MENTAL HEALTH BILL 2013

Committee

Resumed from 10 September. The Chair of Committees (Hon Adele Farina) in the chair; Hon Helen Morton (Minister for Mental Health) in charge of the bill.

Clause 4: Terms used —

Progress was reported on the following amendment moved by Hon Helen Morton —

Page 4, lines 16 and 17 — To delete "mental health practitioner;" and insert —

other health professional;

Hon HELEN MORTON: I wish to table the list of the names of the people and the positions that they held in the agencies that they represented for a snapshot of time for that expert group, as asked of me by Hon Sally Talbot.

[See paper 1849.]

Hon SALLY TALBOT: Can I suggest a way to move through clause 4 for a start that might be helpful to the opposition. The first two amendments in the name of the Minister for Mental Health are related to each other. Originally I think the minister's proposal was to move 1/4 on the supplementary notice paper, which was to delete "mental health practitioner" and insert "other health professional". When we had one of our very helpful briefings—we had several—with the advisers, we raised the question of whether a definition of "health professional" was needed in clause 4. I see that the minister has now produced that. Could the minister talk us through amendment 115/4 on the supplementary notice paper, which is the definition of "health professional" before we come to that first amendment which deletes one phrase and inserts that one?

The CHAIR: I am happy to entertain that, if the minister is happy to talk to amendment 115/4 on the supplementary notice paper.

Hon HELEN MORTON: The term "other health professional", which is in the first amendment to clause 4, is intended to denote qualified professionals who may not be mental health specialists but who may have a role in treating persons with a mental illness. The term is not intended to give special standing to persons who are not qualified professionals or who do not provide treatment for mental illness. In considering the appropriate definition, the Mental Health Commission reviewed the categories of professionals who may be registered under the Health Practitioner Regulation National Law (WA) Act 2010. I am satisfied that the proposed definition contained in this amendment encompasses all the classes of professionals who should be afforded standing under the bill. I can assure members that the option of an inclusive definition was carefully considered. This approach was not adopted for two reasons. First, it would create confusion about who is and who is not a health professional for the purposes of the bill. Second, it could also give undue legal standing to persons who are not professionally qualified to assist in the treatment of mental health conditions. Of course, just because a person is not a health professional for the purposes of the bill, it does not mean that they cannot be contacted by a patient or included in decision-making processes. The right to freedom of communication and to appoint a nominated person is enshrined in part 16 under "Protection of patients' rights".

Hon SALLY TALBOT: By way of clarification, can I ask the minister then who, in her view or in the view of the drafters of this amendment, remains excluded?

Hon HELEN MORTON: The health practitioners who are regulated by the Australian Health Practitioner Regulation Agency who are not covered in the proposals in clause 4 include people such as Chinese medicine practitioners, chiropractors, dentists, medical radiation practitioners, midwives, optometrists, osteopaths, pharmacists, physiotherapists and podiatrists, for example. Those are the people who are covered by the AHPRA regulations.

Hon LJILJANNA RAVLICH: In relation to the exclusion of dentists, there seems to be some nexus with some mental health medications provided to mental health consumers that can have side-effects in terms of the impact on the teeth of people with mental ill health. Can the minister explain why dentists were not included in this schedule?

Hon HELEN MORTON: What we are trying to include in the list are people who provide a mental health treatment, which is an area of definition within the bill. There are many, many people who provide treatments to people with a mental illness, but they are not mental health treatments as defined in the bill. For example, an oncologist or a cardiologist could be providing services to people who have a mental illness, but they are not

mental health treatments. The people being defined are the people who will be involved in providing a mental health treatment.

Hon LJILJANNA RAVLICH: Is "mental health treatment" defined in the bill?

Hon HELEN MORTON: Yes.

Hon SALLY TALBOT: I want to continue on the same point—I need to check this with the minister—because it will speed our passage through clause 28 when we get to it. The minister's advisers may have told her that this issue arose because—I hope Madam Chair will bear with me—the government has proposed an amendment to delete "the person's psychiatrist" in clause 28(9). That is at page 27 of the bill and it concerns proposed amendment 6/28. Would the definition of a health professional that the minister proposes to insert in clause 28 now be defined as the minister has just outlined in clause 4?

Hon HELEN MORTON: Yes.

Hon LJILJANNA RAVLICH: I am just looking at the respective definitions. I can find "mental health advocate", "mental health practitioner" and "mental health service", but not "treatment".

Hon HELEN MORTON: "Treatment" is defined on page 10 of the bill.

Hon STEPHEN DAWSON: I want to put on the record my thanks to the Minister for Mental Health. As Hon Sally Talbot said, at least one of these amendments came out of our briefings. I appreciate the work of the minister's advisers for taking our concerns back and incorporating them in this amendment today.

Amendment put and passed.

Hon HELEN MORTON: I move —

Page 5, after line 26 — To insert —

health professional means —

(a) a medical practitioner; or

(b) a nurse; or

(c) an occupational therapist; or

(d) a psychologist; or

(e) a social worker; or

(f) in relation to a person who is of Aboriginal or Torres Strait Islander descent —

(i) a health professional listed in paragraphs (a) to (e); or

(ii) an Aboriginal or Torres Strait Islander mental health worker;

Amendment put and passed.

Sitting suspended from 1.00 to 2.00 pm

Hon HELEN MORTON: I move —

Page 6, lines 7 to 11 — To delete the lines and insert —

involuntary patient has the meaning given in section 21(1);

involuntary treatment order has the meaning given in section 21(2);

Hon SALLY TALBOT: I seek some clarification of this for the record. It is normally done the other way around. Is there a contradiction with the way it is at the moment?

Hon HELEN MORTON: This amendment addresses quite a minor drafting issue. Drafting as it stands means that the terms are defined twice in the bill. Consequently, the effect of the proposed amendment is to remove one of those definitions.

Amendment put and passed.

Hon SALLY TALBOT: Because we are working with the definitions in alphabetical order, I decided to leave my comments until we had passed the amendment. I refer the minister to the two definitions at the bottom of page 8 of the bill, "private hospital" and "private psychiatric hostel", and draw her attention to page 3 of the explanatory memorandum, which reads in part —

> A general hospital is defined in *clause 4* and, importantly, this definition includes private psychiatric hospitals that are not authorised hospitals …

About six lines later it reads —

> … mental health service does not include a private psychiatric hostel —

There is a definition of that, but there is no definition of "private psychiatric hospital".

Hon Helen Morton: Can the member advise the page and the lines of the explanatory memorandum to which she referred?

Hon SALLY TALBOT: It is on the copy that was provided in the chamber. This is not my own printout. It is on page 3 of the 126-page version of the EM.

Hon HELEN MORTON: There are only two forms of hospital included in the billone is a "private hospital", which has the meaning given in the Hospitals and Health Services Act, and "private psychiatric hostel". However, there are other hospitals that provide a variety services that are private hospitals that are not authorised hospitals under the bill. It is an example of the type of hospital that might be included in the range of other examples.

Hon SALLY TALBOT: What exactly is a "private psychiatric hospital"? Should there not be a definition of that in the bill?

Hon HELEN MORTON: A "private psychiatric hospital" is covered under the definition of "private hospital". I agree with the member that the example given in the explanatory memorandum is not a good example, but there are other hospitals that are not authorised hospitals that are not therefore covered under the definition of "private hospital" and are not covered under "private psychiatric hostel".

[Quorum formed.]

Hon SALLY TALBOT: I think I just asked the minister for another example. I am still not clear.

Hon HELEN MORTON: The examples that I am giving are hospitals such as the Perth Clinic, Hollywood Private Hospital, the Marian Centre and Abbotsford Private Hospital. These are not authorised psychiatric hospitals but they are covered under the definition of "private hospital". The definitions section of the bill states —

> ***private hospital*** has the meaning …

Consequently, these hospitals would be covered by that definition. It goes on to define "private psychiatric hostel". The hospitals that I referred to—the Perth Clinic, Hollywood, the Marian Centre and Abbotsford—are not authorised hospitals. Authorised hospitals are usually hospitals at which persons can be involuntarily detained. Persons cannot be involuntarily detained at these hospitals.

Hon SALLY TALBOT: Can the Marian Centre and the Perth Clinic not take involuntary patients?

Hon HELEN MORTON: There is a clause in the bill that provides that, under very exceptional circumstances, those hospitals can admit an involuntary patient, but they are very exceptional. They are not authorised hospitals under the definition of normally providing services to involuntary patients. I will have a quick look for the clause in the bill that refers to that.

Hon SALLY TALBOT: While the minister's advisers are doing some work on this, I ask: is the purpose of the explanatory memorandum test an indication that, for example, the Perth Clinic and the Marian Centre are included under the definition of "private hospital"?

Hon HELEN MORTON: Yes. Those hospitals have to be licensed by the health department. They fall under the category of "private hospital" but they are not authorised hospitals.

Hon SALLY TALBOT: Are they certified under the Hospitals and Health Services Act 1927?

Hon Helen Morton: Yes.

Hon SALLY TALBOT: Do we want the measures of this bill to be extended to both voluntary and involuntary patients at the Perth Clinic and the Marian Centre et cetera?

Hon HELEN MORTON: To the extent that aspects of this bill cover voluntary patients, yes. Mandatory reporting is an example of that.

Hon SALLY TALBOT: If either of those hospitals have an involuntary patient, would they still be covered by the provisions of the act?

Hon HELEN MORTON: In those exceptional circumstances, which we will get to in clause 64, absolutely.

Hon SALLY TALBOT: In that case, would it be logical to include a definition of or at least a reference to "private psychiatric hospitals"?

Hon HELEN MORTON: It falls under the category of "general hospital" in the list of definitions on page 5 of the bill. These hospitals are not authorised hospitals, so they do not fall under that category. They fall under the definition of "general hospital", which states —

> means a hospital (as defined in the … *Act* …) where overnight accommodation is provided to patients other than any of these hospitals —

It does not fall under paragraph (a), (b) or (c) of that definition. It is every other hospital that is licensed other than (a), (b) or (c).

Hon SALLY TALBOT: When we read the definition of "private hospital", are we to understand that "private hospital" includes private psychiatric hospitals, such as the Marian Centre and the Perth Clinic?

Hon HELEN MORTON: Yes.

Hon STEPHEN DAWSON: The word "care" is used in a number of clauses in the bill. Hon Lynn MacLaren mentioned the issue in her second reading debate contribution yesterday. Members would have received the joint submission from Consumers of Mental Health WA, the Health Consumers' Council WA, the Mental Health Law Centre (WA) Inc and Mental Health Matters 2. They called for "care" to be defined in the bill, saying that that definition should include attending to the welfare and protection of the patient and the patient's interests outside the hospital while they are detained. Did the minister consider including that definition in the bill; and, if so, why was it not included?

Hon HELEN MORTON: That information was considered when it was put to us. The bill defines the term "treatment" but not "care". Clinicians are responsible for providing treatment and care to people who are within the scope of mental health legislation. The bill does not expressly require a clinician or service to coordinate care of a person's needs outside a hospital whilst the person is within the scope of the legislation. However, the bill lists 24 events in which at least one of the support persons is required to be notified. These notifiable events include detention and the making of an involuntary treatment order. Once notified, the support person may be able to take steps to minimise the impact of the person's detention under the legislation upon their everyday responsibilities. Further, the Charter of Mental Health Care Principles set out in schedule 1 refers to a mental health service, acknowledging the responsibilities and commitments of people experiencing mental illness, particularly the needs of children and other dependants.

Hon STEPHEN DAWSON: I think that Hon Lynn MacLaren made a good point. At present, no-one is responsible for ensuring that the power is turned off, the fridge is emptied or the pets are looked after when somebody is made an involuntary patient. I take the minister's point that she has considered it and decided not to include it in the bill. In the alternative, would she consider that it should be in the regulations if it will not be included in the bill?

Hon HELEN MORTON: The stance we took on this is that "care" is understood to encompass a range of activities that mental health services undertake that are not treatment. It is much broader than treatment. It is very difficult to prescribe exactly what that includes. The clinicians' guide will pick up on those areas. The standards will pick up on those areas. "Care" is not able to be defined sufficiently to be put in the bill, and it is over and above what is considered treatment.

Distinguished Visitor — Hilik Bar

The DEPUTY CHAIR (Hon Brian Ellis): Members, before I put the question I would like to acknowledge in the President's gallery today the Deputy Speaker of the Israeli Knesset, Mr Hilik Bar. I apologise if I have the wrong pronunciation. Welcome to the proceedings in this house.

Committee Resumed

Hon SALLY TALBOT: Moving on through the definitions, my last point is about psychiatrists, at the top of page 9. Often when we are dealing with bills, we on this side of the chamber try to canvass unforeseen consequences. Sometimes we have to look really hard to find examples of what-if situations. But in recent years we have had considerable debate about defining psychiatrists in WA because there has been some deal of confusion and misrepresentation, if I can put it that way. Drawing on that recent example and looking at the three-part description of who can be defined as a psychiatrist under the Mental Health Bill, could an overseas medical graduate without psychiatric qualifications be registered as a psychiatrist for the purposes of this bill under that proposed definition?

Hon HELEN MORTON: I have quite a lot of information on this in anticipation of some questioning around it, so I will give the member the information in full. I think that will clarify what the member has just asked and possibly follow-up questions she might be preparing to ask. The Mental Health Amendment (Psychiatrists) Act 2012 amended the 1996 act, replacing the previous definition of psychiatrist in the Mental Health Act 1996

with the same definition included in this bill. Paragraphs (a) and (b) of the definition in the bill refer respectively to medical practitioners who belong to the Royal Australian and New Zealand College of Psychiatrists and medical practitioners who hold full registration in the specialty of psychiatry under the Health Practitioner Regulation National Law (Western Australia) Act 2010. I know they are not the psychiatrists the member is asking about. Paragraph (c) refers to a medical practitioner who holds limited registration under the national law that enables the medical practitioner to practice in the specialty of psychiatry. Section 67 of the national law provides for limited registration of medical practitioners to practice for up to 12 months in an area of need. The medical practitioner can be granted limited registration when the Medical Board of Australia is satisfied that the medical practitioner's qualifications, training, experience and standing are relevant to and suitable for the practices of the profession in the area of need. The responsible minister can determine that there is an area of need where an insufficient number of medical practitioners is practising in a particular geographical area or type of health service. Medical practitioners with limited registration, typically, have qualifications, training and experience outside Australia. They are often highly trained psychiatrists from overseas who proceed to full specialist registration when they satisfy the requirements of the Medical Board.

The Australian Health Workforce Ministerial Council has approved and published a standard relating to limited registration for an area of need. Under the standard, a medical practitioner seeking limited registration as a psychiatrist must, among other things, demonstrate appropriate English language skills and provide a detailed work history and a letter of recommendation from the relevant specialist college—in this case, the Royal Australian and New Zealand College of Psychiatrists. Once limited registration is obtained, the practitioner must comply with a supervision plan, authorise and facilitate provision of regular reports from supervisors to the Medical Board regarding their safety and competence to practice and demonstrate satisfactory performance. If they intend to practice medicine in Australia in the longer term, they must provide evidence to confirm the satisfactory progress towards meeting the requirements for general or specialist registration.

In summary, these processes provide strong assurances that persons afforded limited registration are competent and qualified to perform the duties of a psychiatrist under the bill. I am advised that on average, about eight limited registration psychiatrists practice in Western Australia at any given time. Most of these work in regional areas that would otherwise not have access to specialist psychiatric expertise. Preventing these psychiatrists from performing functions under the act would be a significant departure from current practice and one that would have a detrimental impact on the treatment and care available to vulnerable persons.

Hon SALLY TALBOT: Thank you, minister. What the minister has just given us, which I think is very useful to have on the record, is an expansion of the limited registration referred to in paragraph (c).

Hon Helen Morton: Did you say "explanation"?

Hon SALLY TALBOT: I said "an extended explanation".

Hon Helen Morton: Thank you, I thought you said "expansion", but that is okay.

Hon SALLY TALBOT: I might have said an expansion of the term "limited registration". The minister has put on the record now exactly what one has to do to qualify. I guess the $64 question is: would the person who we only ever refer to by his initial, Dr S, qualify in the circumstances that existed at the time as a psychiatrist under the terms of this bill?

Hon Helen Morton: No; he would not.

Hon SALLY TALBOT: Without asking the minister to reread what she just read into the record, what specifically has changed that would mean that Dr S could no longer practice?

Hon HELEN MORTON: The particular doctor the member is referring to had general registration; he did not have registration as a psychiatrist.

Hon LJILJANNA RAVLICH: On the same issue, the minister will be aware that the Mental Health Law Centre has an issue about the definition of psychiatrist and claims that it is defined in the bill in three ways. It either is or it is not. I am assuming what the Law Centre says is correct. It goes on to state —

> The clause 4(c) definition provides that a medical practitioner who is not necessarily required to have a psychiatric qualification can be granted limited registration to practice as a psychiatrist if the doctor has suitable 'qualifications' (undefined) and 'experience' (undefined).

The Law Centre's argument is that under this definition —

> … limited registration psychiatrists can work as a treating psychiatrist authorised to make involuntary detention orders; a clinical director of a psychiatric hospital to whom the Chief Psychiatrist can delegate

his/her powers; as the Chief Psychiatrist; or as a psychiatrist member of the Mental Health Review Board.

It goes on to say that this definition encourages stopgap measures that will not improve the standard of care of the most vulnerable involuntary patients. Why have the qualifications and the experience remained undefined?

Hon HELEN MORTON: We have had these arguments before. The Royal Australian and New Zealand College of Psychiatrists has a rigorous process for vetting overseas qualifications. The overseas doctor being referred to would have to have the qualifications that satisfy the Royal Australian and New Zealand College to be able to practice. The registration requirements are defined by the Medical Board of Australia and, as already stated, the processes are very robust.

Hon STEPHEN DAWSON: On the same point, why does the bill not state that a psychiatrist has to be a fellow of the Royal Australian and New Zealand College of Psychiatrists? It simply states —

psychiatrist means a medical practitioner —

(a) who is a fellow of the Royal Australian and New Zealand College of Psychiatrists; or

A range of other things. Why do we not make it a requirement that they are a member or a fellow of the college?

Hon HELEN MORTON: I read out that full explanation before. The definition states —

psychiatrist means a medical practitioner —

(a) who is a fellow of the Royal Australian and New Zealand College of Psychiatrists; or

(b) who holds specialist registration under the *Health Practitioner Regulation National Law (Western Australia)* in the specialty of psychiatry; or

They are not a full fellow of the college —

(c) who holds limited registration …

I went through the reasons and the processes by which —

Hon Stephen Dawson: I am not asking the minister to go back over that.

Hon HELEN MORTON: I know. The answer is that we would not ever limit it to only paragraph (a), because that would preclude the psychiatrists who work for us under paragraphs (b) and (c).

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 5 and 6 put and passed.

Clause 7: Matters relevant to decision about person's best interests —

Hon STEPHEN DAWSON: On page 13 of the bill is a list of people whose views must be taken into account by the decision-maker. Clause 7(2) states —

The person or body making the decision must have regard to these things —

(a) the person's wishes, to the extent that it is practicable to ascertain those wishes;

(b) the views of each of these people —

(i) if the person has an enduring guardian or guardian — the enduring guardian or guardian;

(ii) if the person is a child — the child's parent or guardian;

(iii) if the person has a nominated person — the nominated person;

(iv) if the person has a carer — the carer;

(v) if the person has a close family member — the close family member;

A glaring omission is that it does not provide that their current or most recent treating practitioner for their mental illness must also be consulted. Can the minister let us know why that was not included in the clause?

Hon HELEN MORTON: I know that the Mental Health Law Centre has again been seeking a requirement for this. Clause 7 does not require decision-makers to consider the views of other treating practitioners in determining a person's best interests. This is because not every patient has a health practitioner who is well placed to comment on their best interests. However, nothing prevents a decision-maker from consulting other practitioners when it is appropriate in the circumstances—for example, in line with the patient's wishes. That is made clear in clause 7(2)(c). As per the notice paper, I intend to move amendments that will ensure detained

persons have the means and opportunity to contact any current treating practitioner, such as a psychiatrist or GP. These amendments were prompted by feedback received since the bill was passed by the Legislative Assembly.

Hon STEPHEN DAWSON: I take the minister's point that not every patient will have a current practitioner. However, not every patient will have an enduring guardian, or is a child, or will have a nominated person, yet those elements have been included in the bill. When we ascertain a person's wishes and best interests, their treating psychiatrist should be consulted. Clause 7(2)(c) states —

> any other matter that the person or body considers relevant to making the decision.

However, it does not provide that the decision-maker will definitely consult a person's psychiatrist. It seems to me to still be an omission. Does the minister want to comment on that?

Hon HELEN MORTON: I make the additional comment that the standards require communication with other treating practitioners and we cannot list in the bill everybody who may have relevant views because the list would be too long. However, I can assure the member that the guidelines and standards we are putting out will cover off the requirement to which the member refers.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 8: Matters relevant to ascertaining person's wishes —

Hon SALLY TALBOT: I think this comes up later and I cannot find my reference to it, but I wanted to get the minister's comments about the use of the term "must have regard to" when following advance health directives. If the minister would rather defer this discussion to a later stage, I am happy to do that. She probably has a better idea of where it crops up later, but I just cannot find it.

I looked at the Acts Amendment (Consent to Medical Treatment) Act, which I think is the relevant act, and the Guardianship and Administration Act. References can be found in a number of places, but division 3 is about the jurisdiction of the State Administrative Tribunal. Perhaps I could ask the minister, first of all, why the bill does not state "for the purposes of ascertaining their wishes, the person or body must implement any instructions contained in an advance health directive"?

Hon HELEN MORTON: We can either cover off on this now or when Hon Stephen Dawson moves to insert new clause 8A. It comes down to the same issue. I may as well refer to it now. We do not support Hon Stephen Dawson's proposed amendment to insert new clause 8A. I gave some indication of why that is so in my second reading speech but I will expand on that now. I set out the scenario in which a person with severe depression intentionally makes an advance health directive that precludes all viable treatment options. If such a person were deemed to be at serious risk, he or she could be detained under the act but could not be treated, in effect, making the hospital a detention facility rather than a place of recovery. Hon Sally Talbot is not suggesting a person cannot be involuntarily detained; a person can be involuntarily detained if they meet the eligibility criteria to which we have referred, which includes posing a significant risk of harm to themselves or others. If a person has been detained involuntarily, but the clinicians are unable to provide treatment, that person will languish in that hospital in torment and in the situation that they are in for, I would say, forever and a day until their illness progresses to such a stage that they would be picked up under the emergency part of the legislation anyway. When I look at AHDs I ask myself why we let people reach that stage before we provide them with involuntary treatment in an emergency circumstance. If such a person was deemed to be at serious risk, he or she could be detained under the act, but not treated. The proposed amendment would not adequately address this scenario.

I am flagging why I will not support the proposed amendment. Provided that the advance health directive was in the correct format and that the witnessing requirements were met, the State Administrative Tribunal would have no grounds to overturn the AHD. A key point here is that the witnessing requirements under the Guardianship and Administration Act do not require the involvement of a person trained in the identification of mental illness and in the assessment of capacity. This is problematic because determining the capacity of a person with mental illness can be a highly complex matter. This problem is compounded by the fact that under the bill the capacity test for making an AHD is weaker than the test for establishing capacity. The result is that a person who wishes to evade the safeguards of the Guardianship and Administration Act could do so without significant difficulty. The reality is that the provisions of that legislation are not appropriately adapted to the mental health context, and as such should not apply in full.

An additional consideration is that the Guardianship and Administration Act already creates an exception, in the case of attempted suicide. If it is appropriate to overrule an AHD in order to save a person who has harmed themselves, why is it not acceptable to act to prevent such harm arising in the first place? In making this point

I note that persons who are subject to involuntary orders have, by definition, been deemed to be at serious risk as a result of their illness. I wish to stress that the sort of problematic scenarios I have discussed are not the norm. As I have stated previously, I believe that clinicians should always respect AHDs when it is reasonable to do so. I believe the provisions of the bill are strong enough to achieve this outcome.

In my response to the second reading debate I made it clear that if the psychiatrist deemed it necessary to provide treatment that is inconsistent with an AHD, the decision and the associated reasons must be documented and reported to the patient, their support persons, the Chief Psychiatrist and the Chief Mental Health Advocate. The Chief Psychiatrist has the power to overturn the treating psychiatrist's decision and mandate compliance with the patient's AHD.

Hon SALLY TALBOT: My first question is: in that list of conditions that the minister referred to at the end, does that include a part 9 notification?

Hon Helen Morton: Which conditions?

Hon SALLY TALBOT: The minister said in a case in which a treating psychiatrist overturned an AHD, a number of people would have to be notified. Is it included as a part 9 notifiable event?

Hon HELEN MORTON: This requirement under AHDs is actually stronger than part 9. There are more people who need to be notified.

Hon SALLY TALBOT: I want to make one more point and then I think we will pursue some other points when we get to Hon Stephen Dawson's proposed amendment. I think there are other amendments he proposes to move that we need to talk about. The minister admits that she is drawing on an extreme situation. I think they were the exact words that the minister used. The minister said she is going to the far end of the spectrum about events that may occur. What concerns me is that in drawing on such an extreme example in which somebody has tried to kill themselves, presumably what the minister has in her mind's eye is a person who needs to be revived otherwise they will die because, for example, they have taken an overdose. When that person's advance health directive is consulted, it says "do not resuscitate me if I am in a comatose state" or something like that. I have discussed the use of advance health directives with people with mental illnesses. They often refer to the fact that when they go into a psychotic state they will perhaps turn on one of their carers; for example, accuse their mother of attempting to murder them. This may be something that is now recognised as part of their psychosis. What they wish to do is somehow put in writing, in a way that has some kind of legal force, the fact that when they say while they are in a psychotic episode, "Do not let that woman near me because she is trying to kill me", that is actually because of their psychosis but they actually would like their mother to have a direct say in their care. That was a specific example raised with me, but there are many others of a similar kind of hue.

A problem may arise if there is a situation in which there are limited resources available and a treating psychiatrist who does not know the family history or is unable to make phone calls to people who can give her or him some background. It might not be the case if a person was admitted to Royal Perth Hospital or one of the metropolitan hospitals. There could be a dramatic situation in which a life is at stake, essentially, and the person who has in fact been requested to be the main consulted carer is being sidelined because a treating psychiatrist is not willing to take what the treating psychiatrist might see as an enormous risk. I wonder whether this is throwing the baby out with the bathwater. We could have advance health directives that would serve a very specific practical purpose, but clause 8 will give treating psychiatrists a way to get around an advance health directive.

Hon HELEN MORTON: Hopefully, I can put Hon Sally Talbot's mind at ease about that. To start with, I want to put into context the comments the member made about me talking about the "extreme". I spoke initially about the fact that a person may require involuntary care. I do not see that at the extreme end. A lot of people who receive involuntary care are in the community and in the open wards of a hospital —

Hon Sally Talbot: I think it was when the minister was citing a specific case of somebody who had attempted suicide.

Hon HELEN MORTON: I mentioned that later on. When a psychiatrist has deemed that a person needs involuntary care and that patient has an AHD that says, "Whatever happens to me, don't give me that care", it means that person will maintain ongoing involuntary status because they are not able to receive the treatment that would enable their health and wellbeing to improve. An extension of that is most likely—but not necessarily always—that their illness will deteriorate to the point at which eventually they would be picked up by the emergency clauses under the bill. Why do we have to wait for that to happen before we can start to provide treatment, especially for someone who is an involuntary patient? This applies only to people who are being involuntarily provided with treatment. That is the first point I would like to make.

The second point is that advance health directives deal only with treatment. They do not deal with whether a person can or cannot be involved et cetera. Under the bill, carers have a right to be there, unless there is a reason for excluding them. That could be a clinical —

Hon Sally Talbot: But it would include consent to treatment, would it not?

Hon HELEN MORTON: The what?

Hon Sally Talbot: An AHD.

Hon HELEN MORTON: Absolutely. The member is saying that it might just be they cannot have somebody live with them if they want them there. Treatment issues are separate from who can come and be with them and who can help nominate things on their behalf. Consent to treatment is a separate issue in that.

The third thing is that carers' rights are distinct from an AHD. Obviously, when we get to part 17 that will be covered under carers' rights. The main issue is that, by saying that we automatically have to agree to AHDs in these cases, we would end up having many patients who are at risk of harm to themselves and other people being detained, with increased seclusion, increased restraint and increased detention in psychiatric hospitals, because these people are not able to be given the treatment that would preclude that from happening. The extension of that is that they would be back in institutional care.

Hon SALLY TALBOT: With respect, the minister has confused two arguments here. I am not suggesting that we should have a piece of legislation that requires the treating psychiatrist to consent to every aspect of an AHD. We do not have a piece of legislation like that in the state. That is why I referred at the outset of my remarks to division 4 of the Acts Amendment (Consent to Medical Treatment) Act 2006, which is the referral to the State Administrative Tribunal. I understand what the minister is saying about the technicality of the AHD, but I would have thought that to put a SAT appeal in there would have provided exactly the safeguard that we are looking for.

Hon HELEN MORTON: I have actually covered why referral to the SAT would not achieve the outcomes that the member is mentioning. If the member wants me to go over that again, I am happy to do it, but that is the circumstance.

Hon ADELE FARINA: I apologise if the minister has already gone through this issue, because I came in a bit late. I do not understand the point of having an advance health directive if it can then be overruled, and if people are putting things into an advance health directive that will impact on their treatment and wellbeing, that is a concern. Surely they should be prevented from putting that into the advance health directive in the first place. It seems to me that we are allowing a legal document to be created in which a person expressly states their wishes, believing that those wishes will be carried out in the circumstances described in the advance health directive, while we have in this bill a lot of provisions that say that there are circumstances in which it might be overruled. To me, that is really concerning because if I were to make an advance health directive I would expect it to be adhered to. It also concerns me that, although the minister said that there is a list of people who would need to be notified if an advance health directive is being overturned, I do not think that is actually specified in the bill. If it is, can the minister tell me where it is, because I am not aware of it?

Hon HELEN MORTON: It is specified at clause 179, so that is the last part of what the member was talking about. I do not actually know what else I can say. I do not believe that any of us would prefer to have somebody being involuntarily detained indefinitely without receiving treatment and progressively getting worse, especially a young person, when involuntary treatment can provide the treatment necessary for this person to become well. I know that when we passed the advance care directives legislation, it was primarily about people at the end stage of life. We are not talking about that here. We are talking about people who have a mental illness and can be detained involuntarily. I do not believe that anybody is suggesting that we cut involuntary treatment orders out of the bill completely, so we will have people who are involuntarily detained and not being able to be given the treatment that is required for them to be able to become sufficiently well to go back and live in the community with their family and get on with their work and do the things they want to do, if they had made a treatment order that stated that they were not to be treated involuntarily. That is not what this is about.

Hon Adele Farina: Surely, people should not be allowed to make an order of that nature.

Hon HELEN MORTON: Unfortunately, as I mentioned, under the legislation, so long as they meet the witnessing requirements and the requirements around the correct format, the SAT would not have any opportunity to overturn that. Equally, in the United States there are some historical examples where this has occurred, and patients have wallowed in severe illness in detention for a long time. We are not going to let that happen in Western Australia.

Hon ADELE FARINA: I am not suggesting that we should, but it seems to me that we need some tighter guidelines at the beginning on what is permitted and what is not permitted to be in an advance health directive, so that everyone understands the scope of an advance health directive, rather than give someone the false impression that they have made an advance health directive and that it will be followed in the event that they are in the circumstances that they have described. I would have thought that if there is concern about people making an advance health directive that could impact on their treatment in a very negative way as the minister has outlined, why are we allowing them to make an advance health directive in those terms? It just seems to me that we should be honest upfront and just say that people cannot make an advance health directive in those terms; it can only be made in these limited circumstances.

Hon HELEN MORTON: The member is going into what should or should not be amended or changed or strengthened in the Acts Amendment (Consent to Medical Treatment) Act 2006. We were both members in this house when that legislation went through. It went through a full committee stage, outside of the Parliament. I was part of that committee. Obviously, I sought to change, amend, strengthen or remove some aspects of that bill through the process, which we did. I believe that we have a better act as it is. However, as the member knows, anyone can make an advance care directive. It is not always possible to know whether a person has the capacity when they have made the directive. I recall discussions around advance care directives when it was said that it could be written on the back of an envelope, so long as it was properly witnessed.

Hon Sally Talbot: But that is true.

Hon HELEN MORTON: I know it is, and consequently they are as legal as one that is filled out on the proper form. We are saying that we support advance care directives, we believe in them and encourage them through the new processes. It would be a retrograde step to say that people with mental illness should not make advance care directives, but there are times when that advance care directive can be overturned and the safeguards and the processes for doing that are built into this bill for people in involuntary care.

Hon SALLY TALBOT: I think we would have needed to have this conversation sooner or later, minister, so I do not think this is adding to the time that we are spending on this bill, because nobody wants to hold this up. However, I want to take up one thing the minister said that I had not thought of when we started this discussion. The minister said that an advance health directive refers only to treatment. Does that mean that a person cannot make an advance health directive that says, "I shall not be made an involuntary patient"—because that is not about treatment but is about the mode in which treatment is provided—or is the minister suggesting that there is some treatment that is given only to involuntary patients, not voluntary patients?

Hon HELEN MORTON: An advance health directive is only about treatment. It is not about detention. A person cannot use an advance health directive to prevent them from being detained. But a person can use an advance health directive to identify what treatments they are not prepared to have. So, advance health directives will continue to apply, and persons will continue to be able to be detained. The absence of that provision would be an even more unacceptable outcome, because it would mean that we cannot detain persons who might cause harm to themselves or other people.

Hon Sally Talbot: But an advance health directive cannot say, "You can't detain me".

Hon HELEN MORTON: That is correct. That is what I have just said. I have answered that.

Hon Sally Talbot: So they can detain —

Hon HELEN MORTON: Yes, they can detain, but they cannot treat. I do not know whether the member is suggesting that we should not continue with that.

Hon Sally Talbot: I am just clarifying the point that the minister made.

Hon HELEN MORTON: I have said very clearly that an advance health directive applies only to treatment, not detention.

Hon STEPHEN DAWSON: It is interesting that the minister says that she supports advance health directives, when she really does not—she only supports them to a degree, because she supports them being overruled.

Hon Helen Morton: Do you not support them being overruled if someone is suicidal and about to take their life?

Hon STEPHEN DAWSON: I have made the point in this place previously that people make an advance health directive when they are well, and they take into regard what treatments they have had before and what has worked and what has not worked. They go into this knowingly. If the minister says that she supports them, but then she also supports them being overruled, the minister does not really support them; she only supports them to a degree.

Hon Helen Morton: I think you should clarify that that is your opinion.

Hon STEPHEN DAWSON: In my opinion, that is what the minister is saying. I firmly believe that advance health directives should be appealable to the State Administrative Tribunal, which is an independent body that can look at them and make a decision. Clause 8(2) provides that regard must be given to an advance health directive. However, there is no formal place in which advance health directives can be kept. Therefore, how can we be confident that any treatment that is given has taken regard of an advance health directive that has been made, when we may not know whether an advance health directive exists or where it is? That would certainly be the case for regional patients.

Hon HELEN MORTON: That is no different from the situation of any person anywhere who makes any form of advance health directive. It is up to the family or the individual to make their advance health directive known to the people involved.

Hon STEPHEN DAWSON: I would say it is different from advance health directives that deal with other treatments. In this case, we are talking about treatment that may involve ECT and psychosurgery. That is very different from other forms of treatment. I therefore contend that particularly in the case of mental health patients, there should be some formal place in which these AHDs can be kept, such as a central repository, or perhaps they should be registered. Has the minister or the government considered registration, particularly for mental health patients, of AHDs?

Hon HELEN MORTON: The debate around having a central repository for AHDs was fully canvassed at the time we debated the advance health directive legislation. With regard to a person who is a mental health patient or has a mental illness, the mental illness may come on at a certain time; the person may not necessarily know that they have a mental illness; or the person may not know that they need to register their AHD with this particular place versus that particular place. There is the option of having some kind of administrative process for people who are known to have a mental illness and want their AHD to be registered through some central process; that could be done administratively. But that is not something that has been brought to our attention in this way. One of the safeguards in the bill is around these persons having a nominated person. I would think that if these persons did have an AHD, their nominated person would know about that. It is also around the increasing role of mental health advocates, who can also be informed if a person has an AHD in place. I think those are easier processes to use, rather than having some central repository that needs to be known. That is also why we have clause 8, which provides that clinicians must make an effort to ascertain the wishes of the patient, including whether the patient has an AHD. That is not something that can just be ignored. Clinicians need to make an effort to suss out whether a person has an AHD and find out what the person's wishes are. To be honest, I think those are better mechanisms by which a person's AHD would become known, rather than imagining that people might register that AHD in some place or through some central agency.

Hon SALLY TALBOT: I want to put a hypothetical scenario to the minister, just to clarify this point. A person may be driven to the point of suicide because of pain caused by cancer. If that person attempted to commit suicide and was then examined by a psychiatrist, and that psychiatrist was made aware of an advance health directive that stated that the person did not want to be treated with chemotherapy, could the treating psychiatrist overrule that advance health directive? I am using that example to illustrate the case in which the advance health directive refers to treatment or intervention for a physical illness as opposed to a mental illness.

Hon HELEN MORTON: I guess this is another area that might alleviate the concerns that Hon Stephen Dawson was referring to as well, because he talked about people who have made it clear that they know what sort of medication has an effect on them et cetera and who do not particularly want that medication to be prescribed for them. I do not have the Acts Amendment (Consent to Medical Treatment) Act in front of me, but I do recall that section 110ZIA of that act provides that if a person has attempted suicide, an advance health directive that has been made by that person can be overturned. I do not know if that answers the member's concerns.

I will just clarify the second part, which is whether a psychiatrist can overrule an AHD when, for example, a person with terminal cancer says that he does not want any more cancer treatment. The psychiatrist cannot overrule the advance health directive. To make it absolutely clear, psychiatrics can only overrule for psychiatric treatment.

Hon SALLY TALBOT: I am really grateful to the minister's advisor for drawing our attention to section 110ZIA of the other act. Having read that section, why would a treating psychiatrist need to overrule?

Hon Helen Morton: It is not all about suicide.

Hon SALLY TALBOT: If it is not about suicide, I am back to my first argument. If it not about suicide, it is not about saving a life; rather, it is about options for treatment.

Hon HELEN MORTON: It is about saving a life; it is not about suicide. Suicide is only one form of life issues that we are dealing with in this bill. I talked at length about someone who is in involuntary care but who is not necessarily suicidal. Such people can have a psychotic illness, a form of depression or an eating disorder but that does not necessarily mean that they are suicidal. However, they require involuntary care. If we accept the amendment, they would languish and would not get treatment. One of the other problems with that is that some of those people may become suicidal; and, if that is the case, that would be picked up under the act. Why would we want to leave them waiting for that to happen when the treatment could be provided?

Clause put and passed.

New clause 8A: Advance health directive —

Hon STEPHEN DAWSON: I move —

Page 14, after line 2 — To insert —

8A. Advance health directive

(1) Notwithstanding anything in this Act to the contrary, the scheme of the *Guardianship and Administration Act 1990* relating to advance health directives must be followed in its entirety in order to give them full force and effect.

(2) A psychiatrist must not act contrary to an advance health directive unless the State Administrative Tribunal has determined that the psychiatrist can do so.

(3) The State Administrative Tribunal shall have jurisdiction to make a determination in subsection (2) and shall, in exercising this jurisdiction, follow the provisions of the *Guardianship and Administration Act 1990*.

I do not propose to have an extended debate about this amendment. The minister has made it clear that she has already made comments about this. I will make a point that I have previously made—namely, people make advance health directives when they are well. A person has to be competent to make an advance health directive. This is binding on health practitioners. When people are well, they know what treatment works for them. They have an intimate knowledge of the treatment. They know what has and has not worked before. They are the ones who know what drugs work and what drugs do not work. I agree that advance health directives should be able to be overturned, but only in rare cases. If a psychiatrist seeks to go against the wishes of a patient, I contend that the case should go before the State Administrative Tribunal for its consideration and determination as to whether the AHD should be adhered to. The bill states that a psychiatrist must have regard for an AHD, but it should not remain as it stands. SAT should make the decision about whether to allow alternative treatment. I seek the minister's comments about that.

Hon HELEN MORTON: The government does not support the amendment.

Hon SALLY TALBOT: I will speak very strongly in favour of the amendment moved by Hon Stephen Dawson. Any bill that deals with mental health in 2014 should move beyond the stage of defaulting to a position that the psychiatric profession knows best. The Mental Health Law Centre, amongst others, has documented many cases of people who have sought legal help on the basis that the medication that was provided to them was killing them. In some situations that claim was proven to be the case. We are cutting the ground out from under those people. They might be very isolated cases and they might be due to mistakes made by the medical profession or to very specific individual circumstances, but in the general case, the minister must be aware that there is a profound ideological and philosophical distinction between the two types of support that are provided to suicidal people in this very state. They are encapsulated by the two major service providers, one of which prevents death at all costs while the other works with the person who makes contact.

I do not want to necessarily take sides in that debate at this moment in time. It is not appropriate to have that debate in the house. However, I point out to the minister that we have never had that debate in this house and we have never had debate about this clause and the extent to which it puts in statute form a default position that says that people will never be allowed go down a path whereby mental illness results in their death. That is absolutely profoundly and categorically wrong; therefore, I support unequivocally the amendment that puts the respect for AHDs into this piece of legislation.

Hon HELEN MORTON: I reiterate that the government does not the support the amendment for the reasons that I have already mentioned. I add once more that the bill quite clearly outlines that a treating clinician must have regard for an AHD.

Hon ADELE FARINA: I apologise because I am coming in a bit late in the debate. I am not clear why the government is so opposed to having the State Administrative Tribunal or an independent arbiter play a role in

this. I would appreciate it if the minister articulated the reasons that the government is so opposed to that proposal.

Hon HELEN MORTON: I am not sure whether the member was in the chamber when I clearly outlined why that is the case. I am happy to do it again. The proposed amendment would not adequately address the scenario of going to SAT, because provided that the AHD was in the correct format and the witnessing requirements had been met, SAT would have no grounds to overturn an AHD. A key point here is that the witnessing requirements under the Guardianship and Administration Act do not require the involvement of a person trained in the identification of mental illness and assessment of capacity. This is problematic because determining the capacity of a person with a mental illness can be a highly complex matter. This problem is compounded by the fact that the capacity test for making an AHD is weaker than the test for establishing capacity under the bill. The result is that a person who wishes to evade the safeguards in the Guardianship and Administration Act could do so without significant difficulty. The reality is that the provisions of that legislation are not appropriately adapted to the mental health context and, as such, should not apply in full.

Division

New clause put and a division taken, the Deputy Chair (Hon Alanna Clohesy) casting her vote with the ayes, with the following result —

Ayes (10)

Hon Robin Chapple *(Teller)*	Hon Kate Doust	Hon Lynn MacLaren	Hon Amber-Jade Sanderson
Hon Alanna Clohesy	Hon Sue Ellery	Hon Ljiljanna Ravlich	
Hon Stephen Dawson	Hon Adele Farina	Hon Sally Talbot	

Noes (19)

Hon Liz Behjat	Hon Donna Faragher	Hon Col Holt	Hon Michael Mischin
Hon Jacqui Boydell	Hon Nick Goiran	Hon Peter Katsambanis	Hon Helen Morton
Hon Paul Brown	Hon Dave Grills	Hon Mark Lewis	Hon Simon O'Brien
Hon Jim Chown	Hon Nigel Hallett	Hon Rick Mazza	Hon Phil Edman *(Teller)*
Hon Brian Ellis	Hon Alyssa Hayden	Hon Robyn McSweeney	

Pairs

Hon Ken Travers	Hon Peter Collier
Hon Samantha Rowe	Hon Martin Aldridge
Hon Darren West	Hon Ken Baston

New clause thus negatived.

Clauses 9 to 18 put and passed.

Clause 19: Explanation of proposed treatment must be given —

Hon SALLY TALBOT: I referred to this in my remarks on clause 1 and the minister looked a little puzzled. I thought that at some point over the past couple of years the minister indicated that it was appropriate to have some form of statutory disclosure of potential conflicts of interest relating to, perhaps, pecuniary advantage gained by a psychiatrist's admission of a patient to a certain facility, treatment with a certain drug or administration of a certain procedure. I may have dreamt it—I do not often dream about the minister—but I am sure I either heard or read somewhere that at some stage during the development of this bill, the minister said that she thought that should be given due consideration. Am I wrong?

Hon HELEN MORTON: I believe that a form of it was included in the 2011 draft bill and due consideration has been given to it since then.

Hon SALLY TALBOT: Why has it been left out? Perhaps the minister could do us the courtesy of talking us through her thought processes.

Hon HELEN MORTON: The member is referring to the amendment to clause 19 in Hon Stephen Dawson's name.

Hon Sally Talbot: I am referring to a small part of that.

Hon HELEN MORTON: I will cover the whole thing again. The proposed amendment to clause 19 is not supported. Clauses 19 and 20 of the bill oblige clinicians to provide the person responsible for making a treatment decision with information about the proposed treatment, including any risks and alternatives and the opportunity to obtain external advice. These requirements will ensure that treatment decisions are made on an informed basis and, in doing so, will safeguard the integrity of informed consent under the bill. The exposure draft Mental Health Bill 2011 included additional highly prescriptive requirements around information, advice and assistance that must be provided before informed consent may be given. The requirements were streamlined following consultation on the 2011 draft.

Before I deal with the components of the amendment to be moved by Hon Stephen Dawson sequentially, I emphasise that clause 19 applies equally to voluntary patients and involuntary patients, advising patients that they can refuse admission or treatment and that they can withdraw consent at any time. In relation to involuntary patients, clause 180 sets out the requirements for ascertaining a patient's wishes. However, there is no right to refuse admission or treatment, and insertion of proposed paragraph (d) would be in direct conflict with other provisions of the bill and the overall purpose of the involuntary treatment orders.

In relation to voluntary patients, first, part 5 division 2 of the Mental Health Bill requires informed consent. The division expressly states that failure to offer resistance does not constitute giving consent. Later in the bill, part 13 requires informed consent to be recorded and filed. If the person is unaware that they may refuse treatment, the requirement for informed consent has not been met. Second, it is easy to envisage scenarios in which it may be inappropriate for the clinician to expressly advise the patient that they may withhold consent. If a patient presents for treatment of their own volition and expresses to the clinician a desire to obtain specified treatment, it may be unnatural for the clinician to recite the person's right to refuse treatment. Paragraph (e) states —

Does Hon Sally Talbot want me to go any further?

Hon SALLY TALBOT: It might be more productive if we deal with just one paragraph at a time, otherwise we will have to keep coming back to the minister's notes. Does the minister want to deal with paragraph (d), because I want to deal with paragraph (f)?

Hon HELEN MORTON: Does anyone else want to deal with (d)? I have covered paragraph (d).

The DEPUTY CHAIR (Hon Alanna Clohesy): Does anyone want to cover paragraphs (a), (c), (d) or (e)? The minister is addressing the amendment that has not technically been moved.

Hon STEPHEN DAWSON: I move —

> Page 20, after line 2—To insert —
>
> ; and
>
> (d) advising that the person may refuse to consent to the admission or treatment and that, if the person does give consent, the person can withdraw consent at any time; and
>
> (e) advising that the person may obtain independent legal and medical advice about the admission or treatment before consent is given and that the person may request assistance to obtain that advice; and
>
> (f) informing the person about any financial advantage that may be gained by any medical practitioner or mental health service in respect of the admission or treatment, except information about the fees and charges payable by or on behalf of the person for the admission or treatment; and
>
> (g) informing the person about any research relationship between any medical practitioner and any mental health service that may be relevant to the admission or treatment.

Hon SALLY TALBOT: Thank you for the information, minister. I have a question about proposed paragraph (d). I think I heard the minister say she would oppose the amendment because it is contrary to fundamental principles in the bill. Then I heard her say that provisions about consent and withdrawal of consent are covered elsewhere in the bill. Is that correct?

Hon Helen Morton: What paragraph are you asking me about?

Hon SALLY TALBOT: I am asking the minister whether it is her view that paragraph (d) contradicts fundamental principles in the bill, in which case what are they; or is it a duplication of provisions contained elsewhere in the bill?

Hon HELEN MORTON: I will read my response to this amendment in full. I think that is the way to get the full picture and then we can focus on one section or the other. As I mentioned before, the proposed amendment

to clause 19 is not supported. Clauses 19 and 20 of the bill already oblige clinicians to provide the person responsible for making a treatment decision with information about the proposed treatment, including any risks and alternatives, and the opportunity to obtain external advice. That is already covered. These requirements will ensure that treatment decisions are made on an informed basis and in doing so safeguard the integrity of informed consent under the bill. As I mentioned, exposure draft 2011 includes some additional and very highly prescriptive requirements around information, advice and assistance that must be provided before informed consent may be given. These were streamlined following consultation on the 2011 draft. In that instance I clarified that what we are talking about here applies to both voluntary and involuntary patients so that people are aware that we are talking about the lot.

I am now referring to the amendment, particularly paragraph (d), which I think is the first area Hon Sally Talbot wanted to talk about. In (d) it suggests advising patients that they can refuse admission or treatment and that they can withdraw consent at any time. My response to that is that in relation to involuntary patients, clause 180 sets out requirements around ascertaining a patient's wishes. However, there is in fact no right to refuse admission or treatment, and insertion of proposed paragraph (d) would be in direct conflict with other provisions of the bill and the overall purpose of the involuntary treatment orders. Does the member want me to stop at that point, because it is the issue in relation to paragraph (d)? Does the member want further discussion on (d)?

Hon SALLY TALBOT: The minister mentioned alternatives. I think she said "risks and alternatives". Can she tell me where the reference is in the bill?

Hon HELEN MORTON: I draw the member's attention to clause 19(1)(b).

Hon SALLY TALBOT: Will those alternatives include an alternative to admission?

Hon HELEN MORTON: Yes, it does refer to options for alternative treatments. Only those treatments that are relevant to that person's condition are included in that.

Hon SALLY TALBOT: Can the minister tell me specifically why the bill does not refer to the option of refusing consent? I cannot see in clauses 19, 20 or 180 reference to withholding consent. I point out also the curious use of words in 180(2) where it states —

> For the purpose of subsection (1), sections 19 and 20 apply (with the necessary changes) in relation to ascertaining the patient's wishes …

Hon Helen Morton: I am trying to pinpoint what you are asking.

Hon SALLY TALBOT: Why is there no specific reference to withholding consent or withdrawing consent?

Hon HELEN MORTON: As I mentioned before, we are dealing with both voluntary and involuntary patients. An involuntary patient cannot withdraw consent; that is the first point I make. For voluntary patients the issue of not providing consent is implicit; either someone has given consent, not given consent or withdrawn consent. I believe that that is well understood by everyone—if someone consents, they do; and if they do not consent, they do not.

Hon STEPHEN DAWSON: Proposed clause 19(1)(e) reads —

> advising that the person may obtain independent legal and medical advice about the admission or treatment before consent is given and that the person may request assistance to obtain that advice ...

Can the minister advise the house why she does not support that part of the amendment?

Hon HELEN MORTON: I did not get up to proposed clause 19(1)(e), so I will go over that now. This is about the independent legal and medical advice and assistance to obtain advice. Such a requirement would ignore the reality that there are many situations in which it would be inappropriate for a clinician to raise the issue of independent legal advice with the patient. For example, when a person presents for treatment of their own volition, legal advice is likely to be irrelevant. Raising this issue unnecessarily could disrupt the therapeutic relationship between the patient and practitioner and deter the patient from obtaining the treatment they want and need. Our aim should be to encourage people to obtain help for mental health conditions in the same way that they do for other health conditions and not to create unnecessary barriers. The bill must enhance care and not create an obstacle between people experiencing mental illness and their clinicians. The importance of obtaining legal advice and other information on rights escalates in certain situations, such as when a person is admitted to an authorised hospital or made an involuntary patient. This is reflected in clauses 244 and 245 of the bill, which require the patient and their support persons to be provided with information on rights in specific circumstances.

Hon STEPHEN DAWSON: If we are to be open and honest with patients, surely we should be telling them all the way along what assistance they may be able to access, which includes legal and medical advice. Surely we should not be keeping elements of their entitlements or rights hidden from them.

Hon HELEN MORTON: I do not know when the last time was that Hon Stephen Dawson went to his general practitioner or some other doctor, but I am quite sure that before the member sat down and explained that he had a pain in the back or anything else, the doctor did not stand there and tell him about the need to get legal advice before he provided his service to the member.

Hon ADELE FARINA: Would the minister have less opposition or no opposition to proposed clause 19(1)(e) if "legal and" was removed and it referred only to "independent medical advice"?

Hon HELEN MORTON: The answer is: no, I would not support it.

Hon Adele Farina: Why?

Hon HELEN MORTON: If Hon Adele Farina looks at clause 20, she will see that it covers off on what she is suggesting. It provides for —

> (b) a reasonable opportunity to discuss those matters with the medical practitioner or other health professional who is proposing the provision of the treatment …

[Quorum formed.]

Hon ADELE FARINA: The minister said that clause 20 provides —

> (b) a reasonable opportunity to discuss those matters with the medical practitioner or other health professional who is proposing the provision of the treatment …

The whole point of the amendment proposed by Hon Stephen Dawson is for the patient to get independent legal or medical advice. The problem, as I see it, is that clause 20 does not require the patient to be told that they are entitled to get independent legal or medical advice. That is an important distinction between the amendment proposed by Hon Stephen Dawson and clause 20. It is fine to say that a person can obtain other advice, but it is not helpful if they are not made aware that they can do that. I do not see it as particularly unreasonable to ask the medical practitioner treating the person to inform them that they have a right to get independent legal and medical advice, if that is what is proposed in clause 20 in any event. Having pointed out clause 20, I understand even less why the minister is opposing the amendment proposed by Hon Stephen Dawson.

Hon HELEN MORTON: I will reiterate what I said earlier about proposed clause 19(1)(e). The bill must enhance care and not create an obstacle between people experiencing mental illness and their clinicians. The importance of obtaining legal advice and other information on rights escalates in certain situations, such as when a person is admitted to an authorised hospital or made an involuntary patient. This is reflected in clauses 244 and 245 of the bill, which require the patient and their support persons to be provided with information on rights in specific circumstances. It is important that we do not compel clinicians to raise these matters in every single case. Clause 20, "Sufficient time for consideration", provides —

> A person cannot be asked to make a treatment decision about the provision of treatment to a patient unless the person is given —
>
> ...
>
> (c) a reasonable opportunity to obtain any other advice or assistance in relation to the treatment decision that the person wishes.

We have settled on that provision because we do not want to compel clinicians to undertake in every single case to advise the patient that they may obtain advice. We do not want to create an obstacle between the clinician and the patient as legal or medical advice does not need to be obtained in every case anyway. Clause 20(b) is a better clause than the proposed amendment to it because it refers to "reasonable". It preserves that flexibility to respond appropriately as needed. Similarly, subclause (c) refers to "reasonable". In drafting the bill as it is, we have sought to, and I think have, ensured that it is a requirement that these are considered in that process, but not a requirement that it has to happen in every case.

Hon STEPHEN DAWSON: There is no definition of "reasonable" in the bill. Clause 20 (b) and (c) refer to "a reasonable opportunity". Are we talking about time? Are we talking about hours? Are we talking about providing people information? I know we are on clause 19, but I think it is important that I touch on clause 20. What is "a reasonable opportunity"? What are we saying? What are people getting? Why are we not advising them that they can access a range of information, or why are we not informing them; not simply giving them "a reasonable opportunity"?

Hon HELEN MORTON: The member may be aware that the term "reasonable" is used frequently in legislation. It refers to what a reasonable person could expect under those circumstances.

Hon ADELE FARINA: It is possible that a patient who wanted to get another medical opinion had to wait a month to get access to that other medical opinion—they might not be able to get an appointment for a week or

a month, or whatever. Is it possible that the treating doctor, psychiatrist, whoever, could actually say, "No, because your health will deteriorate significantly within that period of time if you do not get treatment straightaway" and push the issue about making the decision to press ahead with treatment regardless? The word "reasonable" suggests that there is some balance that will have to be made between giving a person an opportunity to get further advice and not taking too long so it does not impact on their health. Those words that have been very carefully chosen indicate that someone has a balancing decision to make. It concerns me how that might be applied.

I still really do not understand the minister's objection. For example, I had to have major surgery a number of years ago. The surgeon went through everything that could possibly go wrong with the surgery and advised me to get independent advice before making a decision to proceed with the surgery. Because he knew that I was practising law at the time, he was meticulous in going through every single possible thing that could go wrong because he wanted to ensure that he had himself covered. I have to be honest, by the time he finished I said, "Does anyone actually say yes at the end of this?" because it is quite a frightening list. I went ahead with the surgery. Some of those complications that he outlined I experienced. It did not prohibit me from actually making the decision to go ahead with the surgery. I do not know why the minister thinks that advising a patient about their rights puts up a barrier between the doctor and the patient.

Hon Helen Morton interjected.

Hon ADELE FARINA: That is what the minister has indicated.

Hon Helen Morton: We are not advising about that.

Hon ADELE FARINA: Advising that they can get independent advice if they want to?

Hon HELEN MORTON: I draw the member's attention to clause 19(1)(c) that states the patient must be warned of all of the risks inherent in the treatment. That is covered. There is no suggestion that medical practitioners will not be doing that with their patients.

Hon Adele Farina: But I said, in addition to that, that surgeon also advised me that I could get a second opinion from another surgeon before making a decision.

Hon HELEN MORTON: Equally, psychiatrists often encourage patients to seek second opinions, but it is not mandatory; it is an option that is given to patients.

Hon Adele Farina: It is interesting that the surgeon in my case, once he knew that I was practising law, was very keen to make sure that he ticked off all those squares. This bill suggests that a person with mental health problems should not be given the same consideration.

The DEPUTY CHAIR (Hon Alanna Clohesy): Hon Adele Farina was engaging in a conversation. It is clearly a very important point to her, but the minister has the call.

Hon HELEN MORTON: I understand the importance of what the member is referring to. I can categorically say that no doctor can force a voluntary patient into anything. That is coercion. That is not allowed to happen—I know that and Hon Adele Farina knows that. If that were to be the case, they could be referred to the Australian Health Practitioner Regulation Agency. That would have serious consequences for the doctor. I am really clear about that. Hon Adele Farina's scenario does not cover the case for involuntary patients. She is really only referring to voluntary patients and their consent. To require further safeguards around the advice that doctors are providing and the requirement covered in clause 19(c) and what is already covered under clause 20 further stigmatises a voluntary patient who may feel that they are entering into some kind of legal process unnecessarily around mental health treatment. I have experienced similar circumstances when I have been to see a GP or a specialist and they have laid out for me all of the options. I do not think that will be any different for a psychiatrist—they will lay out the options or alternatives for a person to consider. They also know that people can get a second opinion, and often they encourage people to get second opinions. It is no different from any other form of health care in this respect. We are talking about voluntary patients—people accessing mental health treatments. I am also advised that the clinicians' guide being developed by the Chief Psychiatrist will put into context, and make clear for people, the word "reasonable".

Hon STEPHEN DAWSON: My proposed amendment at 55/19 deals with the issue of disclosure of any financial advantage that may be gained by a medical practitioner or a mental health service. I understand there were references in the 2011 draft bill to require the treating doctor to disclose any financial interest, yet there has been no inclusion in this bill. I do not believe that the minister is supportive of my proposal at clause 19(f). Why were those references in the draft bill removed? Why is the minister so against doctors or medical practitioners having to disclose financial interests or financial advantages that they might gain?

Hon HELEN MORTON: Once again, I want to make sure that people who are seeking treatment for a mental illness are treated no differently from people who seek treatment for any other form of illness. The insertion of subclause (f) would duplicate existing requirements. In particular, the Medical Board of Australia's "Good Medical Practice: A Code of Conduct for Doctors in Australia" addresses conflicts of interest including of a financial nature. Paragraph 8.11.3 of that code requires doctors to inform patients when they have an interest that could affect, or could be perceived to affect, patient care. The code has standing under the Health Practitioner Regulation National Law (WA) Act 2010 and noncompliance can have serious consequences, including loss of professional registration. I do not think that this is any different from any other form of medical consent.

Hon SALLY TALBOT: That is an interesting piece of advice. Does the act that the minister referred to cover every professional defined in clause 4?

Hon HELEN MORTON: It applies mostly to people who provide medication, which is covered in that area. I would say though, that the Health Practitioner Regulation National Law (WA) Act 2010 covers all those categories of people, with one exception—that is, social workers. We believe that the clause as it is currently written is sufficient to cover the potential risk of social workers being involved in one form or another. That is not acceptable.

Hon SALLY TALBOT: So it covers the three definitions of "psychiatrist"?

Hon HELEN MORTON: Absolutely.

Hon STEPHEN DAWSON: Proposed paragraph (f) refers to not only medical practitioner but also mental health services. I could not imagine that the act that the minister referred to deals with mental health services. Can the minister confirm that that is the case?

Hon HELEN MORTON: Before I answer that question I will just add one other comment to the one I made in relation to social workers. I think the concerns people are expressing relate to those people who can actually prescribe treatments. Social workers are not involved in prescribing. They are part of a treatment team, and that is why the risk factors are covered. To reply to the last question about whether it covers a service, a service employs people to prescribe or to provide treatment. This service in itself is not a prescriber, and as such, the clinicians are the people who seek the consent, not the service. Consequently, the clinicians are covered in the way that I have already mentioned.

Amendment put and negatived.

Clause put and passed.

Clause 20: Sufficient time for consideration —

Hon HELEN MORTON: I move —

> Page 20, line 22 — To delete "medical practitioner or other".

Hon STEPHEN DAWSON: Can the minister provide the house with the rationale for this amendment?

Hon HELEN MORTON: I might be jumping up and down quite a few times, because this amendment is consequential on the definition that was amended at the beginning of the bill. There will be many of these amendments. The amendment I am moving to clause 20 corresponds with the insertion of the definition of "health practitioner" in clause 4. If the member does not want me to get up every time, he might say whether he will support that in future.

Hon ADELE FARINA: Could the minister just elaborate a little bit more? This amendment may be consequential to an amendment to a definition, but the minister has not really explained why it necessarily transpires that this amendment needs to be made. Perhaps the minister could put that on the record.

Hon HELEN MORTON: It is now redundant. The reference is in the definition that we moved earlier on in clause 4. The amendment to clause 48 is page 40, lines 2 to 14; and at page 41, line 1—if we are going that far. The amendment I will move to clause 48 corresponds to the insertion of the definition of "health professional" at clause 4, and so it goes on at different stages throughout the bill. Wherever we have previously used "medical practitioner" we are changing that to "health professional". The definition of "health professional" at the beginning of the bill now includes medical practitioners.

Hon ADELE FARINA: In relation to the phrase "sufficient time" and "a reasonable opportunity", would there be a distinction as to what is sufficient time and what would be considered reasonable between a voluntary and an involuntary patient?

Hon HELEN MORTON: I just want to make it clear again that when a person is an involuntary patient, they can be treated without consent. The complexity around different people's conditions does not mean that they will not have the treatment explained to them et cetera. However, the complexity around the different conditions is what determines the amount of time taken and the individual person's needs. It is not about whether they have a voluntary or involuntary status. That is secondary to what is required by that individual for those requirements to be met under clause 20.

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 21 and 22 put and passed.

Clause 23: Community treatment order —

Hon STEPHEN DAWSON: Can the minister advise us about the parameters a community treatment order—the length of time that they remain in force? Can the minister point to where that is contained in the act?

Hon HELEN MORTON: The criteria for making a community treatment order are found at clause 25(2). The time frame for the making of a community treatment order is found at section 115(2).

Hon STEPHEN DAWSON: I thank the minister for that, and I am happy to move on and ask my questions when we get to clause 115.

Clause put and passed.

Clause 24 put and passed.

Clause 25: Criteria for involuntary treatment order —

Hon STEPHEN DAWSON: I move —

> Page 23, lines 1 and 2 — To delete the lines.

The words in this clause are substantially different from the words that are found in the Mental Health Act 1996. There is a concern that by substituting the words "a significant risk of serious harm" for the narrower criteria that are found in the current act, this bill expands the criteria for detaining and treating patients without consent. Can the minister advise us why this change has been made? I will be straight. There are a large number of concerns in the sector in relation to this clause. In the joint submission to members of the Legislative Council on this bill, which was endorsed by the Consumers of Mental Health WA, the Health Consumers' Council, the Mental Health Law Centre, and Mental Health Matters 2, this was one of the major issues that they raised and have concerns about, so I propose to spend some time drawing this out with the minister.

The DEPUTY CHAIR (Hon Alanna Clohesy): Minister, because this will probably be a fairly extensive debate, I will leave the chair until the ringing of the bells, and we will resume the debate after question time.

Committee interrupted, pursuant to standing orders.

[Continued on page 6095.]

Sitting suspended from 4.13 to 4.30 pm