

MENTAL HEALTH BILL 2013

Introduction and First Reading

Bill introduced, on motion by **Dr K.D. Hames (Minister for Health)**, and read a first time.

Explanatory memorandum presented by the minister.

Second Reading

DR K.D. HAMES (Dawesville — Minister for Health) [1.32 pm]: I move —

That the bill be now read a second time.

I am pleased to finally introduce the Mental Health Bill 2013. This bill has been a long time in the making and has been keenly anticipated within the mental health sector and by those committed to the mental health reform agenda. The Mental Health Bill 2013 will replace the Mental Health Act 1996, a piece of legislation that is recognised as containing legal provisions that need to be brought up to date with current best practice in mental health, including by reflecting principles of recovery for those living with mental illness. The bill is a progressive and effective tool to, first and foremost, promote and protect the rights of persons with severe mental illness in addition to, importantly, promoting access to mental health treatment, care and support. The legislative framework also recognises the role of carers and families in providing care and support to people who have a mental illness, and for related purposes.

Although this bill will repeal the Mental Health Act 1996, we will shortly introduce a related bill that is intended to be read cognately. That bill will make consequential amendments to various connected legislative provisions, provide for transitional provisions, and make some minor amendments to the current legislation to cover the period until this bill becomes operational and replaces the current act. Subsidiary legislation will follow, together with a clinicians' guide, guidelines developed by the Chief Psychiatrist, and other resources. All these materials will provide a legal framework for the implementation and enforcement of the legislation. Legislation does not, and should not, compel best practice, but these other materials will provide flexibility and promote continuous improvement.

The introduction of this bill today comes in the recognition that legislative change is only one part of the important reform process that is going on in the mental health sector. This bill brings vital change, but it is not the role of this bill to increase the number of psychiatrists, create more beds or increase community-based services; that is not the role of the Mental Health Act in Western Australia, or in other Australian jurisdictions. A bill such as this has a specific role, focused primarily on the processes, safeguards and protections around involuntary treatment and detention. The overall purpose of this bill is to bring mental health legislation into line with current community expectations; to codify good practice from an Australian and international perspective; and to further emphasise the importance of human rights, particularly given that Australia is a signatory to the United Nations Convention on the Rights of Persons with Disabilities of 2006. This bill broadly reflects the approach recommended in a statutory review of the operation and effectiveness of the current act conducted by Professor D'Arcy Holman from the University of Western Australian in 2002–03, better known as the Holman review.

In 2003, following an extensive review and consultation process that involved convening a number of working groups, consideration of numerous public submissions, and direct consultations with community groups in rural and remote areas of WA, a synthesis of the Holman review was published. This synthesis foreshadowed a series of proposals for legislative reform for the purpose of subjecting the proposals to public scrutiny for further comment. A second round of public submissions was received, numbering over 300, which led to further recommendations for change. In December 2003, a document outlining the final recommendations, titled "The Way Forward", was presented to the then Minister for Health. The majority of the recommendations were accepted by the previous government. "The Way Forward" recommends that the current act be repealed and replaced with a new legislative framework. The recommendations advance the rights of persons experiencing mental illness, and support the responsibilities of clinicians in balancing quality of care for persons experiencing mental illness with important issues of community welfare.

Following a change of government in 2008, the appointment of a Minister for Mental Health, and the establishment of the Mental Health Commission, the bill, as drafted in 2007, was further scrutinised. Advice was sought from key stakeholders and experts in the field from within Australia and overseas, which resulted in further redrafting of the bill. On 16 December 2011, the draft bill for public comment of the Mental Health Bill 2011 was launched by the Minister for Mental Health, Hon Helen Morton MLC. Public submissions were sought between December 2011 and March 2012. To facilitate discussion on the draft bill, the commission published a 90-page explanatory guide to the draft bill and convened over 40 forums in Perth and Western Australia. These sessions were attended by nearly 600 participants, including consumers, clinicians, members of government and

non-government organisations, and people who simply had a common interest in the future of mental health in Western Australia. The commission received approximately 1 200 written submissions providing feedback on the draft bill. Oral submissions arising from comment at public forums were also noted. All suggestions were welcomed and made a significant contribution to the green Mental Health Bill 2012. The green bill was refined from the original bill and it was decided that an additional round of public consultation would be beneficial. The green bill was tabled in Parliament on 8 November 2012 with the clear understanding that it did not represent the government's final position and that it was open for further public comment. The commission welcomed submissions until 28 February this year and received over 100, all of which, where authors permitted, have been made available on the Mental Health Commission's website. In this latest round of consultation more than 500 issues were raised. This demonstrates that, as with earlier consultation, there has been extensive and constructive community debate around this legislative reform. Adding to this round of consultation was the input provided by internationally respected mental health adviser Gregor Henderson, who also played a key role both in providing feedback and in generating discussions within the mental health sector. This bill, then, is the culmination of literally years' worth of consultation and community, stakeholder and expert feedback, and I take this opportunity to sincerely thank every person who has taken the time to express their views and concerns, and often to share their individual experiences.

The creation of mental health legislation is always going to be a delicate balancing act and the extent of this necessary balancing act was reflected in the feedback, which so often proposed competing imperatives. Although some stakeholders may argue that the legislation should enable clinicians to have the professional discretion and ability to intervene when it is their judgement that it is necessary, others will argue that there should be very limited capacity to involuntarily detain or treat someone against their will. Added to these competing positions is the community's right to feel safe and assured that those with severe mental health issues are receiving support and treatment in the least restrictive environment appropriate in their circumstances. Finally, there is the right for family members and carers to ensure that their loved ones will always get the support and intervention they require in times of crisis, and to be involved in clinical decisions, whilst simultaneously respecting the individual patient's right to privacy and to determine their own individual recovery.

In essence, this bill seeks to juggle competing rights and concerns. We must remember, when legislating for mental health, that this bill will only ever deal with a minority of the people who experience mental illness—that is, those who are the most unwell; most at risk to themselves and others; and those people who, due to the extent of their illness, potentially lack the insight necessary to determine the best pathways to their own recovery at a particular point in time. The majority of people who live with mental illness will never come within the provisions of this legislation. Most of these people will continue to contribute to and engage in their own recovery, on their own terms, successfully, whilst participating in the community.

At this point it is important to note that the bill is not intended to, and does not, apply to outpatients voluntarily seeing their own GP, psychologist or psychiatrist. This, however, does not mean that these primary health professionals cannot be involved in a person's treatment, support and discharge planning; in fact, this is expressly stated in the bill. In the feedback on both the draft bill and then the green bill, a number of stakeholders expressed concern about the size of the bill and indicated a preference for a smaller, simpler bill. Yet paradoxically many of these same stakeholders also expressed a strong preference for additional provisions to be included in the legislation, which would have made the bill larger and more complex than it currently is. I acknowledge that, in the future, it will be desirable to move to a smaller piece of legislation that is potentially competency based, and this is something that the mental health sector can still work towards. But this piece of legislation, within the scope of the existing mental health reform agenda, is deliberate in its intent to specifically prescribe the clinical responses, rights and recourse around provisions that enable the involuntary detention and treatment of people who are at risk by reason of a severe mental illness.

Put simply, this bill has been developed within an environment of distrust, which has characterised the mental health system in this state since the Lunacy Act 1871, and also in mental health systems in other jurisdictions. For too long consumers and carers have complained of a system in which they feel, and too often are, systematically disempowered and ignored. This bill seeks to remedy much of that dynamic through the articulation of clear processes and safeguards around the involuntary treatment system. This context is important for an appreciation of why the decision was made to create a bill that is a reflection of where the mental health sector currently is in Western Australia. While it is important to commit to the goal of a future act that may be simpler and smaller, right now we are dealing with an environment of historical disempowerment and a certain level of distrust, which many people affected by severe mental illness and working within the system are keen to reverse.

This bill brings an unprecedented capacity to review decisions and treatment for both consumers and their carers or family members. A key part of this bill is the addition of the charter of mental health care principles, which has been statutorily enshrined as a schedule to this bill. These principles provide an important framework for the

way in which service providers are expected to deliver mental health services. Heavily influenced by the recovery model, the charter spells out the best practice approach within which those who are entrusted with the care of the most mentally unwell people must operate. Failure to do so leaves people experiencing mental illness, and their families and carers, with an option to pursue a complaint against the service provider, through the Health and Disability Services Complaints Office, also known as HaDSCO. The bill has strengthened the role of HaDSCO to improve support for individuals who wish to pursue complaints against mental health services.

The bill significantly reforms the judicial processes surrounding involuntary detention. The Mental Health Tribunal replaces the Mental Health Review Board, and with it comes a significant extension of the scope of matters that can be brought to proceedings, as well as an increase in the range of people who have standing to bring on a matter. As always, consumers, psychiatrists and other acknowledged interested parties can issue proceedings. For the first time, however, family members, carers and a consumer's nominated person expressly have the potential to initiate proceedings. If someone has been denied the free exchange of information, or has been denied automatic input into the creation of treatment, support and discharge plans—both important and critical steps recognised within the recovery process—then there is automatic recourse to the tribunal. When, in the tribunal's determination, a remedy is required, the tribunal is now able to issue mental health services with a compliance notice. Noncompliance with a notice attracts a fine of up to \$10 000. The oversight role of the tribunal may be seen by some as excessive; however, it should be acknowledged that, in the vast majority of cases, these provisions will be largely unnecessary, as competent clinicians who already appropriately inform and engage with consumers, carers and family members will not have their clinical practices challenged. Time frames surrounding review of involuntary status and community treatment orders have also been tightened, going some way towards ensuring that an individual receives timely assessment and review. Finally, when a consumer, carer or family member disagrees with a clinical decision that has been made, they have the opportunity to complain to the Chief Psychiatrist who, in turn, has the power to review a clinical decision and, if necessary, reverse or amend the decision.

A critical part of ensuring the success of this legislation will be the creation of easily understood and accessible materials. The bill mandates the requirement for services to ensure that patients, family members and carers receive information about their rights in an appropriate way. The commission has prioritised the creation of materials in a number of languages and in a number of accessible formats that will clearly and easily explain the rights of consumers, families and carers and, just as importantly, how they can ensure that those rights are upheld. An extensive process is also in place to ensure that clinicians are aware of their obligations under the new bill. A clinician's guide is being written and education processes are being planned and undertaken. In essence, everything is being done to ensure that all stakeholders have both input into and full knowledge of the proposed changes.

Development of the draft clinician's guide has commenced as a joint project between the Mental Health Commission and the Office of the Chief Psychiatrist and will be progressed during the implementation process. The guide will be available once the legislation becomes operational and will include as addendums the Chief Psychiatrist's guidelines and flow charts. From this clinician's guide, other shorter guides will be developed—for example, for medical practitioners. It is recognised that the language and content of the guides for consumers, carers and the general public will differ from the clinician's guide.

The commission has also established an implementation reference group in anticipation of the passing of this legislation. This group is constituted by representatives from government departments, peak bodies, consumers and families and carers, and, with a number of subgroups, it is intended and expected that this highly representative structure will ensure a smooth transition to the new ways of operating.

I now wish to speak to the substance of the bill and to highlight the key components.

Rights: the bill, like the current act, allows for people experiencing severe mental illness to be treated and cared for at times without their consent, which makes protection of the human rights of these people the cornerstone of this legislation. This requires clinicians to act with respect and dignity towards patients and their families and carers, and to respect their right to make decisions about their own lives. These values are reflected throughout the bill, including in the Charter of Mental Health Care Principles in schedule 1 of the bill. The charter has been reviewed further since the green bill to develop the principles around recovery, choice and self-determination, in addition to changes in relation to the principle about Aboriginal and Torres Strait Islander people. The charter requires mental health services to make every effort to comply with the principles when providing treatment or support to patients. Failure to do so can result in a complaint which could be investigated by the Health and Disability Services Complaints Office.

Other rights for involuntary patients include the right to an independent further opinion about their treatment, which can be requested by the patient or a support person, which includes a family member, carer, nominated person, parent of a child, guardian or enduring guardian. Failure to provide a further opinion can be reviewed by

the Chief Psychiatrist and the Mental Health Tribunal. A person can request an additional opinion after receiving a further opinion, but if it is unwarranted, after having had regard to the Chief Psychiatrist's guidelines, the additional opinion does not have to be provided. A refusal to provide an additional opinion can be reconsidered by the Chief Psychiatrist.

Patients have the right to freedom of communication, which may be restricted in some cases by the psychiatrist. Restrictions can be reviewed by the tribunal on application by the patient, any of their support persons, a mental health advocate or any other person with a sufficient interest in the matter.

Patients have a right to access their medical record, which is in addition to their provisions in freedom of information legislation. However, access may be refused for confidentiality reasons or when access would pose a risk to the patient or another person. The patient is able to nominate a lawyer, who will have unfettered access. The decision to deny access can be reviewed by the tribunal. Patients have the right to nominate another person, such as a friend or acquaintance, to be the patient's nominated person so as to receive information and to be involved in decision-making. The tribunal has jurisdiction to vary a nomination or to declare it invalid.

Patients have the right to have their wishes considered by their psychiatrist and if the patient's psychiatrist makes a decision that is inconsistent with an advance health directive or enduring power of guardianship, he or she must record this decision and the reasons for it, and provide a copy to the patient, the patient's support persons, the Chief Psychiatrist and the Chief Mental Health Advocate. This decision can be reviewed by the Chief Psychiatrist.

Involuntary patients and mentally impaired accused persons in authorised hospitals have the right to a treatment, support and discharge plan, which is to be developed in collaboration with the patient and their support persons. If the patient or support person is denied this opportunity, this can be reviewed by the tribunal. Further, the tribunal can, when conducting a review of any issue, make recommendations to clinicians on the treatment, support and discharge plan. Patients and their support persons have the right to make a complaint to the Health and Disability Services Complaints Office in addition to the mental health service.

Involuntary patients and mentally impaired accused persons in authorised hospitals have the right to be visited or otherwise contacted by an advocate from the Mental Health Advocacy Service within seven days, or 24 hours if the patient is a child. There is also the right to an initial and periodic review of involuntary status by the tribunal within shorter time frames than in the current act. Importantly, patients have the right to an explanation of right in a form and language that the patient is most likely to understand. A support person is also entitled to receive an explanation of rights. Again, the tribunal can review any failure by a clinician to comply. There is a duty on staff not to ill-treat or wilfully neglect a patient, and to report unlawful sexual contact or unreasonable use of force by staff to the Chief Psychiatrist. Noncompliance is an offence with a penalty of up to \$15 000 and two years' imprisonment. Patients have additional rights when it is proposed that the patient be given emergency psychiatric treatment, electroconvulsive therapy or psychosurgery, and when the patient is secluded or restrained.

Referral: doctors, including psychiatrists and authorised mental health practitioners, can refer a person to a psychiatrist for examination. Authorised mental health practitioners are nurses, social workers, psychologists or occupational therapists with at least three years' experience in mental health, and are specifically authorised by the Chief Psychiatrist. In rural and remote areas, which is anywhere external to the metropolitan area, assessments can be conducted by audiovisual means, but only when it is not reasonably possible for the person and the clinician to be within each other's physical presence. This will allow earlier intervention for people in remote communities who are experiencing mental health illness and are at risk to themselves or others. A health practitioner, or in relation to a person of Aboriginal or Torres Strait Islander descent an Aboriginal mental health worker, must be with the patient when such an assessment is conducted. Referred persons may, if refusing to remain at a safe place such as an emergency department, be detained for up to 24 hours. In the metropolitan area, this can be extended by 24 hours to a maximum of 72 hours. Outside the metropolitan area, it may be extended in 24-hour blocks up to an additional 72 hours. This will provide a clear legal framework to do what was previously done in reliance on a duty of care and it provides for referred persons to be safely cared for so that they can be transported to a place for examination by a psychiatrist. When assessing a person of Aboriginal or Torres Strait Islander descent, the practitioner must, to the extent that it is practicable and appropriate, involve an Aboriginal and Torres Strait Islander mental health worker and significant people from the person's community, such as elders and traditional healers.

Debate interrupted, pursuant to standing orders.

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