MENTAL HEALTH BILL 2013

Consideration in Detail

Resumed from 27 February.

Clause 10: Objects —

Debate was adjourned after the clause had been partly considered.

Dr A.D. BUTI: We were discussing the issue of this clause before the recess, two weeks ago. Clause 10, being the objects of the legislation, should set out its whole aim with respect to dignity, and that is good. However, if we are dealing with dignity and the least possible restrictions on freedoms and rights, should there not also be a more explicit clause stating that when in doubt over any issue, the liberty of the subject is paramount in any decision regarding the interpretation of any clause? The interpretation of any clause should be construed in favour of the liberty of the subject. I am talking about only when there is doubt; in that case, things should be construed in favour of the liberty of the subject.

Ms A.R. MITCHELL: We will always rely on common law in these cases. It is no different from any other case; all those things that apply to common law would be used.

Dr A.D. BUTI: When it is said that common law will be referred to, will there be a list of cases that will be looked at? I am talking about a provision in the legislation. As we know, legislation overrides the common law in any case, so should we not make the legislation more explicit? By relying on common law, is it being said that when in doubt, common law always gives preference or construes any ambiguity in favour of the liberty of the subject? Does it or does it not? I do not think common law necessarily does that. We do not have a bill of rights in Australia, so I am not sure about common law when it comes to the freedom of people. We do not have a bill of rights; we are not the United States. Therefore, there have to be provisions in the legislation; that is why we have equal opportunity legislation. Clause 10(1) states —

> The objects of this Act are as follows —
>
> (a) to ensure people who have a mental illness are provided the best possible treatment and care —
>
> (i) with the least possible restriction of their freedom; and
>
> (ii) with the least possible interference with their rights; and
>
> (iii) with respect for their dignity;

What I am asking for would do no more than what that clause presumably provides, but it is still unclear when there is doubt about who gets preference. Why not make it more explicit in the legislation so that if there is any doubt when interpreting any clause of this bill, it will be construed in favour of the liberty of the subject? When it is said that common law will be referred to, will we have to go to court every time there is some doubt? I am not sure that the precedents in this matter will provide enough detail.

Ms A.R. MITCHELL: The idea of the objects of the legislation is that they are not mandatory. As we have all commented, the bill is very large, but throughout this bill there are a number of narrower clauses that are specific. I refer the member to clause 24(6), which is an example of a clause that is much more specific and mandatory. The objects are not specific and there is a reason for that; however, throughout the bill there are many clauses that give much greater clarity.

Dr A.D. BUTI: Of course reference is made to objects when interpreting a clause, otherwise there would be no need for objects. Once again, to assist and to ensure that people's freedom is not unduly interfered with, what is wrong with having a clause in the objects—the parliamentary secretary states that they are not mandatory anyway, so I am not sure there would be such resistance—so that when construing a situation where there is ambiguity or doubt in the interpretation of a clause, it will always be construed in favour of the liberty of the subject?

Ms A.R. MITCHELL: The objects of the bill have been set up this way so that it encompasses a framework that is supportive of patients at all times. As I said before, throughout the bill there are specific areas that will show the compliance and greater support that the member is looking for. Parliamentary Counsel has advised that this is the best way to go for this bill.

Clause put and passed.

Clause 11: Regard to be had to Charter —

Dr A.D. BUTI: Part 4 and this clause deal with the Charter of Mental Health Care Principles. Clause 11 states that regard should be had to the Charter of Mental Health Care Principles. When it states that "regard should be

had", I presume that is not mandatory, and it is discretionary. What relevance can we really put to this clause, which is perhaps a good-feeling clause that has been inserted into this bill to try to make it look as though it is more concerned about the rights and freedoms of people who may have a mental illness than is actually the case? Put another way: is there any penalty if someone performing a function under this legislation does not have regard to the principles set out in the Charter of Mental Health Care Principles? Are there any ramifications for that person?

Ms A.R. MITCHELL: The member is correct. The Charter of Mental Health Care Principles is an aspirational document and not a mandatory document, but the member would see in clause 12 the word "must" comply and words such as that that will come up throughout the bill. It is very difficult to have set standards in the words that are being used in the charter. We are talking about dignity, passion—things that are not necessarily measurable—so throughout the bill there are ways that once again this must be adhered to.

Clause put and passed.

Clause 12: Compliance with Charter by mental health services —

Dr A.D. BUTI: As the parliamentary secretary stated, clause 12 has a greater obligation attached to it than clause 11. Clause 12(2) states that a mental health service "must"—which means that it is mandatory—make every effort to comply with the Charter of Mental Health Care Principles when providing treatment, care and support for patients. If it is mandatory and that is not complied with, what are the ramifications? If there are no ramifications, then the mandatory threshold of this clause means nothing.

Ms A.R. MITCHELL: The words "must make every effort to comply" mean that failure to comply with the charter can result in a complaint to the Health and Disability Services Complaints Office, and then it will have to act on that.

Clause put and passed.

Clauses 13 and 14 put and passed.

Clause 15: Determining capacity to make decisions —

Ms A.R. MITCHELL: I move —

Page 17, line 22 — To insert after "if" —

another person who is performing a function under this Act that requires that other person to determine that capacity is satisfied that

There are proposed amendments for clauses 15, 18 and 25, and because there is an amendment proposed for clause 25, it is important to apply those principles in clause 15 and subsequently clause 18. However, I will talk about clause 15 first. Because we are proposing to take out the other section of clause 25, there was a need to strengthen the capacity of clause 15. That is the basis of this amendment.

Amendment put and passed.

Ms A.R. MITCHELL: I move—

Page 17, after line 28 — To insert —

(ca) weigh up the factors referred to in paragraphs (a), (b) and (c) for the purpose of making the decision; and

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 16 and 17 put and passed.

Clause 18: Capacity to make treatment decision —

Ms A.R. MITCHELL — by leave: I move —

Page 19, line 2 — To delete "does not have" and substitute —

has

Page 19, line 3 — To delete "unless" and substitute —

if another person who is performing a function under this Act that requires that other person to determine that capacity is satisfied that

Page 19, after line 10 — To insert —

> (ca) weigh up the factors referred to in paragraphs (a), (b) and (c) for the purpose of making the treatment decision; and

These amendments follow on from what was done in clause 15. It is important to strengthen the capacity of people to make treatment decisions and more surety is being given to patients, carers and families with these amendments.

Dr A.D. BUTI: I seek some clarification, Mr Acting Speaker. If I want to speak against an amendment but not necessarily vote against an amendment, am I able to do so? I wanted to speak about the other amendment. Actually, I do want to vote against the amendment.

The ACTING SPEAKER (Mr P. Abetz): You are certainly free to speak.

Dr A.D. BUTI: The parliamentary secretary has clearly set out the reason that she brought in these amendments, which is really the same as clause 15, which I wanted to speak to but, unfortunately, I did not. In a way, these amendments defeat the purpose of the good amendment that she proposes to move to clause 25. The sole requirement of clause 25 is the issue of capacity; that is, the parliamentary secretary seeks to remove "unreasonably refused treatment". That is welcome. We will talk about that when we get to clause 25. In many respects, the good of that amendment is being chipped away or ruined by the amendment that she made to clause 15, which has been passed, so it is too late for me to deal with it.

The problem we have with the parliamentary secretary's amendment to clause 18 is that it once again gives undue balance of power to the authorities over the patient. Surely the capacity of a person under clause 19, which we will deal with shortly, should refer to information provided as per clause 19 and the effect of a treatment decision, matters involved in making the treatment decision and the effects of any treatment decision. They surely are sufficient to ensure that only a person who is competent to make a decision will make the decision. The parliamentary secretary is saying that we have to weigh up the benefits. Obviously, it is easier to argue that a psychiatrist who deals with these matters on a daily basis has greater expertise in determining whether someone should be treated. That does not necessarily mean that the views of the patient are wrong; they just may be different. By saying that we have to weigh up the benefits of treatment or refusing treatment gives an undue preference to the views of the profession over the patient, which really takes away any good that the parliamentary secretary will make with the amendments she seeks to move to clause 25. Specifically, evidence of a patient's incapacity as a weighing up factor will give, as I said, undue weight to the experts because on a daily basis they assess the risks involved in treatment vis-a-vis the benefits involved in treatment and vice versa. Surely we just need to ensure that a person has the capacity to refuse treatment. Clause 18 states —

> A person does not have the capacity to make a treatment decision about the provision of treatment to a patient unless the person has the capacity to —

Paragraphs (a), (b), (c) and (d) set out the criteria, as does clause 19. Surely that is enough. Why do we need this additional clause that talks about a weighing up exercise? That takes away any benefit that is accrued by the parliamentary secretary's sensible amendment to clause 25.

Ms A.R. MITCHELL: The member's concerns are noted but I assure him that this clause was drafted after a lot of discussion with the Chief Psychiatrist and other clinical advisers to get the wording right. It is there because there was concern prior to this bill being introduced that some people were treated involuntarily without good assessment. This is all part of protecting people who are placed in care as involuntary patients. It gives further weight to the capacity test that the psychiatrist needs to go through. We have discussed all that with them because, as the member knows, this has come in at a later time than the removal of the words "unreasonable refusal".

Dr A.D. BUTI: In her response, the parliamentary secretary really spoke about what I am trying to argue. Of course there has been much thinking and consideration prior to drafting this amendment. I do not question the amount of effort and time spent trying to get this bill right. As the parliamentary secretary stated earlier, we had the original clause 18 with those criteria relating to capacity. That was considered to be okay. Then the government looked at clause 25 and it thought maybe it is not okay that we have this clause that enables a person to unreasonably refuse treatment. The problem with the phrase "unreasonably refused treatment", as the parliamentary secretary knows, is that it becomes a circular argument because the psychiatrist is saying that a person should be treated. If that person refuses to be treated, obviously the psychiatrist will say it is unreasonable that they are refusing to be treated, or there is more chance the psychiatrist will say that. That phrase has been taken out but surely the parliamentary secretary saw that was a problem and she should be commended for seeking to move an amendment that deletes that provision in clause 25.

In quite a sneaky way—I am not saying that the parliamentary secretary means to be sneaky—she seeks to insert to clause 18 this issue of weighing up the benefits. People either have the capacity or they do not have the capacity. That is what clause 18, in its original form, goes to—the capacity of a person to make a decision relating to treatment. The provision was in the bill, and it included the criteria that would determine whether a person has capacity. That is sufficient. There is no need to add to this other clause that really does the work that the original clause 25 did but the parliamentary secretary decided should be amended because it would probably give undue power to the treating psychiatrist. Therefore, the amendment to clause 18 removes any benefit that the amendment to clause 25 will have.

Division

Amendments put and a division taken, the Acting Speaker (Mr P. Abetz) casting his vote with the ayes, with the following result —

Ayes (33)

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

Noes (16)

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

Pairs

Mr T.R. Buswell	Mr M.P. Murray
Ms W.M. Duncan	Ms L.L. Baker
Mr G.M. Castrilli	Mr C.J. Tallentire

Amendments thus passed.

Clause, as amended, put and passed.

Clause 19: Explanation of proposed treatment must be given —

Dr A.D. BUTI — by leave: I move —

Page 19, after line 23 — 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.

Page 19, after line 23 — To insert —

and

(d) 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

(e) 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.

Clause 19 is very important, because it deals with explanation of proposed treatment. Subclause (1) states —

Before a person is asked to make a treatment decision about the provision of treatment to a patient, the person must be provided with a clear explanation of the treatment —

(a) containing sufficient information to enable the person to make a balanced judgment about the treatment; and

(b) identifying and explaining any alternative treatment about which there is insufficient knowledge to justify it being recommended or to enable its effect to be predicted reliably; and

(c) warning the person of any risks inherent in the treatment.

That is all very fine. However, it is also very important that the person be advised of their right to obtain independent legal and medical advice. Even though one could argue that the 2011 draft of the bill was overly prescriptive in the information that needed to be provided to patients with regard to the risk of treatment, the person should also be given the right to withdraw consent to treatment at any time. People do change their minds. I am sure treating psychiatrists change their minds. If treating psychiatrists have the right to change their minds, surely the patient should also have the right to change their mind. When people are engaged in a contractual negotiation, such as buying a house, they have the right to obtain independent legal advice. However, in the case of something as fundamental to a human being as treatment for a mental illness, it is not stipulated in the bill that there is an obligation to tell the person that they have the right to obtain independent legal and medical advice. That is the reason we have moved the first amendment.

The second amendment deals with the issue of disclosure of any financial advantage that may be gained by any medical practitioner or mental health service. The references in the 2011 draft bill to requiring the treating doctor to disclose any financial interest have not been included in this bill. It is alarming that a patient will not be provided with details of any financial connection or advantage that the treating doctor may receive in respect to that person's treatment. There is also no obligation to inform the person of any research relationship that may exist between a medical practitioner and any mental health service.

Ms M.M. Quirk: I am interested in what the member for Armadale has to say and I would like him to continue.

Dr A.D. BUTI: Thank you, member for Girrawheen.

Under the guidelines and principles of the Australian Medical Association, doctors are obliged to disclose any financial interest. In academic and legal circles, there is also a requirement to disclose any financial interest. In the parliamentary profession in which we are all engaged, it is incredibly important that we disclose any financial interest. In local government, at the beginning of every council meeting, councillors are required to disclose any financial interest or conflict of interest. There is no greater conflict of interest than when a financial advantage can be obtained. We are very concerned that the obligation for the treating doctor to inform the patient of any financial advantage or financial link that they may have, or any research relationship that they may have with a mental health service, has been removed from the bill. That is the reason we have moved the second amendment.

Ms A.R. MITCHELL: I seek some clarification from the member about the amendments that he has moved. They both say "Page 19, after line 23", and then they both seek to insert paragraphs (d) and (e).

Dr A.D. Buti: I have just noticed that. I might seek some clarification from the Clerk.

The ACTING SPEAKER (Mr P. Abetz): I understand that if both amendments are successful, the numbering of the last two paragraphs would need to be modified. That is just a clerical matter, so we will treat the amendments in that way.

Dr A.D. BUTI: Obviously there is confusion because the clause has not yet been amended. The parliamentary secretary could treat the amendments as four paragraphs to be added to line 23 or she could accept only part of them. However, she is probably not going to accept any part of them, so it will not really make much difference.

Ms A.R. MITCHELL: I thank the member. The most important aspect of this Mental Health Bill is that people with a mental illness should not be treated any differently from people being treated for any other medical procedure. Agreeing to the member's amendments on giving legal advice and things like that will actually make mental health patients different from other patients with a physical illness.

Dr A.D. Buti: They are different.

Ms A.R. MITCHELL: No. Mental illness is an illness. It is not different. This is part of the whole stigmatisation that we have often talked about in our speeches in the second reading debate. People just do not get legal advice when they go to the doctor. If I went to the doctor and he wanted to change some medication I was on from, let us say, 10 milligrams to 20 milligrams or something, it would be silly of me to go and get legal advice to see whether that was okay. It would spoil the relationship I have with my doctor. The same should apply to a mental health patient. The element of trust in that association is very important. However, clause 20(c)

provides the patient with a reasonable opportunity for that to occur, if they wish. We do not believe it is essential to make it mandatory. We do not believe it is a good thing for the treatment of people with a mental illness.

I will go to the financial disclosure section, given that we are dealing with both amendments. I think every person in this chamber agrees that disclosure of information to any patient, whether it be a person with a mental illness or any other illness, is absolutely essential and should be provided by any person in that profession.

I say once again that conflicts of interest are already addressed in the professional standards and codes that guide the work of medical practitioners. I refer to the Medical Board of Australia's code of conduct for doctors in Australia. If a doctor fails to comply with these standards, it can have serious consequences for them and can result in loss of their professional registration. We therefore believe that the provisions in the member's amendments are covered because psychiatrists come under that professional code as well.

Dr A.D. BUTI: I find it quite alarming that the parliamentary secretary says that a mental health patient is just like any other patient. If I go to the doctor for an ingrown toenail, is there a chance that I will be incarcerated against my will? Of course there is not. How silly to say that a mental health patient is just like any other patient! I totally agree with the parliamentary secretary that we should not stigmatise patients. However, we do not have a bill of this size for someone who wants an ingrown toenail operation. This is a major piece of legislation. It is probably one of the most detailed pieces of legislation that will come before Parliament during this parliamentary term. The reason it is so detailed is that a mental health patient is not the same as any other patient. How absurd! Which patient goes to a doctor and may not actually go home that night? There are very few, unless they need an emergency operation. There is the chance that a mental health patient will be incarcerated and held without their will as an involuntary patient. When does a police officer pick up from the streets someone who has an ingrown toenail? Of course they do not. They will pick up someone under this bill because they may have a mental illness that may be of harm to themselves or to the community. Therefore, parliamentary secretary, please do not stand and say, "They are just like any other patient. It doesn't really matter. You go to the doctor and you have a relationship with your doctor." Of course people have a relationship with their doctor. The doctor should also have an obligation to advise a mental health patient that the consequences of treatment can be significant. Which other patient might be subject to electroconvulsive therapy or psychosurgery? I know that might be the case with some degenerative diseases, but do not, please, stand in this place and equate a mental health patient with any other patient, because they are not like any other patient. The powers provided under this bill are incredibly significant and the consequences of people subjected to an order under this bill are enormous; therefore, they should be able to receive independent legal or medical advice. That is not breaking the relationship. When I was a solicitor, my firm often told clients to go and seek other advice. That did not mean that our relationship was strained. If anything, it could build a relationship because the patient would know that the doctor was telling them to go and get independent legal or medical advice, which would be a reflection of the doctor's concern for that person. It would not break that relationship.

The parliamentary secretary talked about professional guidelines et cetera. However, I go back to the 2011 draft of the bill which contained a requirement for treating doctors to provide advice that a person may refuse to give consent et cetera, and that they may obtain independent legal and medical advice. There were also references to financial disclosure in the 2011 draft of the bill that have been removed.

The Australian Medical Association recognises the need for full disclosure of any potential conflict of interest. We have a very prescriptive bill in front of us. It needs to be prescriptive because of the consequences. Why would we not therefore include a clause that requires disclosure to a patient of any financial advantage to be gained by the doctor from providing the treatment, rather than saying that doctors can refer to some professional guidelines? What is the opposition to having a clause in the bill, which contains 580-odd clauses, on a potential conflict of interest in gaining a financial advantage?

Dr G.G. JACOBS: I want to make a contribution, if I may, parliamentary secretary. The member for Armadale referred to the bill as prescriptive. It needs to be prescriptive, but these four subsets in the member for Armadale's amendments are overly prescriptive and full of unnecessary legalese. I do not like the member's example of an ingrown toenail. I will give a real example of a case of invasive surgery. Let us say, for instance, that on my leave I am called up to the hospital because the surgeon has left town and I am the next best thing. I find a patient on examination and history with classical appendicitis. There is already a consent mechanism, a quite prescriptive consent form. That form always has an option for a person to withdraw their consent at any time. Informing the person that I would do the operation for purely clinical reasons and to their benefit but then telling them I would get $250 from the Western Australian Country Health Service for performing the operation would be inappropriate and unnecessary. A practitioner may, for instance, be overservicing by taking out an appendix in every second person without good clinical reason, but members can be sure that there are mechanisms in the system to deal with that issue. The amendment states that the person should be informed

about any financial advantage. To me, as the practitioner taking out the appendix, that is not relevant. It is actually quite insulting to the profession to suggest that, in this case, a procedure to treat mental illness—whether it be electroconvulsive therapy or psychosurgery—would be done for some financial advantage to the practitioner. We know that there are professional codes of practice and professional accreditation systems. Of course, I believe that practitioners value their professional ethics. The amendment states that a person should be informed about any research relationship. The practitioner could say, "I'm taking out your appendix because you are part of a trial. Some appendixes I leave in and others I take out, and we are doing a double-blind trial, if you like, to see whether things are better if we leave the appendix in and treat with antibiotics versus surgery." I do not believe these amendments are necessary. It does not happen in other areas of medicine. As the parliamentary secretary said, whether it be psychosurgery, ECT or an appendicectomy, we do not prescribe these things in those procedures. I believe there are already checks and balances within the profession, whether it be psychosurgery, ECT or an appendicectomy. I believe that the clause that the parliamentary secretary also referred to about sufficient time for consideration does indeed cover that possibility for people to reflect and consider whether or not they consent.

Dr A.D. BUTI: I thank the member for Eyre for his contribution. In regard to the financial advantage amendment, I do not think he has read the whole provision. If he reads the proposed amendment, he will see that it states —

> 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 —

I repeat, "except" —

> information about the fees and charges payable by or on behalf of the person for the admission or treatment;

Of course everyone receives professional fees for doing an operation et cetera. I am not talking about that.

Dr G.G. Jacobs: What are you talking about?

Dr A.D. BUTI: I am talking about a financial advantage on top of that.

Dr G.G. Jacobs: Like what?

Dr A.D. BUTI: A kickback.

Dr G.G. Jacobs: A kickback?

Dr A.D. BUTI: Member for Eyre, have no doctors ever got a financial advantage by prescribing a certain drug? Has there been no case in history of medical practitioners receiving a financial advantage by prescribing a certain drug?

Dr G.G. Jacobs: So you are —

Dr A.D. BUTI: No. Is there a history of that?

Mr W.J. Johnston: The silence is the answer.

Dr A.D. BUTI: I will say no more on that.

Ms A.R. MITCHELL: I will respond to the member for Armadale's initial comments. I remind the member that this clause is about mental illness in general, not just involuntary treatment. That is why I used examples that would be across anyone with a mental illness, and not just someone in involuntary care. The other thing is that the member is right that there was a clause in the draft. It was taken out at the request of the Australian Medical Association because it felt that it was discriminatory against psychiatrists and that there was no need to duplicate the code that they already operate under.

Dr A.D. BUTI: I thank the parliamentary secretary for that clarification. It is quite interesting that it was taken out on the recommendation of the AMA, but what about the patient? There is no need to respond.

Ms A.R. Mitchell: No, I am not going to respond.

Division

Amendments put and a division taken, the Acting Speaker (Mr P. Abetz) casting his vote with the noes, with the following result —

Ayes (18)

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

Noes (34)

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

Pairs

Mr M.P. Murray	Mr T.R. Buswell
Mr P. Papalia	Ms W.M. Duncan
Ms L.L. Baker	Mr G.M. Castrilli

Amendments thus negatived.

Clause put and passed.

Clauses 20 to 24 put and passed.

Clause 25: Criteria for involuntary treatment order —

Dr A.D. BUTI: Thank you very much, Madam Acting Speaker.

The ACTING SPEAKER (Ms L.L. Baker): I am sorry; the parliamentary secretary just wants to query something.

Ms A.R. MITCHELL: I was under the impression that I would move the amendments in my name to clause 25 first.

The ACTING SPEAKER: The member for Armadale goes first; his amendment is two lines before yours.

Ms A.R. MITCHELL: I apologise, member for Armadale.

Dr A.D. BUTI: Although a lot of attention has been given to electroconvulsive therapy and psychosurgery, which we will get onto a lot later, clause 25 is, in many respects, probably the most important clause of the bill because it concerns the criteria for an involuntary treatment order. Let us be clear about this: we are talking about the criteria that will allow a person to be involuntarily subjected to treatment. In other words, a determination can be made that a person should undergo treatment, whether they consent to it or not. We have already discussed the amendment to be moved by the parliamentary secretary that will remove the words "unreasonably refused treatment", which we support, although we believe that the benefit of that has been, in many respects, minimised or completely quashed by the amendments made to clause 18, but so be it.

This is an interesting clause for a number of reasons. As I said, this is the clause that outlines the criteria for determining the involuntary detention of a patient. How we have got to this stage on this clause is interesting. It is important for me to provide some history on this clause. The former member for Bassendean, who as we know had a keen interest in mental health, highlighted some of the concerns with the criteria for involuntary patients. I want to go back to the contribution he made on 24 May 2012 about one of his constituents, Maryanne Connor. I refer to *Hansard* of 24 May 2012. I will obviously not read his whole contribution, but it is important that I read parts of it. The former member for Bassendean, Martin Whitely, stated —

> Maryanne, her mother, and her mother's cousin, Hon Paddy Embry, a former member of the Legislative Council, are in the Speaker's gallery today. I am really very concerned by the treatment that Maryanne has received from Fremantle Hospital psychiatric services, and by the operation of the Mental Health Review Board. I might point out that considerable effort has been made by the president of the Mental Health Review Board to prevent me making the details of this public, and I am just very thankful I have parliamentary privilege …

He further stated —

> I was invited by Maryanne and her mother, Mary—I will refer to Mary as "her mother", because it will make it a little easier with the similarities in their names—to attend a Mental Health Review Board hearing about Maryanne's involuntary patient status. I have to say that what happened at the Mental Health Review Board shocked and angered me. I thought the Mental Health Review Board was there, first and foremost, to protect patient rights, but I saw anything but that happening at that hearing.
>
> What is not in dispute is that Maryanne has a mental illness; Maryanne is a diagnosed schizophrenic. She has also been treated by a private sector psychiatrist for three years who has had her on —

He referred to certain medication. He continued —

> It is fair to say that this treatment has been arrived at after many years and a long, sad history of adverse reactions to other psychotropic medications, particularly antipsychotics. Maryanne and her mother acknowledge that Maryanne has a mental illness—that is not in dispute—and they are happy with the treatment of the private psychiatrist.

They were also happy with some other drugs that were prescribed. He continued —

> It is very relevant to this to highlight some of the history of Maryanne's treatment.

The former member for Bassendean said that she had tried a variety of medications, some of which had had major side effects on her life. He then talked about problems with other treatment that she had received.

Mr D.A. TEMPLEMAN: I am intensely listening and would like the member to continue.

Dr A.D. BUTI: I thank the member for Mandurah. What concerns us about the criteria utilised in the bill is that, unfortunately, Maryanne was admitted as an involuntary patient on the issue of damage to reputation. She had been treated over a number of years. No-one disputes that she had a mental illness. Mr Whitely went on to talk about the good news she received in 2009, when her mother found a private sector psychiatrist who prescribed a treatment regime that seemed to work for her. He then stated —

> What is relevant is that on roughly 12 March, so not that long ago, Maryanne, on the advice of a previous treating clinician, tried a drug holiday. It turns out, and it is acknowledged by Mary and Maryanne, that it may not have been successful, and there were some problems that I will outline later. It is important to note that that started on 12 March, and she was hospitalised on 23 March. On 15 March she met with her private psychiatrist, as she did every two to three weeks, and had a normal meeting and no problems were identified. Maryanne used to have fortnightly coffees with an occupational therapist, and that happened on 22 March; unbeknown to Maryanne's mother, that occupational therapist was actually a designated caseworker from Fremantle Hospital.
>
> What happened is fairly murky, but there seems to be some indication that Maryanne may have raised her voice at this coffee meeting. Maryanne denies this, and the Mental Health Review Board never heard any detailed evidence of it, which is just outrageous, and I will talk about that later on. So we have this vague notion that Maryanne had in fact raised her voice on the morning on 22 March, a Thursday morning. On the Thursday afternoon, the caseworker, an occupational therapist, reappeared with a colleague, a mental health nurse, who sat down around the kitchen table in Maryanne's mother's house, where Maryanne lives. Maryanne, it is fair to say, was uncooperative in the sense that she did not want to answer questions. When they asked her questions about her treatment, she said basically that it was none of their business. Maryanne's mother assures me that there were no raised voices, and there were no allegations that there were raised voices. She was simply, as I understand it, uncooperative and said, "Mind your own business. It has nothing to do with you," which is a normal human reaction when people are interfering in your life and you do not want it.
>
> I might point out that the occupational therapist, her caseworker, had missed many appointments—three or four appointments over the period. She was supposed to roll up every two weeks and take Maryanne for a cup of coffee. She had missed three of four appointments and had left Maryanne waiting on the front veranda and had not bothered to call to let her know that she was not coming. That all happened on the Thursday. On 23 March, the next day, at 8.30 in the evening two policemen and two mental health nurses from Fremantle Hospital appeared on Maryanne's mother's doorstep. They said that they were going to take Maryanne to the psychiatric unit of Fremantle Hospital. Maryanne's mother asked them for the paperwork. They said they had no paperwork, but they had the authority to remove Maryanne.

The ACTING SPEAKER (Ms L.L. Baker): Excuse me member, is there further information that needs to be added or have you already read this into *Hansard*?

Dr A.D. BUTI: No; in my contribution to the second reading debate I read parts of it but not to this extent.

The ACTING SPEAKER: If we already know —

Dr A.D. BUTI: Members do not; they know the basis of this but the detail that I am reading at the moment was not read into *Hansard* in my second reading debate, only parts of it were.

The ACTING SPEAKER: Continue then, member.

Dr A.D. BUTI: I quote —

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

Et cetera, et cetera; further on, Mr Whitely discusses the criteria under the current act —

> The fifth criteria—this is the one on which the whole case hinges upon and is outlined in the Mental Health Act 1996—is the potential for "serious damage to the reputation of the person". This is why Maryanne was robbed of her liberty, drugged against her will and effectively put in jail against her wishes, against her mother's wishes and, most importantly, against the wishes of her treating psychiatrist …

I will leave it at that. The way this bill has been drafted is interesting because at first glance it appears that the criteria for involuntary patients have, in many respects, not been narrowed.

Mr D.A. TEMPLEMAN: I know that the member for Armadale was about to conclude, but he needs a bit more time. I am very interested in hearing his question that is about to come.

Dr A.D. BUTI: That is because we now have an all-encompassing clause that includes a significant risk of serious harm not only to the person with a mental illness, but also to another person. We have a situation. If I remember correctly, the parliamentary secretary did admit in her second reading speech—I stand corrected—that reputation is a factor to be considered. In any case it is in the explanatory memorandum. It goes against undertakings by the Minister for Health on the Paul Murray radio program that the issue of reputation would no longer be a criterion.

It is okay for us to damage our reputation. We can damage our reputations; I am sure we do it all the time. The public thinks we damage our reputations on a daily basis. However, that is not a criterion for an order of involuntary treatment to be instigated against any of us. What discrimination do we have here? If one is a mental health patient and they damage, or potentially damage their reputation, it is a criterion that can be used for an involuntary treatment order. For the rest of the population that is not a criterion. In the previous amendment the parliamentary secretary said that mental health patients should be treated like everyone else. They are not treated like everyone else. The member for Eyre talked about an appendix. Tell me, is a patient who goes to the doctor with appendicitis in danger of being subject to an involuntary treatment order if they shout at their treating doctor? Of course not! Of course people should be made involuntary if they are a significant risk to themselves, but not in the way that the clause is drafted—"a significant risk of serious harm to the person or to another person". If one looks at the explanatory memorandum, reputation is included as one of those possibilities. How absurd! A person might shout at someone which could damage their reputation and that would be a criterion that could lead to an involuntary treatment order.

We on this side of the house are completely opposed to the broadness of the clause because "a significant risk to the health and safety of the person or to the safety of another person" is fine, but "a significant risk of serious harm to the person or to another person" is basically a broad criterion and a catch-all criterion. This is a problem for the parliamentary secretary. She is soon to bring an amendment to remove that "the person has unreasonably refused treatment"—which is good—but the benefit of that is cancelled out by the amendments she has made to clauses 15 and 18. At first glance it appears that the criteria have been reduced, but they have not been reduced because there is this broad criterion of "a significant risk of serious harm to the person or to another person" and in the explanatory memorandum that includes reputation. That is just obscene! The first criterion of a serious risk to the health and safety of the person or safety of another person is fine. In regards to the "significant risk of serious harm", we seek to amend that provision by deleting "harm to the person or another person" and include "financial harm to the person". Therefore, I move —

> Page 23, lines 1 and 2 — To delete "harm to the person or to another person" and substitute —
>
> financial harm to the person

Ms A.R. MITCHELL: Member, I do not think any of us would dispute the fact that financial harm to the person is a risk but we do not understand why the member is just having financial harm as a risk given that, obviously,

harm can occur in so many forms and each of those can be very, very important to a patient. I will not go back through the case that the member mentioned, but I will say that for a person to become an involuntary patient there is not just one criterion to be met. They have to meet all the criteria. That means it is not just one or the other.

Dr A.D. Buti: What are they? What are the other criteria?

Ms A.R. MITCHELL: If I could just finish, member. The member referred to someone shouting in regard to this clause. Under this bill, shouting is not considered a serious issue. I am sure that a psychiatrist would experience a lot of things—I am not a psychiatrist nor have I been in that situation—but I am sure that shouting would not be classed as a serious issue. We are not sure why the member has moved to amend the clause to just "financial harm" because my understanding is that one of the worst harms that people can experience is relationship harm—the breakdown of marriages and the breakdown of relationships between parents and children. In many ways, those sorts of things are far more serious and make the return to health somewhat more difficult and it is likewise with damage to reputation. If a very sensible person who suffers from a manic phase of bipolar disease runs down St Georges Terrace naked once or on a regular basis, that is significant risk to them and their reputation. There are a number of ways that significant risk needs to be looked at and all those things will be considered in determining capacity.

Dr A.D. BUTI: I take the parliamentary secretary's point about why I would just include financial harm to the person, and that is fair enough. The point on the more important issue still remains; that criterion is a catch-all criterion. The parliamentary secretary mentioned the example of a person running naked down St Georges Terrace. More than likely, that person is in a state that would cause significant risk to the health or safety of that person or to another person. It is more than likely; it is a very high probability. That person would be caught up in the subparagraph that comes before the "significant risk of serious harm" subparagraph. The parliamentary secretary also talked about marriages. Excuse me! The divorce rate in Australia is phenomenal. Are we also, under this act, going to act as a marriage guidance authority? Unfortunately, people do damage their reputation with family members and others but that should not be a criterion for making them subject to an involuntary treatment order just because they have a mental illness. However, if a person did not have a mental illness and had damaged their relationship with someone, they would not be subject to an involuntary treatment order. Would a psychopath come under this criterion because they often damage reputations? The bully in the workplace often damages reputations too, but they will not come under an involuntary treatment order. These criteria discriminate. I asked the parliamentary secretary a question about the criteria in that I wanted her to tell me what those criteria are, and she said that shouting would not be considered damage to reputation. We actually have an example that the former member for Bassendean articulated of a person shouting, and that setting off a train of events that led to them being an involuntary admission. Where in this bill is it stated that shouting would not possibly form damage to reputation—I do not know where that is—and what are the various criteria the parliamentary secretary referred to?

Ms A.R. MITCHELL: I firstly clarify that the criteria for becoming an involuntary patient are covered under clause 25(1). I state again that to become an involuntary patient a person has to meet all of those criteria—not one part of the criteria on its own. They must all be met for that person to become an involuntary patient.

Dr A.D. Buti: If you read it, that's not true. It says "or".

Ms A.R. MITCHELL: It says "all".

Dr A.D. Buti: If it is "or", it is one or the other; it does not have to meet both.

Ms A.R. MITCHELL: No; all is all, not one or the other. I write them differently and they mean different things to me.

Ms S.F. McGurk: Or.

Ms A.R. MITCHELL: No; it is A-L-L.

The Chief Psychiatrist will develop guidelines as well, so there will not be all that specific stuff in the legislation. The wording in this bill is consistent with just about every other Australian jurisdiction as well.

Dr A.D. BUTI: Can the parliamentary secretary please articulate why the Minister for Mental Health gave a commitment on 6PR that reputation would be excluded as a criterion for an involuntary treatment order and why it is now included? It is included because it is outlined in the explanatory memorandum to the bill. Why has the minister changed her mind on the issue? She made a commitment on the Paul Murray show that reputation would no longer be a criterion for an involuntary treatment order.

Ms A.R. MITCHELL: I can only state again that one criterion will not determine involuntary treatment, and I am sure that that is how the minister wanted that to be understood.

Dr A.D. BUTI: Clause 25(1)(b) states —

> that, because of the mental illness, there is —
>
> (i) a significant risk to the health or safety of the person or to the safety of another person; or

Which means it does not have to be "also" —

> (ii) a significant risk of serious harm to the person or to another person;

If someone is not covered under paragraph (b)(i), they may be picked up in the catch-all, broad-phrased subparagraph (ii). Under significant risk of serious harm to a person or another person, reputation is a criterion that can be utilised. Therefore, a person can be subject to an involuntary treatment order if they satisfy the criteria that they have a mental illness, they are at significant risk of damaging the reputation or a relationship with another person, and that person does not have capacity et cetera. On the way this legislation is written, as long as a person has a mental illness, they are considered not to have capacity, the treatment is considered to be reasonable, the person cannot be adequately provided with treatment in a way that involve less restrictions, and the only risk is a risk to reputation, that person can be made an involuntary patient. The only damage that may be forthcoming is a damaged reputation, and for that they can be made an involuntary patient. They can significantly risk damaging reputation without being a significant risk to the health and safety of their person or to that of another person. It is not that they have to satisfy subparagraphs (i) and (ii); they have satisfy only (i) or (ii).

Ms A.R. MITCHELL: I say again that the criteria for involuntary treatment order is all of clause 25(1), so paragraphs (a), (b), (c), (d) and (e). Firstly, the person must have a mental illness. I think a lot of the other situations the member for Armadale referred to such as bullying are not the same as a person having a mental illness. That is the first priority right at the start, and those other criteria come in there. It is generally understood that a person with a mental illness tends to behave out of character, so the capacity factor comes in as well. Those criteria cover all of those things and one cannot be taken in isolation.

Dr A.D. BUTI: It is understood that people need to have a mental illness under the definition; that is the problem here. Once a person has a mental illness, an involuntary treatment order can be issued if they might be in danger of damaging their reputation. That is stated in the explanatory memorandum in regards to one of the criteria. Damage to a person's reputation will not be a significant health or safety problem to the community; it obviously will not be. It may not be nice to damage a reputation, I understand that, but we do it all the time. These criteria say that if a person with mental illness damages their reputation, they can be subject to an involuntary treatment order. Being subjected to an involuntary treatment order per se is a damage to a person's reputation. If it is known to the community that a person has been subject to an involuntary treatment order, that in itself will be a damage to their reputation. I understand that there needs to be the ability to order involuntary treatment in regards to significant risks to the health and safety of the person or to the safety of another person. That is sufficient, and I should have gone with that in my amendment, but I did not. If there is a significant risk to the health and safety of the person or to the safety of another person, it surely is a significant risk of serious harm to that person or another person. Therefore, why do we need this catch-all category? Why could we not have just stayed with "a significant risk to the health or safety of the person or to the safety of another person"? I think no-one would disagree that if a person has a mental illness and they are potentially a significant risk to the health and safety of themselves or another person, an involuntary treatment order should be instigated. Why do we need to add —

> (ii) a significant risk of serious harm to the person or to another person;

Can the minister please explain the difference between clauses 25(1)(b)(i) and 25(1)(b)(ii), and why they are both in the bill? I have asked the parliamentary secretary an important question.

Amendment put and negatived.

The ACTING SPEAKER (Ms L.L. Baker): I need to read a statement concerning clause 25 before we move on to the next amendment. Two members have indicated a wish to move amendments to clause 25 of the Mental Health Bill 2013. The parliamentary secretary wishes to delete lines 3 to 8 on page 23 and the member for Armadale wishes to add words immediately before the semicolon on line 8. Irrespective of the outcome of the parliamentary secretary's amendment, without action from the Chair the member for Armadale would be prevented from moving his amendment. To preserve the rights of both members as far as possible, it is my

intention to put a test vote on both of the amendments, assuming that both members are still intent on moving the amendments.

Dr A.D. Buti: Just to help, Madam Acting Speaker, because of the amendments the parliamentary secretary has flagged, I will not be moving my amendments.

Ms A.R. MITCHELL — by leave: I move —

> Page 23, lines 3 to 8—To delete the lines and substitute —
>
> (c) that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself;
>
> Page 23, lines 26 to 31—To delete the lines and substitute —
>
> (c) that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself;

The issue of unreasonable refusal initially came about because of a review into the legislation and it seemed reasonable. However, over recent months, a number of stakeholders have had an impact on us. The Royal Australian and New Zealand College of Psychiatrists, the Western Australia Association for Mental Health and the Mental Health Law Centre approached the government and indicated that these provisions could be quite difficult and unnecessary because it would be possible for a person who has the capacity to make a treatment decision to unreasonably refuse to have treatment, and that unreasonable refusal of treatment could then instigate an involuntary order. This amendment brings this clause back to just the person's capacity, which is why we strengthened the capacity tests earlier in the bill.

Amendments put and passed.

Clause, as amended, put and passed.

Clause 26: Referral for examination at authorised hospital or other place —

Dr A.D. BUTI: I seek a clarification from the parliamentary secretary. Clause 26(1) states —

> A medical practitioner or authorised mental health practitioner …
>
> (a) the person is in need of an involuntary treatment order; or
>
> (b) if the person is under a community treatment order — the person is in need of an inpatient treatment order.

I assume that "community treatment order" and "inpatient treatment order" refer only to mental health patients; is that right?

Ms A.R. MITCHELL: Yes.

Clause put and passed.

Clause 27 put and passed.

Clause 28: Detention to enable person to be taken to authorised hospital or other place —

Dr A.D. BUTI: The opposition has a couple of amendments to this clause. I move —

> Page 26, line 6 — To delete "or physical"

I find this clause interesting and am interested in the parliamentary secretary's explanation. Clause 28(1) refers to —

> … the person's mental or physical condition, the person needs to be detained to enable the person to be taken to the authorised hospital or other place.

The answer to my question asking for clarification about clause 26 was quite clear that the involuntary treatment order or inpatient treatment order was for mental health patients only. I wonder how "physical condition" comes into play in mental health. The clause is quite clear and states that it is the "person's mental or physical condition". It does not state "and"; it states "or". As the bill reads now, a person can be detained if their physical condition requires them to be detained. I hope that is an oversight, because if it is not an oversight, it is a very new reading of authorising detaining people with a mental illness.

Ms A.R. MITCHELL: Member, the word "physical" needs to be kept in the clause, so we will not support this amendment. For example, when someone self-harms, there is a physical issue that needs to be dealt with, or it could be an eating disorder that has —

Dr A.D. Buti: The self-harming is due to the mental illness.

Ms A.R. MITCHELL: But the physical aspect needs to be considered as well.

Dr A.D. BUTI: The problem with the example the parliamentary secretary used is that the mental condition of the patient who self-harms would be sufficient to detain them. Including the words "physical condition" opens up other areas. A person may have a mental illness but not to the degree that requires detention. The treating psychiatrist might like to detain the patient and if the patient has a physical condition, under the plain reading of the legislation—we can only go by the plain reading of the legislation—if the matter came to court, the court would allow a mental health patient to be detained if it was believed that the patient's physical condition required them to be hospitalised. That is absurd. A person who self-harms has a mental illness. People are detained not because they have cut their wrist, but because of the mental illness that is causing them to do that.

It is very disappointing that the parliamentary secretary will not agree to the amendment because—let me make it clear and put it on the record—the plain reading of this clause means that if a medical practitioner is treating a mental health patient who has a physical condition, he or she can be hospitalised for that physical condition. That is absurd when the mental part of that criterion would be sufficient to detain them. This is a Mental Health Bill, not a mental and physical health bill. It is absurd that physical condition should be included, especially given the example the parliamentary secretary gave—that is, they are self-harming because of their mental condition.

Ms A.R. MITCHELL: This clause should not be read in isolation; it should be read in conjunction with other clauses. I refer to clause 25 and the referral process in clause 26. It is a combination of these together, not one in isolation. The bottom line is that there is a mental illness. A person may choose not to speak or do all sorts of other things. If they have reached a serious point in their physical condition, people who have a mental illness do different things. This clause provides an opportunity to protect and help people, which we believe is necessary for this legislation.

Dr A.D. BUTI: Exactly. It should be read in conjunction with other clauses; that is why this clause is nonsensical. Clause 26 refers to involuntary treatment order et cetera for a mental health patient. It is the mental health that is the trigger for the detention. There is no need to have the physical condition. Its inclusion is simply broadening the criteria. It is an absurd clause for the parliamentary secretary to continue to argue for. It is mental health that triggers a person's treatment under this bill, not their physical condition.

Ms A.R. MITCHELL: This is about referring a patient, rather than detaining. It is the referring, and then those other things come in as well.

Dr A.D. BUTI: "To enable the person to be taken to the authorised hospital or other place" is detention, not referral. They are actually being taken somewhere. As the parliamentary secretary said, it has to be read in conjunction with other clauses of the bill. The plain reading of this clause is that the person could be detained. It has even got the word "detained" in the paragraph. It states "the person needs to be detained to enable the person to be taken to the authorised hospital or other place". I would imagine the plain reading of "detained" means that a person is detained. "Detained" means detained. Under the reading of this clause, they can be detained because of their physical condition, even though we are dealing with mental illness. May I add that a person can be detained "under orders made under this section for a continuous period of more than 72 hours"? The more I think about it, it is absurd that the parliamentary secretary is remaining stubborn about the opposition's very reasonable amendment to remove the word "physical". The plain reading of this clause is that someone who has a mental illness, who has a physical condition, can be detained for up to 72 hours. That is absurd! Why will the parliamentary secretary not remove "physical condition"? This is about mental illness—not about physical condition.

[Quorum formed.]

Dr A.D. BUTI: I have got to go back to this clause, because I do not understand why the government would be so stubborn and so not open to a reasonable suggestion. All the opposition is seeking is to delete the words "or physical". As it currently stands, it is clear under clause 28(1) that a medical practitioner can order someone with a physical condition to be detained. This is a mental health bill. Mental health is what it is all about. That paragraph refers to the person's mental condition. There is no problem there. It is obvious. We are talking about mental illness. "Mental condition" is appropriate. "Physical condition" does not need to be included because the plain reading of this clause is reference to the person's mental or physical condition. It is not mental and physical condition; it is mental or physical condition. It means that someone who has a mental illness can be discriminated to the extent that they can be detained, and under subclause (3), for up to 72 hours if they have a physical condition. That is absurd. We are talking about mental illness. There are already enough clauses in this bill to take away a person's freedom and liberty, and another possible criterion is being added of "physical condition". The parliamentary secretary has not been able to show me an example in which just having "mental condition" would not suffice. She raised the example of self-harm. People self-harm because they have a mental

condition. The mental condition is enough. It will trigger the use of that clause. Will the parliamentary secretary tell me where someone's physical condition, not their mental condition, will necessitate them to be detained for up to 72 hours for treatment? If the parliamentary secretary cannot, she should agree to our amendment.

Ms A.R. MITCHELL: The two conditions are required. Let us come back to the diagnosis of a mental illness. If a GP suspects that someone is in need of assessment, that person is referred to a psychiatrist for that assessment. While that assessment takes place, they may need to be held for different reasons. After that assessment, the person may be free to go. It does not necessarily mean that they will automatically become an involuntary patient. We are talking about a referral process, which means that during the time the person is at an authorised hospital with the person who carries out the assessment, they may be kept there for their safety.

Dr A.D. BUTI: The parliamentary secretary still has not answered my question. In her response, she spoke about a person's mental illness. That is what we are talking about—a person's mental condition. That is the trigger or the criteria for which that person can be detained. They can be detained for up to 72 hours—three days. Why would the parliamentary secretary allow someone to be detained because of their physical condition? They may have a mental illness but a plain reading of this clause suggests that a person could have a mental problem at that time that does not require them to be detained but because they have a physical condition that might require hospital treatment, they can be detained for up to 72 hours. The parliamentary secretary may say that they could refuse treatment for a physical condition because of a mental problem. They should be detained because of a mental condition not because of a physical condition. They should be detained because they will not accept treatment. Their mental illness should be the trigger under this bill, not their physical condition.

The way the clause is written, a person can be detained because of their mental or physical condition, not their mental and physical condition. A person does not have to satisfy a current mental condition to be detained for up to 72 hours; they just have to show that they have a mental illness that may not require treatment at that time but because they have a physical condition that may require treatment, they can be detained for up to 72 hours. The parliamentary secretary's self-harm example, which is the only example she has been able to utilise—I have invited her to provide me with other examples, which she has not been able to do—is the result of a mental condition. One self-harms because of a mental problem. That is sufficient to detain a person. They should not be detained because of a physical problem.

Ms A.R. MITCHELL: I gave other examples of physical problems that could determine whether a person is detained. I say again that this is done in context. If a GP refers someone for an assessment, sometimes the capacity to assess their mental illness has not occurred either, so that process has to be gone through before someone can be detained. We have that to consider as well. It is hard to come up with examples but if someone arrives at a GP's clinic and they have done themselves some serious harm, whether it is a case of not eating or something else, they may choose not to speak. They have not been assessed as to their capacity. We cannot assume that mental illness is the cause of their problems—it is associated—otherwise they will be victimised. They have to be assessed. If the person has not been receiving treatment, the most obvious sign may be physical; therefore, we cannot rule it out.

Mr W.J. JOHNSTON: I want to clarify the parliamentary secretary's answer. Would it not be easier to just refer to the mental state? Is the parliamentary secretary saying that the physical characteristics of a person—she gave the example of someone not eating—are symptoms of the underlying mental problem? If the practitioner did not have a view that there was a mental problem, they would not be able to use the Mental Health Act to take action because there is no belief that there is a problem with that person's mental health. There has to be a connection. Instead of using the word "or", why does the clause not have the words "mental health" or "mental health and physical health"? If we use the word "or", the Mental Health Act will be used when it does not apply. I suggest that the parliamentary secretary go back and read the objectives of the act, which she and I had a conversation about the other day. The act is solely focused on mental health. How can we use an act for a matter that is not covered by its purpose? It does not seem to work.

If the parliamentary secretary is saying that a person turns up and looks like they are not eating properly and it is determined that that is the symptom of a potential mental health problem, there still has to be a potential mental health problem, otherwise the Mental Health Act does not apply in the first place. When the doctor gets sued, he will not be able to use the Mental Health Act to protect himself because there is no connection to the Mental Health Act. The parliamentary secretary needs to go back and look at the purpose of the act. It does not seem to help anybody to have the provision written in the way that it is written, unless the parliamentary secretary can explain how a doctor does not believe someone has a mental health problem but believes they have a serious physical problem. I do not see how that could then possibly found the action because this act is solely related to mental health problems. If there is not a mental health problem, the act itself does not apply and we go back to the purpose of the bill. I ask the parliamentary secretary to give a circumstance in which a physical symptom was seen and how that physical symptom, which was not evidence of a mental health issue, could be used to found

action under an act that is solely related to mental health. If she can, I think the member for Armadale might be assisted.

Ms A.R. MITCHELL: We are all saying the same thing. Sometimes the mental illness becomes evident by physical conditions.

Dr A.D. Buti: That is the criteria.

Ms A.R. MITCHELL: We are talking about a referral. Referring a person sometimes means that people are held. We are talking about an examination by a psychiatrist. At that time mental illness may not be obvious. The physical condition of someone with severe depression, for example, might be related to weight loss, which is the first trigger point.

Mr W.J. Johnston: That's a symptom, isn't it? It's not the illness; it's the symptom.

Ms A.R. MITCHELL: We are only talking about the referral to be examined. That is the difference. We have that time in between the person being referred and the examination.

Mr W.J. JOHNSTON: I thank the parliamentary secretary for that response. It was very interesting, but, unfortunately, it did not relate to the question I asked. I would appreciate it if she could go back to the point I am making. If she is saying that the physical characteristics are obvious when the patient comes in and they are symptoms of a potential mental illness, I understand that, but then we do not need the word "or". She is saying that these are the symptoms of the potential mental health illness. If someone is seeking treatment for their symptoms, which are physical characteristics, not a mental illness, this legislation does not apply. The treating physician will not have access to these provisions because the legislation itself cannot be used. The powers under this bill can be used only within the scope of the bill, and the scope of the bill is mental illness.

Let us get back to the question that I am asking rather than the question the parliamentary secretary answered. Can the parliamentary secretary explain how a medical practitioner will have access to the referral and detention et cetera under this provision for a physical illness when the doctor does not suspect a mental health illness?

If there is no mental health illness, they do not have the power to use this provision. They have the power only if there is a mental health illness. Does the parliamentary secretary understand the point I am making? They can access the power that we are talking about only if they meet all the rules for the coverage of this provision. If I go to a doctor with a broken arm, and that is my symptom, the doctor cannot detain me for 72 hours, because he does not have a suspicion that I have a mental illness, and, without a mental illness, the powers under this bill do not apply. I therefore do not understand how the word "or" is of benefit, because there needs to be a connection back to mental illness. The parliamentary secretary needs to explain how a person without a mental illness is covered by this provision of the bill. If I went to a doctor's surgery with significant weight loss, and the doctor did not think that was a symptom of an underlying mental health problem, the doctor would not have the power to refer me under this provision for an assessment, because there is no connection to the powers that are contained in the bill. Therefore, unless we can overcome that difficulty, we will keep going around in circles. To assist in dealing with what has been raised by the member for Armadale, the parliamentary secretary needs to explain how this power can be exercised in the absence of a preliminary diagnosis, or whatever we want to call it, of mental illness. I do not see how this power can be used for anybody, other than in the context of the provisions contained in the bill.

Ms A.R. MITCHELL: I am sorry the member was not here during some of the earlier discussion about other clauses of the bill, because they should be read in conjunction with each other.

Mr W.J. Johnston: That is right. That is exactly what I am saying.

Ms A.R. MITCHELL: Thank you, member. I am trying to finish my response. When a person presents to a general practitioner, there is no assessment of their mental health condition at that stage. That is done by a psychiatrist. But if there is reason to think that there may be a mental health condition, the person's physical condition can be used for the referral for the examination to determine mental capacity.

Mr W.J. JOHNSTON: The parliamentary secretary has said that a referral can take place only if there is a suspicion of a mental illness. That is exactly the point that the member for Armadale and I are making. I agree with the parliamentary secretary that we need to read the whole bill; of course we do. I appreciate the briefing that I received from the member for Armadale and Hon Stephen Dawson, and I have read through not the whole bill but many parts of the bill, and I have concerns about a number of issues, some of which I raised the other day. I missed the debate on clause 10, unfortunately, because I had other issues to deal with. But let us get back to the point. The parliamentary secretary has said that if the medical practitioner suspects that the physical characteristics of the person are a symptom of an underlying mental health issue, the medical practitioner can take action. I agree with that, of course, because that is what this bill is about. It was not us who said that a referral can be made based solely on the physical presentation. We should use terminology that makes it clear

what the bill actually says. It is not about physical characteristics. It is about suspicion of an underlying mental health issue. As I have said on many occasions, we should say only what we mean. We should not use words that we do not mean. If we do not need a power, we should not give it to ourselves. We should give ourselves only the powers that we need to exercise. I think that is what the member for Armadale has tried to focus on, and that is what I have tried to explain. We need to get back to the fact that there needs to be a mental health issue.

Dr G.G. JACOBS: I hope I do not confuse this issue even more, but obviously there is some concern around whether this clause deals with a mental or a physical condition. From my experience as a medical practitioner for over 25 years, there are some conditions that present to a doctor that are physical and that have not evolved into a mental health condition. There may be situational crisis or an impulsive behaviour that leads to a physical condition such as slashing the wrist and severing an artery. When that patient presents to a doctor, obviously the immediate and most life-threatening consideration is the severed artery. It is possible that there may also be a mental health condition. However, it is very likely that in the early phases that will not be identified. The most important consideration is to deal with the physical problem that is threatening the life of that person—the bleeding blood vessel—rather than detaining the person. "Detaining" is an awful word, I know, but it enables the person's mental condition in and around and behind that event to be assessed. It is not about classifying a person who has a physical condition and detaining that person for 72 hours when they do not have a diagnosed mental illness. However, it is paramount—because it is life-saving—that the person be detained for their own wellbeing because of the physical state that they are in. People might say that if a person slashes their wrist, there must be something wrong with that person—they must have a mental condition. I can say as a medical practitioner that a person may experience a situational crisis during which, for a split second, they become impulsive and inflict physical harm on themselves. If the person presents to a medical practitioner, the primary concern is, obviously, the bleeding artery that needs to be attended to in order to save the person's life, and all the argy-bargy—excuse the expression—about does the person have a mental condition, and is it a recognised or diagnosable mental condition, will need to be answered and will be answered. However, that will occur in only some cases, not a lot of cases. I concede that perhaps we have been struggling with giving members a lot of scenarios of different physical conditions. This is not about putting people away for a physical condition that should not come under this Mental Health Bill. The primary concern is the physical state that the person is in and trying to save that person's life, and although there may be an evolving mental health condition, the medical practitioner does not have the luxury of trying to discern whether the primary diagnosis is an episode of schizophrenia for the first time, or a situational crisis or impulsive behaviour that has caused the person to be in that physical state. As I have said, there are not a lot of cases. But it should be in the bill. It is not about locking people up and throwing away the key.

Dr A.D. BUTI: I thank the member for Eyre for his further contribution. The fact, though, is he is saying that someone needs to be treated for their physical condition. If they need treatment for their physical condition, let them be treated but do not wrap it up in the Mental Health Bill. If they need emergency treatment, let them have emergency treatment, but do not wrap it up in the Mental Health Bill. I refer again to clause 28 as it is written. The phrase "physical condition" could lead to detention after 72 hours just because a person is classified as a mental health patient. The legal world is full of cases with absurd outcomes because of the way legislation has been written. I hope it is not the intention of the minister to include "physical condition" as a power to detain someone for up to 72 hours. It may not be the intention but it could happen. Unfortunately, the legal world is awash with a litany of absurd injustices due to the way legislation has been written. This can quite easily be avoided by agreeing to the amendment that I have moved.

The rationale for moving that amendment is, using the words articulated by both the member for Cannington and me, basically this is a bill about mental health and mental illness; it is not about physical conditions. A physical condition can be treated in any case. This Mental Health Bill provides the state, through its various agents, with incredible powers under which a certain subsection of our community could be caught. We should do everything possible, as the objects of the bill seek to do, to confine the power of the state over those with a mental illness who are a risk to their own safety or to the safety of the public. Unfortunately, the bill contains wider criteria.

The amendment I have moved is very simple. It is not tricky. It is not sneaky. We think we have provided rational advocacy on the reasons for the amendment. We do not believe the parliamentary secretary has provided any coherent defence of the need for "physical condition" to be included in the clause. The member for Eyre, of course, has far superior medical knowledge than anyone present in this chamber at the moment. The Deputy Premier is not in the chamber and I do not know whether the member for Eyre has greater medical expertise, but the member for Eyre's examples relate to physical conditions. A physical condition does not need to be locked in with a mental illness in the clause, but the words "or physical" will do that. That clause alone will give the great Liberal Party in this state, which claims the virtues of liberty, freedom and smaller government, increasing power. Is it not ironical that the Labor Party, which the other side always accuses of being for big government and for interfering in the lives of people, is seeking to minimise that power? We are trying to do that in a sensible

way without being political about it and by proposing an amendment that we believe is necessary for the bill to achieve its objects. Those objects are to minimise interference in people's freedoms and liberties, which we are told are the virtues of the Liberal Party.

Dr G.G. JACOBS: Forgive me, parliamentary secretary. I do not want to confuse the issue and I hope to provide some clarity. The member for Armadale says that people with a physical condition should have whatever is needed to treat their physical state. That is fine. However, let us take the practical example of the young person who presents at an emergency centre with the impulsive scenario I previously sketched of the potentially life-threatening physical state of a severed radial artery in the wrist. The member for Armadale says, "Just treat it." The concern for practitioners is knowing that the physical state threatens the life of that person but that the person does not allow a treatment procedure to take place. They cannot let the patient leave the hospital. However, they may say that she or he has a mental illness, but the primary concern is the physical state that needs treatment to save a life. It needs attention, if you like, but they cannot let him or her walk out of the hospital. They need to fix it. However, the person might still be in an agitated state because of some situational crisis. We see situational crises in emergency departments every day that trigger people to either seek treatment or be brought in for treatment. They may not necessarily have a prescribed diagnosed mental condition but they need treatment for that physical state and it has to be done because it is lifesaving. The member might say that "mental condition" covers all that because someone must be wrong in the head if they have severed their artery and do not want a practitioner to fix it. The member might say that they are disturbed and in a situational crisis in their life. The member might say that "mental condition" covers all that. It is very likely that such a condition could evolve and become evident in the ensuing days. On further assessment the practitioner might find the initial presentation of some truly prescribed acute mental illness. It might be a part of the phenomenon of an anxiety depression, or whatever, brought on by the situational crisis. Practitioners often talk about people who present there and then in their life and, really, in some cases their physical state needs to be attended to and is yet to be defined as a mental condition.

Dr A.D. BUTI: I hope the parliamentary secretary will excuse me for this exchange but it is important. In the situational example articulated by the member for Eyre, the person might have said that they had severed their wrist but could have a mental condition and would not allow the doctor to operate. If the person has slashed their wrist but does not have a mental illness, can the doctor operate on the person? I do not know. I am asking the member for Eyre to help me clarify my arguments.

Dr G.G. Jacobs: There have been cases, for instance, in which the patient is brought into the hospital comatose and there is some obvious bleeding. There is an ability—the member would know this—under some good Samaritan clause, if you like, for me to do something because I need to.

Dr A.D. BUTI: That is right—exactly. That is my point, member for Eyre. That can be done under the current law, as far as I know. Some clarification may be needed there. If that is the case, which I am sure it is, we do not need this clause in the bill because, as in the example that the member articulated, the power already exists under current laws. What the government is doing here is creating a situation because the person is a mental health patient. That is the point. This clause is saying that we can detain someone only because of their physical condition. That is what we are saying in that clause. It is all right for the parliamentary secretary to say that we need to read the bill as a whole—of course we do—but we can also read clause 28 for what it seeks to do. It refers to detention to enable a person to be taken to an authorised hospital or other place. The criterion for that is a person's mental or physical condition. As the member for Cannington articulated, to come under the purview or jurisdiction of this bill, a person must have a mental illness; otherwise, they do not come under the provisions of this bill. There is a possibility in what we may or may not be saying in this clause. We are saying that clause 28(1) applies to someone who has a mental illness and a medical practitioner believes that they should be detained for up to 72 hours because of a mental condition or a physical condition—not a mental and physical condition; a mental or physical condition. If we look at clause 28 in isolation, which really goes to how I think the member articulated it—I am sure he did not mean to articulate it in the way that I will repeat it to him—a person can therefore be detained for up to 72 hours because of a physical condition. As the member said, they may have a mental illness, but they may not. Under clause 28, they, therefore, could be detained, not because they have a mental illness, but because they have a physical condition. That is absurd. If the Liberal Party went to its members and said, "We are proposing legislation that will allow you to be detained for up to 72 hours just because you have a physical condition and you don't have a mental condition", that would be absurd. I do not think that is a correct reading of that clause, but it could be under the member's articulation or interpretation of it. However, if the interpretation or the articulation is that the person has to have a mental illness to come under the jurisdiction, and once they have that mental illness section 28(1) applies if they have a mental condition or a physical condition, that is absurd. Surely this is about mental illness, not about physical illness. As the member said, he believes that the common law, and maybe statutory law, allows surgery or medical treatment as a life-

saving measure. Therefore, why do we need this physical condition? It is an encroachment of the state more than is necessary.

Division

Amendment put and a division taken, the Acting Speaker (Ms J.M. Freeman) casting her vote with the ayes, with the following result —

Ayes (18)

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

Noes (30)

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

Pairs

Mr M.P. Murray	Mr T.R. Buswell
Mr P. Papalia	Ms W.M. Duncan
Mr J.R. Quigley	Mr G.M. Castrilli

Amendment thus negatived.

Ms A.R. MITCHELL: I move —

Page 26, lines 17 and 18 — To delete the lines and substitute —

(3) The person cannot be detained under orders made under this section for a continuous period of more than —

(a) if the place where the referral is made is in a metropolitan area — 72 hours; or

(b) if the place where the referral is made is outside a metropolitan area — 144 hours.

I will explain why I have moved that amendment. We need to recognise the size of Western Australia as a state geographically. Obviously, in a place outside a metropolitan area, it may not always be easy to access the people who are able to conduct those examinations—the psychiatrists—in the same time that it would take in a metropolitan area.

Dr A.D. BUTI: I just seek clarification from the parliamentary secretary, because, as she knows, I have some amendments on the notice paper that probably mean the same thing. Is a person's psychiatrist the same as the current treating psychiatrist?

Ms A.R. Mitchell: No; that is further on.

Amendment put and passed.

Ms A.R. MITCHELL: I move —

Page 27, line 13 — To delete "the person" and substitute —

the person, the person's psychiatrist

This amendment is actually in response to an amendment that the member for Armadale had put on the notice paper. The advice from parliamentary counsel was a recommendation to put it into the legislation. As such, even though they will be referred to in further amendments as a result of an initial thought of the opposition, we have agreed with that amendment but adjusted the wording so that it was most appropriate.

Dr A.D. BUTI: Does that mean the same as "current treating psychiatrist"?

Ms A.R. Mitchell: Yes.

Amendment put and passed.

Dr A.D. BUTI: I will not move my next amendment as a result of the parliamentary secretary's amendment being passed.

Clause, as amended, put and passed.

Clauses 29 to 31 put and passed.

Clause 32: Application of this Subdivision —

Dr A.D. BUTI: I seek some clarification more than anything. This subdivision applies in relation to a voluntary patient who is admitted by an authorised hospital. That is quite easy to understand, but what about a person who has been made a voluntary inpatient due to an error or oversight? A person might volunteer for something for which they did not mean to volunteer. Will that still be covered? If an error was made in the admission of a person as a voluntary inpatient, does this subdivision continue to apply?

Ms A.R. MITCHELL: It is my understanding that, however a person has become an involuntary patient, it would apply. Whether a person is a voluntary or an involuntary patient, it applies.

Clause put and passed.

Clause 33 put and passed.

Clause 34: Person in charge of ward may order assessment —

Ms A.R. MITCHELL: I move —

> Page 32, line 7 — To delete "inpatient" and substitute —
>
> inpatient, the inpatient's psychiatrist

This amendment is in line with the amendments we made earlier.

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 35 to 40 put and passed.

Clause 41: Form of referral —

Dr A.D. BUTI: This clause prescribes what information is required in a referral. Paragraph (d) on page 36 states —

> in respect of so much of that information as was obtained during the assessment by the practitioner making the referral, distinguish between —
>
> (i) the information obtained from the person …
>
> (ii) the information obtained from another person or from the person's medical record;

There are a couple of things here. Would it not also be prudent and advantageous to include a requirement for comments and information to be received from the patient's choice of current treating practitioner? Unless I am reading that clause wrong, it does not appear that that is included. If not, why would we not include comments and information from the patient's choice of current treating practitioner?

Ms A.R. MITCHELL: My understanding is that that can be considered under paragraph (d)(ii). Information obtained from another person would fit that requirement.

Dr A.D. BUTI: I suppose that is true on a literal reading of the clause, but it would perhaps be more advantageous to include reference to the current treating practitioner; however, I take the parliamentary secretary's statement on that.

Clause put and passed.

Clause 42: Providing information contained in referral to person referred —

Dr A.D. BUTI: I have an amendment to clause 42 that I will move shortly. This clause deals with the issue of providing information contained in a referral to a person referred to. I have some concerns about clause 42(2), which states —

> The practitioner cannot provide the person who is referred any information referred to in section 41(c) that was provided to the practitioner by someone other than the person on condition that the information not be provided to the person.

I understand the issue of confidentiality and that the information may not be provided if people are worried that their names will be disclosed, but surely it is open to abuse if information can be obtained from other people

whose names will not be disclosed—I understand the reasons for it, but it is open to abuse. One way to get around that would be to restrict the other people—the third parties. Would it not be better if that information could be provided only by third parties who are in a personal relationship with the patient? As we all know, there is unfortunately a litany of examples of people engaging in false allegations and dissemination of false information to discredit someone. Am I being unrealistic to expect that there may be a case of a work colleague who seeks to damage the reputation of a person by providing certain information? Am I being unrealistic to say that a neighbour might provide information that could be damaging? I do not think I am being unrealistic. I understand the need for confidentiality and for names not to be disclosed, but should we not also as a safeguard restrict who those third parties can be? Surely they should be people involved in a personal relationship with the patient. They, of course, may also be involved in scuttlebutt and false allegations, but hopefully it would be restricted, and it, surely, on face value would not be open to the same opportunities of abuse as the acceptance of third party information from anyone who can remain anonymous. I have a major concern that because of the way the provision reads at the moment, we are allowing third party information to be provided confidentially that could have enormous consequences for the patient. I go back to the objects of the bill, which are to minimise interference with the rights and freedoms of the patient. If we are going to do that, why not restrict which third party information is allowed? I will wait for the parliamentary secretary's response before I move my amendment.

Ms A.R. MITCHELL: The member has covered a couple of areas and I will move around them a bit. If the member is referring to a situation that could potentially be perceived as malicious, I am sure he is aware it is an offence pursuant to the Criminal Code to procure apprehension or detention of a person not suffering from a mental illness or to unlawfully detain a person who is not mentally ill. The other side of that is that the Chief Mental Health Advocate has specific information set out in clause 358 and the regulations associated with that role are quite clear. Also, a patient can always seek access to his medical records if they are not available —

Dr A.D. Buti: They are not easily available; they remain the property of the medical practitioner—the Breen v Williams High Court decision tells us that—they are not the patient's records.

Ms A.R. MITCHELL: It is my understanding that the patient can seek to obtain those records and that can be done through the doctor, and I suppose through a legal practitioner if required.

Dr A.D. BUTI: In regards to obtaining medical records, there may be legislation that overrides Breen v Williams. There are two medical practitioners in the house who may be able to correct me, but quite clearly the common law position is that the medical practitioner has the property of those records for the good reason that they will not be inhibited in what they write in those records. That way the doctor need not be concerned that the patient may read those records and there will be something in them that they do not want the patient to read. In regards to that, I do not think it is much of a safeguard.

The parliamentary secretary mentioned the Chief Mental Health Advocate, which is quite interesting because it goes to our amendment that I will talk about shortly. The parliamentary secretary talks about criminal conviction et cetera, but that is ex post facto. Surely, here we are trying to ensure that something wrong does not happen. There is not much joy for a person subjected to something under this Mental Health Bill, which may involve incarceration or detainment, sometimes for good reason, but sometimes as a result of information provided by a third party who seeks to damage that person. If a narrowing of the parties who can provide that third party information is not agreed to, that third party information can be provided on a confidential basis. I worked for a number of years in the academic world and I can say that many academics have engaged in false allegations against colleagues. There have been some horrendous allegations. If members think politics is hard, it ain't nothing! Go to the academic world to see what that is like. There are many false allegations made in the academic world, but there is generally a right to know who has made those allegations. In this case, these allegations can be made by anyone. I may think someone in my electorate will be my Liberal opponent in three years' time. What is one way I can damage them? I can make confidential allegations that could lead to them being classified as a mentally ill patient. That would not be good for their potential future career as a politician.

Can the parliamentary secretary not see the potential for damage in this case? It can easily be rectified by reducing the types of people who can provide third party information. The issue of criminal conviction is ex post facto; it is too late. The issue of having access to medical records is problematic because of the question of who has ownership of them. The parliamentary secretary mentioned the Chief Mental Health Advocate, so it is an opportune time for me to move our amendment to clause 42. I move —

Page 36, after line 21 — To insert —

(2A) Any information provided to the practitioner under subsection (2) must be notified to the Chief Mental Health Advocate.

As the parliamentary secretary mentioned the Chief Mental Health Advocate, surely she would agree with such an amendment.

Ms A.R. MITCHELL: The reason we have not specifically included the Chief Mental Health Advocate is that they have access to all the records anyway. They will receive that information, but we did not believe it was necessary that they be included initially.

Dr A.D. BUTI: When the parliamentary secretary says that they have access to all the records, when in the time sequence do they actually have access to those records? We are talking here about providing information contained in a referral to a person referred. Are they provided with all information regarding referral to a person who has been referred? If so, when are they provided with that information? What is the time line?

Debate adjourned, pursuant to standing orders.