MENTAL HEALTH AMENDMENT BILL 2015

Receipt and First Reading

Bill received from the Council; and, on motion by **Ms A.R. Mitchell (Parliamentary Secretary)**, read a first time.

Explanatory memorandum presented by the parliamentary secretary.

Second Reading

MS A.R. MITCHELL (Kingsley — Parliamentary Secretary) [10.59 pm]: I move —

That the bill be now read a second time.

Members will likely recall the extensive debate that was undertaken in this place last year in relation to the Mental Health Bill 2013. The Mental Health Act 2014 was proclaimed on 10 November and will commence on 30 November 2015.

The development of the Mental Health Bill was underpinned by years of genuine consultation with stakeholders. Countless amendments were made to various draft bills based on input from consumers, families, carers, advocacy groups and the general public. However, some matters raised were simply not in the scope of the bill. The role of mental health legislation in Western Australia, and every other Australian jurisdiction, is not to create more beds, increase the number of clinicians or increase community-based services. Resourcing is an issue appropriately left for other mental health reform initiatives, including "The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025".

The reason I am emphasising this is that the substantive amendment in the Mental Health Amendment Bill 2015 presents an opportunity for improvement in this area. It can ensure that the number of psychiatrists in the state is not unnecessarily limited. The amendment bill includes several other minor amendments to the act that I will detail shortly. The substantive amendment to the act, clause 4, would be to section 4 of the act—the definition of "psychiatrist".

The cornerstone of the act is the power to make an involuntary treatment order with respect to a person experiencing mental illness who meets certain criteria. An involuntary treatment order allows a person to be treated without consent, and potentially detained in hospital. This is undeniably coercive. However, it is often a necessity. Competing imperatives arise here, and there is need for a considered balance. This is reflected in the strict criteria for the making of an involuntary treatment order, and the robust corresponding safeguards in the act. An involuntary treatment order can be made only by a psychiatrist. A medical practitioner should have the power to make an involuntary treatment order only if they are qualified and competent in the area of psychiatry.

There is also a strong imperative not to unnecessarily reduce the number of psychiatrists who can perform functions under the act. The number of psychiatrists has a direct impact on the accessibility, timeliness, and quality of treatment and care received by people experiencing mental illness. This leads me to the issue that the amendment bill seeks to address. It has recently come to my attention that following the introduction of the Mental Health Bill 2013, the Medical Board of Australia amended a policy that will impact on the operation of the act. The effect of the policy change is that medical practitioners who would previously have been within the definition of psychiatrist will no longer fall within scope and there will effectively be fewer psychiatrists in the state who are able to administer the act. Ironically, this policy change has the greatest implications for medical practitioners from places with some of the best training in the world, including New Zealand, Ireland, Canada, the United States and the United Kingdom.

Following consultation with the Chief Psychiatrist, the Department of Health, the Medical Board of Australia, and the Australian Health Practitioner Regulation Agency, I am confident that an amendment to the act is needed to promote access to mental health treatment, care and support throughout Western Australia. The amendment bill refers to category (b) being persons prescribed by the regulations. The "Mental Health Regulations 2015" are currently being prepared by parliamentary counsel. It is intended that the relevant regulation will refer to a medical practitioner who has a specialist registration or limited registration in psychiatry under the Health Practitioner Regulation (National Law) WA Act 2010. These two categories are referred to in the section 4 definition of psychiatrist in the act. Further, the regulation will refer to individually named practitioners with their medical registration number. Although it is uncommon for legislation to name individuals, it is not unheard of. An example is the Evidence (Prescribed Persons) Regulations 2005, which lists 25 forensic scientists in Western Australia. I am confident that the proposed amendment will ensure that no competent psychiatrist falls through the gaps and is unable to practise based on the technicality of an outdated definition. I am equally satisfied that the amendment will not allow a medical practitioner to practise as a psychiatrist unless they are unequivocally qualified and competent. Ultimately, this will prevent people experiencing mental illness from falling through the gaps.

The national board is a statutory body empowered to change its policies. National boards are ever-evolving and relevant policies may change in the future. Therefore, I am proposing that the additional detail I have mentioned be prescribed in the regulations. We need to futureproof this act and we need to make sure it can adapt and conform as required, but with parliamentary scrutiny, via amendments to the regulations.

I would now like to speak to the practical need for this amendment. If the amendment is not made, clinical practice and service delivery in authorised hospitals and emergency departments will be jeopardised. It is expected that this will become even more of a constraint in the future. Medical workforce projections are that, despite an increasing number of medical graduates, there will be a requirement for uptake of psychiatrists who were formerly on the limited registration pathway, for several years to come. The greatest impact will be in outer metropolitan and regional areas. In these areas there is an increasing need to rely on medical practitioners who would formerly have been categorised as psychiatrists under the act. A shortage of psychiatrists in regional areas means diminished capacity to admit patients and provide timely, quality treatment and care. This has flow-on effects in the metropolitan area and can create backlogs in emergency departments.

The capacity to open 56 new authorised beds at the new St John of God Midland Public Hospital mental health unit later this month would be at risk. Because of the difficulties in recruiting psychiatrists to outer metropolitan and regional services, at least three of the psychiatrists will need to be recruited from overseas. They would not be authorised to make involuntary treatment orders, or to make certain other orders and decisions. To do so would be invalid and unlawful, exposing the doctor, the service, and the state to liability. There is the option for a psychiatrist to treat a person as a voluntary patient even though detention and involuntary treatment are required. The effect of this is the most tangible of all: people with acute mental illness will leave hospital or deteriorate in the community and harm themselves or potentially someone else.

The amendment bill proposes four further amendments to correct errors that have been brought to my attention since passage of the Mental Health Bill. Clause 5 relates to the requirement in the act for involuntary patients to have a treatment, support and discharge plan. The word “authorised” was inadvertently included before the word “hospital” in section 186. We need to ensure that there is no confusion, and that a treatment, support and discharge plan is prepared for involuntary inpatients in general hospitals, as well as in authorised hospitals. Clause 6 will remove the word “therapy” in section 420 of the act, which is a drafting error and is superfluous in context. Clause 7 will amend section 591 of the act. Subsection (3) refers to the Public Sector Management (Redeployment and Redundancy) Regulations 1994. These regulations were replaced by the Public Sector Management (Redeployment and Redundancy) Regulations 2014 following passage of the Mental Health Bill 2013. Clause 7 will update the reference. Clause 8 will correct a cross-reference in section 592, substituting reference to subsection (5) with reference to subsection (6).

I commend the bill to the house.

Debate adjourned, on motion by **Mr R.H. Cook**.

House adjourned at 11.07 pm