psychiatrist is sent or given, within 1 business day, a written notice in the form approved by the Minister.

Division 4—Level 3 detention and treatment orders

29—Level 3 detention and treatment orders

Proposed section 29 provides that the Board may make an order that a person be detained and receive treatment in an approved treatment centre (a level 3 detention and treatment order) if satisfied as to the matters set out as the grounds for a level 1 or level 2 detention and treatment order.

A level 3 detention and treatment order may be made, on application, in respect of a person to whom a level 2 or level 3 detention and treatment order applies.

Subclause (6) provides that the Board may, on application, by order, vary or revoke a level 3 detention and treatment order at any time.

30—Chief Psychiatrist to be notified of level 3 orders or their variation or revocation

The Registrar of the Board must ensure that the Chief Psychiatrist is notified, within 1 business day, of the making, variation or revocation of a level 3 detention and treatment order by the Board.

31—Treatment of patients to whom level 3 orders apply

A patient to whom a level 3 detention and treatment order applies may be given treatment for his or her mental illness or any other illness of a kind authorised by a medical practitioner who has examined the patient.

Subclause (2) provides that the treatment may be given despite the absence or refusal of consent to the treatment.

This clause does not apply to prescribed psychiatric treatment (as defined by clause 3), or to prescribed treatment within the meaning of the *Guardianship and Administration Act 1993*. The administration of prescribed psychiatric treatment (as defined by clause 3) is governed by Part 7 of the measure.

If a medical practitioner authorises treatment of a patient to whom a level 3 detention and treatment order applies that is treatment of a kind prescribed by the regulations, the medical practitioner must ensure that the Chief Psychiatrist is sent or given, within 1 business day, a written notice in the form approved by the Minister.

Division 5—General

32—Detention and treatment orders displace community treatment orders

This clause provides that if a detention and treatment order is made in respect of a person to whom a community treatment order applies and the community treatment order is not revoked, the requirements of the community treatment order do not apply for the period of operation of the detention and treatment order (and if the community treatment order remains in force at the end of that period, the requirements of the order will apply again according to their terms).

33—Duty of director of treatment centre to comply with detention and treatment orders

This clause provides that if a person to whom a detention and treatment order applies is in the care and control of treatment centre staff and a detention and treatment order is made in respect of a voluntary patient in a treatment centre, subject to clause 35, the director of the treatment centre must—

- if the person is not already admitted to the centre, admit the person to the centre; and
- comply with the detention and treatment order.

34—Powers required for carrying detention and treatment orders into effect

This clause provides that treatment centre staff may exercise, in relation to a patient to whom a detention and treatment order applies who is present at, or has been admitted to, the centre, any power (including the power to use reasonable force) that is reasonably required—

- for carrying the order into effect; or
- for the maintenance of order and security at the centre or the prevention of harm or nuisance to others.

35—Transfer of patients to whom detention and treatment orders apply

A patient to whom detention and treatment orders applies may be transferred to another treatment centre if the director of a treatment centre considers it is necessary or appropriate, after first arranging with the director of the other centre for the patient's admission to that centre.

Subclause (2) states that the director of a treatment centre in which a patient has been detained may give a direction—

- for the patient to be transferred to a hospital, or between hospitals, in circumstances where the patient has or has had an illness other than a mental illness, after first arranging with the person in charge of the relevant hospital for the patient's admission to the hospital;
- for the patient's transfer back to the treatment centre after completion of the hospital treatment.
- If a patient to whom a detention and treatment order applies has been transferred to a hospital as a result of a direction under this clause—
- the patient is, while in the care and control of staff of the hospital to be taken to continue in the care and control of the treatment centre staff; and
- staff of the hospital may exercise the powers conferred by clause 34 in relation to the patient as if they were treatment centre staff.

The clause requires that a direction must be given in writing and that specified persons must be notified of a direction.

36—Leave of absence of patients detained under detention and treatment orders

This clause provides that the director of a treatment centre may, by written notice in the form approved by the Minister and subject to any conditions that the director considers appropriate, grant a patient detained in the centre leave of absence from the centre for any purpose and period that the director considers appropriate and specifies in the notice.

A copy of the notice by which the patient is granted leave of absence must be given to the patient before the patient commences the leave.

37—Persons granted leave of absence to be given statement of rights

The clause states that the director of a treatment centre who grants a patient detained in the centre leave of absence from the centre must ensure that the patient is given, before the patient commences the leave, a written statement of rights—

- informing the patient of his or her legal rights; and
- containing any other information prescribed by the regulations.

The clause ensures that various measures are taken in circumstances where a patient is unable to read or otherwise comprehend the statement and that the director must cause a copy of the statement of rights to be sent or given to a guardian, medical agent, relative, carer or friend of the patient as soon as practicable.

38—Cancellation of leave of absence

The director of a treatment centre may, by notice in the form approved by the Minister, cancel any leave of absence from the centre granted to a patient under this Division.

Part 6—Treatment and care plans

39—Treatment and care plans for voluntary patients

This clause requires that the treatment and care of a voluntary patient in a treatment centre must, as far as practicable, be governed by a treatment and care plan directed towards the recovery of the patient.

The treatment and care plan—

- must describe the treatment and care that will be provided to the patient at the treatment centre and should describe any rehabilitation services and other significant services that will be provided or available to the patient at the treatment centre or following the person's discharge from the centre; and
- must, as far as practicable, be prepared and revised in consultation with the patient and any guardian, medical agent, relative, carer or friend of the patient who is providing support to the patient.

40—Treatment and care plans for patients to whom community treatment orders apply

This clause requires that the treatment and care of a patient to whom a level 2 community treatment order applies must, as far as practicable, be governed by a treatment and care plan directed towards the recovery of the patient.

The treatment and care plan—

- must describe the treatment and care that will be provided to the patient under the requirements of the order and should describe any rehabilitation services and other significant services that will be provided or available to the patient under the requirements of the order or through the patient's voluntary participation; and
- must, as far as practicable, be prepared and revised in consultation with the patient and any guardian, medical agent, relative, carer or friend of the patient who is providing support to the patient.

41—Treatment and care plans for patients to whom detention and treatment orders apply

This clause requires that the treatment and care of a patient to whom a level 2 or level 3 detention and treatment order applies must, as far as practicable, be governed by a treatment and care plan directed towards the recovery of the patient.

The treatment and care plan—

- must describe the treatment and care that will be provided to the patient while in detention at the approved treatment centre and should describe any rehabilitation services and other significant services that will be provided or available to the patient while in detention at the treatment centre or following the person's discharge from the centre; and
- must, as far as practicable, be prepared and revised in consultation with the patient and any guardian, medical agent, relative, carer or friend of the patient who is providing support to the patient.

Part 7—Regulation of prescribed psychiatric treatments

Division 1—ECT

42—ECT

Under this clause, ECT (electro-convulsive therapy) must not be administered to a patient unless—

- the patient has a mental illness; and
- ECT, or a course of ECT, has been authorised for treatment of the illness by a psychiatrist who has examined the patient; and
- written consent to the treatment has been given—
- by or on behalf of the patient; or
- if the patient is under 16 years of age or consent cannot be given by or on behalf of the patient—by the Board on application under this clause.

Subclause (2) limits consent to a course of ECT to a maximum of 12 episodes of ECT and a maximum period of 3 months, and any second or subsequent course of ECT for a patient must be separately consented to after the commencement or completion of the preceding course.

ECT administered to a patient in order to determine the correct dose for future episodes of ECT in a course of treatment must be counted as a single episode of ECT in that course of treatment for the purposes of this clause.

Consent to the administration of ECT extends to the administration of anaesthetics required for the purposes of the ECT treatment.

Under subclause (6), consent to a particular episode of ECT is not required if a psychiatrist considers that—

- the patient has a mental illness of such a nature that administration of that particular episode of ECT is urgently needed for the patient's well-being; and
- in the circumstances it is not practicable to obtain that consent.
- Notice of the administration of an episode of ECT to a patient without consent in reliance on subclause (6) must be sent or given to the Chief Psychiatrist, within 1 business day—
- advising the Chief Psychiatrist of that action; and
- containing any other information prescribed by the regulations.

Subclause (8) makes it an offence to contravene subclause (1).

Division 2—Neurosurgery for mental illness

43—Neurosurgery for mental illness

This clause provides that despite any other Act or law, neurosurgery must not be carried out on a patient as a treatment for mental illness unless—

- the patient has a mental illness; and
- the neurosurgery has been authorised for treatment of the illness by the person who is to carry it out and by 2 psychiatrists (at least 1 of whom is a senior psychiatrist), each of whom has separately examined the patient; and
- the patient is of or over 16 years of age and written consent to the treatment has been given—
- by the patient; or
- if consent cannot be given by the patient—by the Board on application under this clause.

An application for the Board's consent under this clause may be made by a medical practitioner or mental health clinician.

Subclause (3) makes it an offence to contravene subclause (1).

Division 3—Other prescribed psychiatric treatments

44—Other prescribed psychiatric treatments

This clause provides that the regulations may regulate the administration of any prescribed psychiatric treatment (other than ECT or neurosurgery) by imposing requirements for prior authorisations or consents (or both).

Part 8—Further protections for persons with mental illness

45—Assistance of interpreters

This clause states that if—

- a medical practitioner or authorised health professional intends to conduct an examination of a person for the purposes of the measure; and
- the person is unable to communicate adequately in English but could communicate adequately with the assistance of an interpreter,
- the medical practitioner or authorised health professional must arrange for a competent interpreter to assist during the examination of the person.

46—Copies of Board orders, decisions and statements of rights to be given

This clause provides that the Registrar of the Board must ensure that the patient is given, as soon as practicable after the making by the Board of an order or decision in respect of the patient, a copy of the order or decision and a written statement of rights informing the patient of his or her legal rights and containing any other information prescribed by the regulations.

The clause ensures that various measures are taken in circumstances where a patient is unable to read or otherwise comprehend the statement and that a copy of the order or decision and statement of rights are sent or given to a guardian, medical agent, relative, carer or friend of the patient as soon as practicable.

47—Patients' right to be supported by guardian etc

This clause provides that a patient is entitled to have another person's support, wherever practicable, in—

- the exercise of a right under the measure; or
- any communications between the patient and a medical practitioner examining or treating the patient or between the patient and the director or staff of a treatment centre in which the patient is treated or detained.

48—Patients' right to communicate with others outside treatment centre

Subclause (1) ensures that a patient in a treatment centre is entitled to—

- communicate with persons outside the centre; and
- receive visitors at the centre; and
- be afforded reasonable privacy in his or her communications with others,
- subject to any restrictions and conditions that have been approved by the Director of the centre as being reasonably required for carrying into effect any detention and treatment order that applies to the patient or for the maintenance of order and security at the centre or the prevention of harm or nuisance to others.

Subclause (2) provides that no restrictions or conditions are to be applied under this clause to communications by post between a patient in a treatment centre and any of the following, or to visits to a patient by any of the following:

- the Minister;
- the Board;
- the Public Advocate;
- the Chief Psychiatrist;
- the Health and Community Services Complaints Commissioner within the meaning of the *Health and Community Services Complaints Act 2004*;
- a member of Parliament;
- a legal practitioner (in the practitioner's professional capacity);
- a person representing, or acting on behalf of, a person or body referred to in any of the preceding paragraphs;
- a person of a class prescribed by the regulations.

49—Neglect or ill-treatment

This clause provides that a person having the oversight, care or control of a patient who ill-treats or wilfully neglects the patient is guilty of an offence.

Part 9—Powers relating to persons who have or appear to have mental illness

50—Issuing of patient transport requests

This clause provides that a patient transport request may be issued in respect of a patient as follows:

- if a community treatment order applies to the patient and the patient has not complied with the requirements of the order, a medical practitioner or mental health clinician may issue the request for the purpose of the patient's transport for treatment in accordance with the order;
- if a medical practitioner or authorised health professional has made a level 1 detention and treatment order in respect of the patient at a place other than a treatment centre, the medical practitioner or authorised health professional may issue the request for the purpose of the patient's transport to a treatment centre;
- if the patient is a patient at large, the director of a treatment centre, a medical practitioner or mental health clinician may issue the request for the purpose of the patient's transport to a treatment centre;
- if a detention and treatment order applies to the patient and the director of a treatment centre has given a direction for the transfer of the patient under Part 5 Division 5 to another treatment centre or hospital, the director may issue the request for the purpose of the patient's transport to the other treatment centre or hospital.

51—Powers of authorised officers relating to persons who have or appear to have mental illness

This clause sets out the powers of an authorised officer if—

- an authorised officer believes on reasonable grounds that the person is a patient in respect of whom a patient transport request has been issued; or

- an authorised officer believes on reasonable grounds that the person is a patient at large; or
- it appears to an authorised officer that—
- the person has a mental illness; and
- the person has caused, or there is a significant risk of the person causing, harm to himself or herself or others or property or the person otherwise requires medical examination.

The following powers may be exercised:

- the authorised officer may take the person into his or her care and control;
- the authorised officer may transport the person from place to place;
- the authorised officer may restrain the person and otherwise use force in relation to the person as reasonably required in the circumstances;
- the authorised officer may restrain the person by means of the administration of a drug when that is reasonably required in the circumstances (and authorised under the *Controlled Substances Act 1984*);
- the authorised officer may enter and remain in a place where the authorised officer reasonably suspects the person may be found;
- the authorised officer may search the person's clothing or possessions and take possession of anything in the person's possession that the person may use to cause harm to himself or herself or others or property.

The clause sets out that an officer who takes a person into his or her care and control must, as soon as practicable—

- in the case of a patient in respect of whom a patient transport request has been issued—transport the person, or arrange for the person to be transported by some other authorised officer or by a police officer, in accordance with the patient transport request; or
- in the case of a patient at large—transport the person, or arrange for the person to be transported by some other authorised officer or by a police officer, to a treatment centre; or
- in the case of a person requiring medical examination—transport the person, or arrange for the person to be transported by some other authorised officer or by a police officer, to a treatment centre or other place for medical examination.

52—Powers of police officers relating to persons who have or appear to have mental illness

This clause sets out the powers of a police officer if—

- a police officer believes on reasonable grounds that the person is a patient in respect of whom a patient transport request has been issued; or
- a police officer believes on reasonable grounds that the person is a patient at large; or
- it appears to a police officer that—
- the person has a mental illness; and
- the person has caused, or there is a significant risk of the person causing, harm to himself or herself or others or property; and
- the person requires medical examination.

The clause provides police officers with similar powers to authorised officers, although the powers do not apply to a patient in respect of whom a patient transport request has been issued unless the person has subsequently become a patient at large. An additional power is provided to use reasonable force to break into a place when that is reasonably required in order to take the person into care and control.

The clause also provides that if a police officer has arrested or apprehended a person, the person may, despite any other law, be released from police custody for medical examination or treatment under the measure.

53—Officers may assist each other

This clause spells out that authorised officers and police officers may assist each other in the exercise of powers under the measure.

54—Roles of various officers

This clause contemplates a memorandum of understanding between relevant agencies about the respective roles of authorised officers and police officers.

55—Offence to hinder etc officer

This clause makes it an offence to hinder or obstruct an authorised officer or police officer in the exercise of powers under the measure.

Part 10—Arrangements between South Australia and other jurisdictions

Division 1—Preliminary

56—Interpretation

This clause contains definitions for the purposes of this Part.

57—Ministerial agreements

This clause contemplates intergovernmental agreements relating to the administration of this Part and corresponding laws of other jurisdictions.

58—Requests or approvals relating to actions involving other jurisdictions

The purpose of this clause is to ensure that action is only taken if it is contemplated by the relevant intergovernmental agreement, has been requested or approved by the relevant officer and is in the best interests of the patient or person in respect of whom the action is to be taken.

59—Powers of South Australian officers under corresponding laws or Ministerial agreement

This is a formal provision accepting any conferral of jurisdiction on South Australian officers by a corresponding law.

60—Regulations may modify operation of Part

Flexibility is provided to enable the regulations to adjust the arrangements as necessary to fit in with the law of a particular jurisdiction.

Division 2—Community treatment orders

61—South Australian community treatment orders and treatment in other jurisdictions

This clause enables a South Australian patient to receive treatment under a South Australian community treatment order at an interstate treatment centre.

62—Powers of interstate officers

For the purposes of ensuring compliance with an interstate community treatment order, interstate officers are authorised to exercise powers in South Australia (except any power of forcible entry).

63—Interstate community treatment orders and treatment in South Australia

This clause covers the situation where an interstate community treatment order requires the person to receive treatment in South Australia. The interstate order is to be complied with as if it were a South Australian order on the same terms.

64—Making of South Australian community treatment orders when interstate orders apply

The Chief Psychiatrist is able, under this clause, to make a South Australian community treatment order mirroring an interstate community treatment order for a person who is now in South Australia without the need for a separate medical examination. Such an order is to be regarded as if it were a level 1 community treatment order.

Division 3—Transfer to or from South Australian treatment centres

65—Transfer from South Australian treatment centres

This clause deals with the transfer to an interstate treatment centre of a patient detained in or at large from a South Australian treatment centre at the direction of the director of the South Australian treatment centre, with the approval of the Chief Psychiatrist.

66—Transfer to South Australian treatment centres

This clause deals with the acceptance in a South Australian treatment centre of a patient detained in or at large from an interstate treatment centre. The patient is to be regarded as subject to a level 1 detention and treatment order.

67—Patient transport requests

This clause provides for the issuing of patient transport requests where there has been patient transfer under the Division.

68—Powers when patient transport request issued

This clause ensures that authorised officers have appropriate powers in relation to a patient for whom a patient transport request has been issued.

Division 4—Transport to other jurisdictions

69—Transport to other jurisdictions when South Australian detention and treatment orders apply

This clause deals with the situation where a South Australian detention and treatment order has been issued but the person is to be admitted to an interstate treatment centre.

70—Transport to other jurisdictions of persons with apparent mental illness

This clause provides for the situation where a South Australian officer has taken into his or her care and control a person who appears to have a mental illness and to require medical examination but the person is to be assessed interstate.

71—Transport to other jurisdictions when interstate detention and treatment orders apply

This clause covers the situation where a South Australian officer believes on reasonable grounds that a person in South Australia is an interstate patient at large. The person—

- may be taken into the care and control of a South Australian authorised officer;
- may be transported to an interstate treatment centre by a South Australian authorised officer;
- may be delivered by a South Australian authorised officer into the care and control of an interstate authorised officer (whether in or outside South Australia) for the purpose of the person's transport to an interstate treatment centre;
- may be taken to a South Australian treatment centre by a South Australian authorised officer and detained there pending the person's transport to an interstate treatment centre;
- may be given treatment for his or her mental illness or any other illness in South Australia, without any requirement for the person's consent, as authorised by a medical practitioner who has examined the patient.

The clause also gives interstate officers powers to deal with the person if found in South Australia.

Division 5—Transport to South Australia

72—Transport to South Australia when South Australian detention and treatment orders apply

This clause provides for the transport of a patient back to South Australia if the patient is at large from a South Australian treatment centre and found interstate.

73—Transport to South Australia of persons with apparent mental illness

This clause covers the situation where a person to be assessed for mental illness has been taken into care and control outside the State but the person is to be assessed in South Australia.

Part 11—Reviews and appeals

Division 1—Reviews

74—Reviews

The Board may conduct a review of an order or treatment as it considers appropriate and is required to conduct the following reviews:

- a review of the circumstances involved in the making and revocation of a level 1 community treatment order if the order was not reviewed by the Board before its revocation (which review must be conducted as soon as practicable after the revocation of the order);
- a review of a level 2 community treatment order that has been made in respect of a child and continues to apply to the person 3 months after the making of the order (which review must be conducted as soon as practicable after the end of the period of 3 months);
- a review of the circumstances involved in the making of a level 1 detention and treatment order if the order has been made within 7 days after the expiry or revocation of a previous detention and treatment order applying to the same person (which review must be conducted as soon as practicable after the making of the level 1 detention and treatment order);
- a review of a level 3 detention and treatment order that has been made in respect of a child and continues to apply to the person 3 months after the making of the order (which review must be conducted as soon as practicable after the end of the period of 3 months);
- any review that is required under the regulations.

75—Decisions and reports on reviews

The Board is required to revoke an order if not satisfied that there are proper grounds for it to remain in operation and may otherwise affirm, vary or revoke an order or make an order for review of a treatment and care plan. The Board is authorised to draw particular matters to the attention of the Minister.

Division 2—Appeals

76—Appeals to Board against orders (other than Board orders)

The following persons may appeal against an order to the Board:

- the person to whom the order applies;
- the Public Advocate;
- a guardian, medical agent, relative, carer or friend of the person to whom the order applies;

- any other person who satisfies the Board that he or she has a proper interest in the matter.

77—Operation of orders pending appeal

The Board may suspend or vary the operation of an order pending an appeal.

78—Appeals to Board against transfer to interstate treatment centre

The following persons may appeal against a direction for the transfer of a patient to an interstate treatment centre:

- the person to whom the order applies;
- the Public Advocate;
- a guardian, medical agent, relative, carer or friend of the person to whom the order applies;
- any other person who satisfies the Board that he or she has a proper interest in the matter.

79—Representation on appeals to Board

This clause provides for entitlement to legal representation and for the provision of legal representation.

80—Appeals to District Court and Supreme Court

The *Guardianship and Administration Act 1993* provides for appeal from Board decisions.

Part 12—Administration

Division 1—Minister and Chief Executive

81—Minister's functions

This clause provides that the Minister is to have the following functions for the purposes of the measure:

- to encourage and facilitate the involvement of persons who currently have, or have previously had, a mental illness, their carers and the community in the development of mental health policies and services;
- to develop or promote a strong and viable system of treatment and care, and a full range of services and facilities, for persons with mental illness;
- to develop or promote ongoing programmes for optimising the mental health of children and young persons who are or have been under the guardianship or in the custody of the Minister pursuant to the *Children's Protection Act 1993*;
- to develop or promote services that aim to prevent mental illness and intervene early when mental illness is evident;
- to ensure that information about mental health and mental illness is made available to the community and to promote public awareness about mental health and mental illness;
- to develop or promote appropriate education and training programmes, and effective systems of accountability, for persons delivering mental health services;
- to promote services in the non-government sector that are designed to assist persons with mental illness;
- to develop or promote programmes to reduce the adverse impact of mental illness on family and community life;
- any other functions assigned to the Minister by the measure.

82—Delegation by Minister

This clause provides for delegation of Ministerial functions and powers.

83—Delegation by Chief Executive

This clause provides for delegation of the Chief Executive's functions and powers.

Division 2—Chief Psychiatrist

84—Chief Psychiatrist

The Governor is to appoint a senior psychiatrist as Chief Psychiatrist.

85—Chief Psychiatrist's functions

The Chief Psychiatrist is to have the following functions:

- to promote continuous improvement in the organisation and delivery of mental health services in South Australia;

- to monitor the treatment of voluntary patients and patients to whom detention and treatment orders apply, and the use of mechanical body restraints and seclusion in relation to such patients;
- to monitor the administration of the measure and the standard of psychiatric care provided in South Australia;
- to advise the Minister on issues relating to psychiatry and to report to the Minister any matters of concern relating to the care or treatment of patients;
- any other functions assigned to the Chief Psychiatrist by the measure or any other Act or by the Minister.

The Chief Psychiatrist may, with the approval of the Minister, issue standards that are to be observed in the care or treatment of patients.

86—Delegation by Chief Psychiatrist

This clause provides for delegation of the Chief Psychiatrist's functions and powers.

Division 3—Authorised medical practitioners

87—Authorised medical practitioners

This clause provides for the Minister to make determinations as to the persons who will be authorised medical practitioners for the purposes of the measure.

Division 4—Authorised health professionals

88—Authorised health professionals

This clause provides for the Minister to make determinations as to the persons who will be authorised health professionals for the purposes of the measure.

89—Code of practice for authorised health professionals

The Minister may approve or endorse a code of practice governing the exercise of powers by authorised health professionals.

Division 5—Treatment centres

90—Approved treatment centres

This clause provides for the Minister to make determinations as to the places that will be approved treatment centres for the purposes of the measure.

91—Limited treatment centres

This clause provides for the Minister to make determinations as to the places that will be limited treatment centres for the purposes of the measure.

92—Register of patients

The director of a treatment centre is required to keep certain records about patients.

93—Particulars relating to admission of patients to treatment centres

This clause is designed to ensure that any person who has a proper interest in the matter can determine whether a particular person has been or is detained in a treatment centre. The clause also requires information to be provided to the person detained.

94—Delegation by directors of treatment centres

This clause provides for delegation of the functions and powers of a director of a treatment centre.

Part 13—Miscellaneous

95—Errors in orders etc

This clause is designed to ensure that non-substantive defects in orders, notices and instruments do not render them invalid.

96—Offences relating to authorisations and orders

This clause establishes offences for medical practitioners, authorised health professionals and others in relation to the giving of authorisations or the making of orders.

97—Medical practitioners or health professionals not to act in respect of relatives

Medical practitioners and authorised health professionals are not able to act in respect of any of their relatives.

98—Removing patients from treatment centres

This clause makes it an offence to remove a patient who is being detained in a treatment centre from the centre, or to aid such a patient to leave the centre.

99—Confidentiality and disclosure of information

Personal information obtained by a person in the administration of the measure is not to be disclosed except as authorised or required by the Chief Executive or in the circumstances set out in subclause (2).

Under subclause (2) information may be disclosed—

- as required by law, or as required for the administration of this measure or a law of another State or a Territory of the Commonwealth; or
- at the request, or with the consent, of the person to whom the information relates or a guardian or medical agent of the person; or
- to a relative, carer or friend of the person to whom the information relates if—
- the disclosure is reasonably required for the treatment, care or rehabilitation of the person; and
- there is no reason to believe that the disclosure would be contrary to the person's best interests; or
- subject to the regulations (if any)—
- to a health or other service provider if the disclosure is reasonably required for the treatment, care or rehabilitation of the person to whom the information relates; or
- by entering the information into an electronic records system established for the purpose of enabling the recording or sharing of information in or between persons or bodies involved in the provision of health services; or
- to such extent as is reasonably required in connection with the management or administration of a hospital or SA Ambulance Service Inc (including for the purposes of charging for a service); or
- if the disclosure is reasonably required to lessen or prevent a serious threat to the life, health or safety of a person, or a serious threat to public health or safety; or
- for medical or social research purposes if the research methodology has been approved by an ethics committee and there is no reason to believe that the disclosure would be contrary to the person's best interests; or
- in accordance with the regulations.

100—Prohibition of publication of reports of proceedings

This clause makes it an offence to publish a report on proceedings under the measure except as authorised by the Board.

101—Requirements for notice to Board or Chief Psychiatrist

This clause makes it an offence for a medical practitioner to fail to send or give a notice to the Board or the Chief Psychiatrist as required.

102—Evidentiary provisions

This clause provides evidentiary aids for the purposes of legal proceedings.

103—Regulations

This clause provides general regulation making power.

Schedule 1—Certain conduct may not indicate mental illness

This clause sets out certain conduct that is not to be regarded on its own as being indicative of mental illness. It is based on the United Nations principles for the protection of persons with mental illness and for the improvement of mental health care and similar provisions appear in the corresponding New South Wales legislation.

Schedule 2—Repeal and transitional provisions

1—Repeal of *Mental Health Act 1993*

The *Mental Health Act 1993* is repealed.

2—Transitional provisions

This clause includes appropriate transitional provisions relating to orders, authorisations, consents and proceedings under the current legislation.

Debate adjourned on motion of Hon. D.W. Ridgway.

PUBLIC SECTOR MANAGEMENT (CONSEQUENTIAL) AMENDMENT BILL

Received from the House of Assembly and read a first time.

CROWN LAND MANAGEMENT BILL

Received from the House of Assembly and read a first time.

At 17:58 the council adjourned until Tuesday 3 March 2009 at 14:15.